Royal College of Nursing Scotland

RCN Scotland response to the Scottish Government's consulation on

A National Care Service for Scotland

Introduction

The Royal College of Nursing (RCN) is the world's largest professional organisation and trade union for nursing staff, with members in the NHS, independent and third sectors. RCN Scotland promotes patient and nursing interests by campaigning on issues that affect members, shaping national health policies, representing members on practice and employment issues and development opportunities. With over 40,000 members in Scotland, the RCN is the voice of nursing. As a Royal College, we believe it is the right of everyone to receive high quality, safe care in all settings, and to be treated with dignity and respect.

The Scottish Government is proposing significant changes to the way in which health and care services are delivered in Scotland at a time when services are seeking to recover and remobilise after the Covid-19 pandemic.

Nursing staff have been at the forefront of tackling the COVID-19 pandemic and the past 17 months have highlighted the unique value of nursing as a safety critical profession like never before. The nursing contribution to social care must not be overlooked and the impact of these proposals on community nursing must be properly considered and adequately resourced.

RCN Scotland is concerned that with such a significant proposal, policy makers do not lose sight of other priorities. For any health and social care reforms to be effective, the Scottish Government must first address workforce pressures by implementing the Health and Care (Staffing) (Scotland) Act 2019 and deliver fair pay for nursing staff working in all settings.

The RCN expects that we and our members will be meaningfully engaged with the strategy and detail of any reform process. RCN members have a range and depth and diversity of experience and expertise to which they can bring to bear on the reforms that result from the proposals in this consultation. RCN Scotland members want to see health and social care services that work for the people using them.

RCN Scotland has not answered every question in the Scottish Government's consultation. Our responses reflect the priorities of our members.

Responses to questions

Q1. What would be the benefits of the National Care Service taking responsibility for improvement across community health and care services?

RCN Scotland members welcome the Scottish Government's aim to reduce unwarranted variation and to improve standards, access and transparency for people using social care services. Members are clear, however, that consistency must not be a barrier to innovation, and that where different ways of delivering services are appropriate due to, for example, rurality or local population needs, then these should be enabled in order to deliver the best outcomes

Q2. Are there any risks from the National Care Service taking responsibility for improvement across community health and care services?

The Care Inspectorate currently has responsibility for improvement in social care services. RCN Scotland members have asked that Scottish Government give careful consideration and assessment of available evidence before the decision is taken to de-link social care improvement from scrutiny and inspection, our members with experience in this area point out that scrutiny and assurance are improvement tools in themselves, and that varying in approaches to improvement will be appropriate in different circumstances and situations, of which Quality Improvement methodology is only one approach, with an evidence base in health, not social care services.

RCN Scotland members are concerned that the separation of regulation and improvement would lead to regulation focussed on compliance. Healthcare Improvement Scotland has responsibility for both improvement, and scrutiny and assurance of NHS healthcare services and states that their quality assurance "gives people confidence in the services and supports providers to improve."1

Further, the consultation document itself says that "we have yet to see the impact of large-scale evidence-based improvement work in the integrated world of health and social care." It also states that "we have not been able to consistently scale up good practice – partly due to lack of investment but also due to the many complexities of different professional governance and regulation structures, multi-agency working and the different cultures that underpin practice across the sectors."

RCN Scotland therefore suggests that any changes to improvement responsibilities, methodologies and structures must be evidence based and fully informed by people using services, people staffing and providing services, and people who currently scrutinise, inspect, and support services to improve. Improvement must be based on what works, not what is administratively convenient.

Q4. How can we better co-ordinate care and support?

Whatever model of care and support co-ordination is adopted, it must ensure a person-centred approach which includes co-ordination of health as well as social care needs. Those with lived experience who contributed to the Independent Review demonstrated that health and social care needs cannot be separated, and nursing is fundamental in helping to meet these needs.

Q5. How should support planning take place in the National Care Service?

Support planning must be multidisciplinary, including nursing assessment, where a person has complex needs or in cases where they are already receiving support from another agency, including for their healthcare needs – in which case support planning must involve each relevant agency.

Q6. 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?

Q7. 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?

Q8. Do you agree or disagree that a National Practice Model for adults would improve outcomes?

Questions 6, 7 and 8 are related, so we have answered them together.

It is important that if a National Practice model is developed, it recognises that health and social care needs cannot be separated, and nursing is fundamental in helping to meet these needs.

The development and implementation of any National Practice Model must recognise the nursing contribution in Adult Social Care. With a long-term trend of people using social care services having increasingly complex needs, including clinical needs, it is imperative that system reform takes this into account and nursing is at the forefront of the process. Registered nurses have the clinical knowledge and skills to assess and respond to individuals' changing needs, managing medication, monitoring deterioration, and overseeing infection control. They also provide leadership and oversight to support wider teams.

Q10. To what extent do you agree or disagree with the following statements?

• There should be a nationally consistent, integrated and accessible electronic social care and health record.

• Information about your health and care needs should be shared across the services that support you.

Improvements in data gathering and data sharing have the potential to have a really positive impact on the way that people experience health and social care services, and to enable the professionals providing those services to do so more effectively, efficiently and in a more person-centred way. Such improvements can also enable more joined up planning and commissioning at local and national level, including workforce planning.

Development of a nationally consistent, integrated and accessible electronic care record will be a highly complex undertaking and to be successful, will require significant investment. Robust data security must be absolutely guaranteed. Careful consideration must be given to the governance of such a record to ensure that the person is informed aware and consents to how it is being used, whether to support their own care or for research, policy, planning or other purposes.

RCN Scotland expects the Scottish Government to consult further about progressing plans to develop a national health and social care record.

Q11. 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?

RCN Scotland welcomes common data standards and definitions to support multidisciplinary and multi-agency working, and would expect thorough consultation on the detail of what those would be.

Q12. 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?

The content and submission requirements for data about patients and people who are using social care services should always balance minimising the entry requirements for providers, staff and people using services, while ensuring that relevant, meaningful data is available to optimise care quality at the individual level, and at the aggregate level to plan, commission and improve services. Those being asked to provide data should always be clear about the purpose of the requested information, and be able to understand the benefit of providing it.

Q15. 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?

Outcome measures should be subject to regular review to ensure continuing relevance. Ascertaining the experience of people receiving care and support, their families and carers and using it as a key outcome measure is consistent with a human rights based, person-centred approach to delivering services.

Q19. Do you agree that Scottish Ministers should be accountable for the delivery of social care, through a National Care Service?

The current way that adult social care operates in Scotland is not fit for purpose and needs radical overhaul. Whichever model is pursued by policy makers, the professional nursing potential and contribution requires to be fully understood and appreciated. There is still a tendency, not supported by people who use these services, to view health and social care separately. However, there is a long-term trend of increasing clinical acuity among people who use social care services, and quality health services also play an important role in preventing or delaying many social care needs. It is therefore key that both nursing leadership and practice is recognised as central to any thinking when developing new approaches to social care. This is vital for ensuring that those using services receive care that is high quality, safe and appropriate for their needs.

There is no clear evidence suggesting that one specific model of delivery and funding is inherently better than another; however, whichever model is used requires sufficient resourcing. Inadequate resourcing will lead any model to fail; we must learn this and further lessons from the current attempt to better integrate health and social care services. Our learning must include identification and retention of what is working well in the current integrated structures; good practice must not be lost amidst the proposed significant changes.

We do not take a view on the merits of creating a National Care Service. Our members have told us that they can see potential advantages as well as problems in this proposal.

Whichever model is pursued by policy makers, the professional nursing contribution and perspective must be understood and appreciated. There is still a tendency to view health and social care separately and it is important that policy makers ensure that nursing leadership is present at all stages when developing new approaches to social care, and to the structure of community health and social care services. There is a body of evidence to show that registered nursing is essential for delivering high quality, safe care to people in care homes.

RCN Scotland believe that whatever model is adopted needs to move towards a commissioning process which is based on outcomes, not costs, and which properly recognises the role of nursing in social care, ensuring that everyone using social care services has access to the nursing care they need.

Q20. Are there any other services or functions the National Care Service should be responsible for, in addition to those set out in the chapter?

Community Health services and social care as set out in the consultation have a significant role in addressing the health inequalities that beset Scotland. This role should be recognised in the development of any new structures and alignment ensured with Public Health Scotland and any other bodies with responsibility for reducing health inequalities.

Q21. Are there any services or functions listed in the chapter that the National Care Service should not be responsible for?

These proposals represent the most significant reforms to both community health and social care for decades and will have a significant impact beyond, including on the wider NHS.

The process of structural reform to community health and social care services has the potential to be disruptive. Structural reform must not be allowed to impede other urgent and necessary change in health and social care services, including implementation of the Health and Care (Staffing) (Scotland) Act 2019, to ensure effective care that is safe for both people using services and the staff providing them.

Q23. 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?

Transitions between children's and adult services are difficult and problematic for young people using services across health and social care. Whether locating children's services within the National Care Services along with adults' services will solve that problem is not something on which RCN Scotland can take a view yet; improvement would not necessarily follow, as we see with the issues there are in transitioning from children's to adults' services within the NHS. It is, however, imperative that focus and resource are applied to improving these transitions across health and social care.

Q26. 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?

RCN Scotland does not have a position on the creation of a National Care Service. We do, however, recognise and affirm the importance of community health care services, including the full, wide range of community nursing services in all sub sectors and specialities including adult, children, learning disabilities and mental health. RCN members perceive a risk that community health services will be seen as second order in a National Care Service focussed on social care, and in a National Health Service that is responsible for employing staff and delivering services but not for establishing strategy.

Whatever arrangements are put in place to plan, commission and deliver community health care services, RCN is clear that:

1. The importance of nursing and nursing roles in these services must be recognised and valued in the commissioning and definition of these services
2. The Scottish Government's policy ambition of supporting more people closer to home requires high quality, nursing provision to be available throughout community settings, which is why it is important to implement the Health and Care (Staffing) (Scotland) Act 2019 in community settings, including the development of further workforce tools, in particular for community mental health services.
3. Nurses in community services must be valued equally to their colleagues working in hospital-based services, including ensuring similar opportunities for professional development and career progression.
4. The interface between community health care services and hospital services must not be a barrier between these services, for patients or for staff. NHS delivered services and those commissioned by a National Care Service should share common aims, priorities and standards, and these must be translated into ways of working that enable alignment and integration between social care, community health services and hospital-based services.

Our members working in community nursing are short on staffing capacity while being asked to take on more and more, including expanded vaccination delivery, increased support for care homes, and the increased workload caused by emphasis on swifter hospital discharge and changes to unscheduled care access.

Sustained pressure from the RCN led to a Scottish Government commitment for a 12% increase in the district nursing workforce by 2024. This is what is required to deliver existing workloads, not cover extra demands.

RCN Scotland has been consistently calling for recognition of the critical role of community services within the whole health system, with resourcing to properly reflect this, particularly in light of increased demand.

Q27. 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?

RCN members working in all fields – social care, other community settings, and in hospitals – have expressed their concern that the creation of a National Care Service with the proposed responsibilities for community health and social care services will exacerbate issues which already exist at the interface of primary and secondary health care, and community based and hospital-based services.

Our members are concerned that this consultation is presented without detailed consideration and proposals about how these interface problems can be avoided or how it can be improved. More broadly, the consultation document does not describe a proposal for how a National Care Service would work with the NHS, beyond the commissioning of community health care services and the proposals and questions about the role of the Health Boards' Executive Nurse Directors. People using services and the staff delivering them will encounter barriers and disjointedness appearing despite the best intentions of all involved, if there is no clarity and duty for the National Care Service and the NHS to work together to develop strategy, commissioning plans, workforce plans and service pathways on a practical and strategic level, and locally and nationally. For example, commissioning for palliative care encompasses both hospital-based and community-based services, and services delivered by both the NHS and independent sector providers, including voluntary hospices. Joint commissioning arrangements are going to be necessary across these and other services to make sure that the right pathways, resources and professionals are in place to provide safe, effective, quality, person centred care.

Q29. What would be the risks of Community Health and Social Care Boards managing GPs' contractual arrangements?

GPs' contractual management arrangements must reflect the close interrelation that general practice has with other parts of the health and care system.

RCN Scotland is a member of the Primary Care Clinical Professions Group (PCCPG) which, between the organisations involved, represents over 60,000 clinicians across Scotland. The organisations within the PCCPG have worked together to produce collective priorities for remobilisation and redesign of health and care services in Scotland, stating that the COVID-19 outbreak has highlighted the pressing need for: more planning and consideration of community health and care in designing health structures and services; more efficient multidisciplinary working across primary care that recognises the contribution of each profession; and for IT systems that properly talk to each other.

Nursing is by far the biggest staff group within primary care. Around 20% of NHS Scotland's nursing workforce are based in community settings, with an additional estimated 2,300 nurses (headcount) working in general practice alone. The role the nursing workforce plays in sustaining 24/7 care within our communities and managing the flow into and out of secondary care and other primary care services should not be underestimated.

We seek clarity on these proposals and the relationship between this change and phase 2 of the GMS contract, in order to understand fully the implications, particularly in terms of responsibility and resources, for GP practice nurses and other practice-employed staff.

In the 'Nursing' section of this consultation, the Scottish Government recognises the need for clear care, professional and clinical governance for nurses working in social care. Clinical and professional governance must also be clear and effective for nurses working in other independent settings, including, in contracted general practice.

Proper clinical, care and professional governance is delivered through a complete professional infrastructure that provides clear, unambiguous and appropriate routes for escalation and decision making from every nursing practitioner through to the nurse on the Board. RCN Scotland expect to see this infrastructure put in place to support and protect nurses working in all specialisms and at all levels across our health and social care system.

Q31. What do you see as the main benefits in having social work planning, assessment, commissioning and accountability located within the National Care Service?

RCN Scotland would support the creation of structures and processes that enable a multidisciplinary approach to assessment. Support planning must be multidisciplinary, including nursing assessment, where a person has complex needs or in cases where they are already receiving support from another agency, including for their healthcare needs – in which case support planning must involve each relevant agency.

Q33. 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?

Q34. 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?

Q35. 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?

Questions 33, 34 and 35 are interrelated and their answers are dependent on each other, so we have answered them together.

A key component of supporting care home residents to age well, and to be independent and equal members of society, is managing clinical conditions effectively, at the same time as promptly responding to new symptoms. For many residents, their clinical needs will require the presence of a registered nurse 24/7. Registered nurses in care homes have a valuable role in being able to recognise and act when a person's condition is deteriorating. Their actions can enable greater and more timely clinical intervention within that homely setting and help to prevent avoidable hospital admissions for residents. It may also reduce the need for assessment by primary and community care teams.

With the acuity of care home residents increasing, the best way to ensure nursing input is to have the required skill mix, including Registered Nurses, employed directly by the care home provider, rather than relying on overstretched community nursing services which may not be available at the times that residents need them. Further, implementation of the Health and Care (Staffing) (Scotland) Act 2019, and commissioning and procurement which obliges and funds providers to be able to staff their services in accordance with this Act would be a significant step forward in ensuring that safe, effective care can be delivered to care home residents and community health services' patients.

RCN Scotland welcomes the Scottish Government's recognition of the need for clear care, professional and clinical governance for nurses working in social care. Clinical and professional governance must also be clear and effective for nurses working in other independent settings, including, for example, in contracted general practice, or in hospices.

Nursing will probably be the largest workforce, and nursing services the largest proportion of what the proposed Community Health and Social Care boards deliver. It is therefore imperative that the Boards include significant nursing expertise if they are to provide effective direction, oversight and governance. RCN Scotland also strongly believe that nursing expertise is crucial in the national and strategic leadership of the National Care Service, as well as within the Community Health and Social Care Boards.

This nursing leadership role in the proposed Community Health and Social Care Boards should have full board member status. The role should have standing and statutory footing commensurate with the Chief Social Work Officer as it currently stands.

This role would not, in RCN Scotland's view, need to be undertaken by the NHS Health Board Executive Nurse Director, but should be of the same standing and seniority as an NHS Health Board Executive Nurse Director.

Executive Nurse Directors, or their new equivalents within the National Care Service, must not face any ambiguity about their accountability, duties, authority, or escalation routes. The role parameters must be assessed to ensure that they are able to work within the Nursing and Midwifery Council Code2, and that new legislation is put in place to afford them necessary statutory protection. They must have the necessary authority within the areas of their accountability to take the measures they deem necessary to fulfil their accountable role.

Proper clinical, care and professional governance is not delivered through one leadership role, but by a complete professional infrastructure that provides clear, unambiguous and appropriate routes for escalation and decision making from every nursing practitioner through to the nurse on the Board. RCN Scotland expect to see this infrastructure put in place to support and protect nurses working in all specialisms and at all levels across our health and social care system.

This infrastructure must include the means to ensure consistency of access to education and professional development of social care nursing staff, standards of care and governance of nursing as proposed, and also for relevant professional groups within community health services. It will not be possible for Executive Nurse Directors, or their Community Health and Social Care Board equivalents, to discharge the leadership role proposed without this. Education and professional development must be specifically and properly resourced and the detail of implementation must address the question of how the National Care Service will ensure access to education and professional development for staff employed by contracted providers.

There must be absolute clarity in the legislation where responsibilities sit for overseeing and ensuring consistency of access to education and professional development of social care nursing staff, standards of care and governance of nursing. This clarity is important for not only for social care services as discussed in the consultation document, but also for the community health services which will be the responsibility of the National Care Service and its Community Health and Social Care Boards to commission and procure; while it is envisaged in this consultation that these services will continue to be delivered by the NHS commissioned by the Community Health and Social Care Boards, governance and accountability structures must be robust enough to accommodate changes in service models.

The scope of the role of Executive Nurse Directors, or their Community Health and Social Care Board equivalents, should be clearly defined. The distinction between the areas for which they will be responsible and accountable and those of other roles with statutory functions – for example, the Director of Public Health or the current Chief Social Work Officer - should be unambiguous and transparent.

It is important that the ultimate responsibility and accountability for nursing staffing, standards and governance is corporate – it is the Board, whether the NHS Board or the Community Health and Social Care Board, that must be accountable, rather than an Executive Nurse Director or any other individual Board or staff member.

Q43. Do you think that access to care and support in prisons should focus on an outcomes-based model as we propose for people in the community, while taking account of the complexities of providing support in prison?

Many people in prison come from our most deprived and disadvantaged communities, and have very poor health. They are often disengaged from mainstream health services before and after any prison term. A period of imprisonment therefore presents a unique opportunity to turn around their health outcomes and life chances.

An outcomes-based model will support rights based, person centre care, but it must be able to take into account and respond to the complex range of needs – not only health and social care needs - that many people in prison have.

Development of the model for care and support in prisons must take account of the complexity of how prisons are governed, recognising the role of the Scottish prison Service and the prison governor. Health and social care staff working in prisons are carrying out their role in a complex and highly specialised environment, and require detailed and supportive care, professional and clinical governance to enable them to operate effectively and safely.

Q51. What elements of mental health care should be delivered from within a National Care Service? (Tick all that apply)

Primary mental health services,

Child and Adolescent Mental Health Services,

Community mental health teams,

Crisis services,

Mental health officers

Mental health link workers

Other – please explain

The consultation chapter on mental health lacks detail, particularly given the wider policy focus of the Scottish Government on improving mental health service provision.

The consultation asks what mental health care the National Care Service should be responsible for but does not describe the current system for mental health services provision currently in place, meaning that only people who know the structures already in place will be able to respond. The implications of the creation of a National Care Service for mental health provision require greater thought and the people who use and deliver those services deserve a more detailed consideration of the current situation and the options available to improve access and outcomes. The examples given in the question are a mix of specialist and generalist mental health services; far more detailed work is required to ensure that mental health services are an integrated and valued part of whatever structures emerge from this consultation and that people of all ages who require mental health support and treatment can access that appropriately and timeously.

This question and the one below cannot therefore be answered without determining patient pathways that are both person-centred and transparent. The service model should be determined by the patient pathway and adequately resourced and staffed. This must include recognition of the unique professional contribution of each member of the multidisciplinary team, including mental health nursing. Service models must take into account the needs of all those requiring mental health treatment and support, including those with severe and enduring mental illness, for whom the current recovery focussed service model is not appropriate.

Mental health nursing vacancies have been rising over the past 5 years and over 660 posts (6.5%) are now unfilled3. The national standard is that 90% of people referred for psychological therapies should start treatment within 18 weeks. However, this has never been met and the percentage of patients meeting this target has hovered at around 75%4. As the largest staff group in the NHS mental health workforce, nursing staff play a key role in the delivery of services. Growing the mental health nursing workforce is therefore vital for reducing waiting times and increasing access to services.

Almost 40% of children and young people accessing specialist Child and Adolescent Mental Health Services (CAMHS) were waiting more than 18 weeks as of September 20205. This is despite a significant increase in the CAMHS workforce since 2006. CAMHS are usually delivered by multi-disciplinary teams and nurses are the largest group of professionals in the CAMHS workforce.6

Like other health services, the pandemic has caused disruption to the delivery of mental health services, including diagnosis and treatment. There is also growing evidence around the impact of the pandemic on mental health with bereavement, social isolation, financial worries and social upheaval creating new demand for services as well as exacerbating existing conditions. While work to increase understanding of the impact of the pandemic on mental health and wellbeing must continue, it is clear that growth in the mental health workforce is needed to meet demand.

Any changes to delivery of mental health services must coincide with renewed urgency around reform of mental health legislation, with an emphasis on improving services and embedding the rights of people using them. The role of a mental health nurse has evolved and transformed since much of the legislative framework under which they operate was put into place. The current review of mental health legislation in Scotland, being led by John Scott QC, is considering how to improve individual rights and protections and remove barriers to those caring for their health and welfare. Reform - that results in modernised, clear legislation - is needed to ensure mental health nurses can do their jobs properly.

Mental Health legislation needs clarified. Consolidation should be considered and clearer guidance for service users and staff is required. Legislation could give nurses a greater role in mental health services; they are often the most appropriate clinician to be given legal responsibilities and there should be consideration to giving Advanced Nurse Practitioners a greater role. Legislation also needs modernised to bring it into line with current thinking about the treatment of mental health and the person centred and human rights approach to services. However, any change in the law will only improve outcomes for those using mental health services if the workforce exists to provide safe and effective care.

Q52. 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?

Our members have told us that the metal health services where they work are understaffed and suffering from years of under-resourcing. They tell us of long waits for people who are not in crisis and that as patients deteriorate while waiting for services, crises occur which would have been prevented had adequate provision and staffing been in place. Tightening local government resources have meant that Social Work has been increasingly less able to contribute to supporting people who need help or treatment for their mental health, meaning that community mental health nurses are responding to a wider range of patients' needs.

They have also told us that current community health structures (Integrated Joint Boards) and their predecessors (Community Health Partnerships) have created a disconnect with hospital based mental health services, with lack of coordination and engagement on, for example, referral criteria or commissioning. There is wide variation across Scotland in how people access the services they need, what is available, and how long they must wait for treatment and support.

As stated above, this question, therefore, cannot therefore be answered without determining patient pathways that are both person-centred and transparent. The service model should be determined by the patient pathway and adequately resourced and staffed. It must reflect best practice and evidence, and there must be equity of access across the county. This must include recognition of the unique professional contribution of each member of the multidisciplinary team, including mental health nursing. Service models must take into account the needs of all those requiring mental health treatment and support, including those with severe and enduring mental illness, for whom the current recovery focussed service model is not appropriate.

Q57. "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?

The model or models must ensure consistency of approach about what is delivered locally, regionally and nationally. Our members welcome the prospect of consistent standards for access to and quality of care and they have expressed the hope that the commissioning and delivery arrangements put in place will be able to ensure that the aspiration of equity can be achieved.

Q59. What (if any) alternative alignments could improve things for service users?

The model or models must ensure consistency of approach about what is delivered locally, regionally and nationally. Our members welcome the prospect of consistent standards for access to and quality of care and they have expressed the hope that the commissioning and delivery arrangements put in place will be able to ensure that the aspiration of equity can be achieved.

Q61. 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?

Q62. "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?

Questions 61 and 62 are related and we have addressed them together.

Nursing will probably be the largest workforce, and nursing services the largest proportion of what the proposed Community Health and Social Care boards deliver. It is therefore imperative that the Boards include significant nursing expertise if they are to provide effective direction, oversight, and governance. RCN Scotland also strongly believe that nursing expertise is crucial in the national and strategic leadership of the National Care Service, as well as within the Community Health and Social Care Boards.

This nursing leadership role in the proposed Community Health and Social Care Boards should have full board member status. The role should have standing and statutory footing commensurate with the Chief Social Work Officer as it currently stands.

This role would not, in RCN Scotland's view, need to be undertaken by the NHS Health Board Executive Nurse Director, but should be of the same standing and seniority as an NHS Health Board Executive Nurse Director.

Q66. Do you agree that the National Care Service should be responsible for the development of a Structure of Standards and Processes?

While the RCN does not take a view on the merits of a National Care Service, whatever model is adopted needs to result in a shift away from commissioning based on costs towards a system focused on outcomes.

RCN Scotland agrees with the principle set out in the consultation document and in the Independent Review of Adult Social Care that certain national standards are desirable and necessary to improve equity of access to social care, ensure that services can deliver a preventative approach, require staffing levels and skills mix that are appropriate to the needs of the people using the service, and ensure that the social care workforce has fair pay, terms and conditions.

RCN Scotland would therefore support responsibility for the process and framework determining these standards to sit with an appropriate national organisation. It is important that commissioning of social care, community health services and other health service provision is conducted in an integrated way, with common assessments of future demand, and taking into account the impact that service changes in one area will have in any other. Any commissioning undertaken for social care therefore needs to be conducted in alignment with commissioning of both community and hospital-based health services.

Whatever framework is developed must have Fair Work embedded at its heart, and must ensure that nursing staff in all sectors enjoy at least equivalent pay, terms and conditions as nurses working for the NHS.

Q67. Do you think this Structure of Standards and Processes will help to provide services that support people to meet their individual outcomes?

Any Structure of Standards and Processes should be developed with the specific intention of achieving better outcomes for social care staff. Improving pay, terms and conditions, access to training and professional development, and more integrated working with counterparts in other health and care services, will improve staffing and skill mix and enable more seamless, integrated care. This will support people using services to meet their individual outcomes.

Q68. Do you think this Structure of Standards and Processes will contribute to better outcomes for social care staff?

Any Structure of Standards and Processes should be developed with the specific intention of achieving better outcomes for social care staff, including Fair Work, and ensuring that nursing staff in all sectors enjoy at least equivalent pay, terms and conditions as nurses working for the NHS. This will require engagement with staff, trades unions and professional bodies, among others. It should be reviewed regularly to ensure it continues to be fit for purpose to achieve this intention.

Q69. Would you remove or include anything else in the Structure of Standards and Processes?

A Structure of Standards and Processes should include the requirement to assess current and future nursing needs of the population, and to ensure that commissioning and procurement requirements fulfil these needs.

Q70. Do you agree that the National Care Service should be responsible for market research and analysis?

RCN Scotland agrees that market research and analysis is necessary to support service provision planning and commissioning, and workforce planning. We do not take a view about which organisation should have the duty to undertake that function, but whichever body it is, must have a right to access and use the data necessary to carry out that function.

Q75. Do you agree with the proposals outlined above for additional powers for the regulator in respect of condition notices, improvement notices and cancellation of social care services?

Q76. Are there any additional enforcement powers that the regulator requires to effectively enforce standards in social care?

Questions 75 and 76 are related, and we have answered them together.

RCN members have told us that the proposed additional enforcement powers are welcome, insofar as they go. What is missing is any strategic enforcement to make sure, that, for example, commissioning and procurement are of necessary standard – that the proposed Community Health and Social Care Boards are carrying out their functions as required. RCN Scotland is not recommending a particular organisation to discharge such a function, but we suggest that the Scottish government should engage constructively with stakeholders with an interest in the way that Community Health and Social Care boards would carry out their responsibilities, to determine how they might best be held to account and required and supported to address any failures.

Q77. Do you agree that the regulator should develop a market oversight function?

A market oversight function would be a useful tool to support commissioning and workforce planning and inform policy responses that could enable any local or national market failure, such as significant reduction in service provision in a given geography or speciality, to be pre-empted and measures put in place to support people who need to use the affected services.

Q78. Should a market oversight function apply only to large providers of care, or to all?

A market oversight function will only be useful if it applies to all providers of care. The data provision requirements should be minimised to only what is necessary, in order to ensure that providers are not over-burdened by this new reporting requirement.

Q79. Should social care service providers have a legal duty to provide certain information to the regulator to support the market oversight function?

Yes, they should. Without such a legal duty, the market oversight function will not be able to deliver useful information and insight.

Q80. If the regulator were to have a market oversight function, should it have formal enforcement powers associated with this?

Yes, it should. Formal enforcement powers will be necessary to ensure that providers are discharging their legal duty to provide the necessary information for market oversight.

Q81. Should the regulator be empowered to inspect providers of social care as a whole, as well as specific social care services?

RCN Scotland agrees that the power to inspect providers as well as services will help to improve social care provision. It will help ensure than workforce pay, terms and conditions are sufficient, including training and professional development.

Such a power will support increasing access to training and professional development for social care staff.

This new inspection role must be specifically and properly resourced in order not to divert from the regulator's existing obligations.

Q82. Would the regulator's role be improved by strengthening the codes of practice to compel employers to adhere to the codes of practice, and to implement sanctions resulting from fitness to practise hearings?

Q83. Do you agree that stakeholders should legally be required to provide information to the regulator to support their fitness to practise investigations?

Questions 82 and 83 are related, and we have answered them together.

We agree with these proposals, but care must be taken to specifically define which stakeholders are included in the legal obligation to provide information. Further, stakeholders' legal obligation to provide information to the regulator should include all relevant regulators of social care staff, including the Nursing and Midwifery Council.

Q85. What other groups of care worker should be considered to register with the regulator to widen the public protection of vulnerable groups?

Any expansion of or changes in regulation should be accompanied by correspondent standards around education and training, and consistent employer and employee obligations with other care workers.

Q86. Do you think a 'Fair Work Accreditation Scheme" would encourage providers to improve social care workforce terms and conditions?

The opportunity must be taken to implement fair work for staff in adult social care. For nursing staff, that means pay, terms and condition which are equivalent to those in the NHS.

RCN Scotland is not yet clear that the proposals for an opt-in 'Fair Work Accreditation Scheme' will go far enough in achieving fair work for our members.

RCN Scotland recommend that any such accreditation scheme incorporate the Royal College of Nursing Workforce Standards7 for services where users require nursing care.

Q87. What do you think would make social care workers feel more valued in their role?

Recruitment of nursing staff in adult social care is a challenge. In Scotland, 18% of registered care services report having nursing vacancies and the level is significantly higher in care homes for older people, with 40% reporting nursing vacancies. As has been reported, we are also hearing from our members that recruitment is now even more challenging that these figures suggest.

Even before the pandemic our members working in social care were telling us they felt over-worked and under-valued. Data from RCN Scotland's 2019 Employment Survey8 showed 70% of respondents working in care homes felt under too much pressure at work, and 79% of those working in care homes felt they were too busy to provide the level of care they needed. The pandemic made a bad situation, worse, and in summer 2020 34% of respondents to a member survey told us that staffing levels had deteriorated further9.

Members of RCN Scotland can provide their lived experience anonymously via a tool called Sensemaker. Since nurses have started using this tool, one of the most consistent themes of their experience is concern about staffing levels, including in social care. From July 2021 alone, the following stories were shared:

- From a Registered Nurse working in a Care Home in Ayrshire & Arran: "I have been the only registered nurse for 52 residents, two of which have been at the very end of life. I felt I have not had time to spend with any resident or their family. I feel so sad as I feel privileged to be caring for such a wonderful client group. I have a heavy heart."
- From a member working in a care home in Lanarkshire: "We have been so short staffed in our care home I know my residents' care is compromised."
- Another member working in Lanarkshire's story is simply entitled "Is there a future for care homes?" and the member goes on to explain that they work in a care home with poor skill mix, staff shortages, low morale and high turnover and sickness rates.
- To ensure that nursing is an attractive career option in adult social care and tackle recruitment challenges, nursing staff must be recognised for the complexity of skill and expertise they demonstrate every day and rewarded fairly for the job they do.

To ensure that nursing is an attractive career option in adult social care and tackle recruitment challenges, nursing staff must be recognised for the complexity of skill and expertise they demonstrate every day and rewarded fairly for the job they do.

Nursing staff working in adult social care should be paid at least the same rate as colleagues working in the NHS. The Scottish Government should ensure sufficient funding is put into the adult social care system to achieve this. The Feeley report proposes "a national job evaluation exercise for work in social care, to establish a fair and equitable assessment of terms and conditions for different roles." This should include an evaluation of nursing roles with those doing jobs comparable to NHS roles being paid at least the same as their NHS colleagues.

Fair terms and conditions must include sick pay, to disincentivise staff attending work when they are ill, so improving infection prevention in social care services.

Adequately staffed services would be better able to support student placements, providing a positive and fulfilling learning experience for nursing students, which is needed to encourage more nursing graduates to choose to work in social care and thus improve and maintain nursing staffing levels in social care now and in the future.

Providing social care is skilled, difficult work and this needs to be recognised across government and society. RCN Scotland would support the Scottish Government continuing to make representation to the Migration Advisory Committee to recognise the skill and value of social care workers and to include them in its shortage occupations list.

Q88. How could additional responsibility at senior/managerial levels be better recognised?

Nursing staff working in social care should have at least equivalent pay, terms and conditions as nurses working in the NHS. This includes maintaining differentials between staff working in different roles, helping to provide a clear progression route, career structure and an incentive to develop professionally and learn new skills.

Contracts for social care services must be of sufficient value to enable this, and the conditions attached to those contracts must ensure that such pay, terms and conditions, including access to learning and development, are implemented by employers, and that one staff group is not adversely affected by improving conditions for another group.

Q89. Should the National Care Service establish a national forum with workforce representation, employers, Community Health and Social Care Boards to advise it on workforce priorities, terms and conditions and collective bargaining?

RCN Scotland welcomes the recognition of the need for improved terms and conditions for staff working in social care and we support the establishment of a national bargaining system. National bargaining should include all relevant trades unions, including RCN Scotland.

How this is structured requires further thought, however, than the proposal here.

Workforce priorities, planning and recruitment needs must be developed and set by a separate group or body. They should be determined in an integrated way with NHS workforce planning to ensure that impacts on different parts of the health and care system are addressed. For example, we can see currently that reduced social care capacity has a problematic impact on acute services, as delayed discharges increase. This in turn creates increased demand in community health services, as the delayed discharges result in delays to admissions. Workforce planning can therefore not be successful if it is conducted in silos and must recognise these interrelationships across our health and care system.

National bargaining structures and determination of pay, terms and conditions has to be a separate process, which will include reflecting the priorities identified in workforce planning.

Q90. 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
Workforce planning skills development for relevant staff in social care
Something else (please explain below)

Delivery of adult social care is built on a highly skilled but low paid workforce, which has been expected to go above and beyond to keep the system running. We know that workforce shortages were having a major impact on the provision of care, staff morale and wellbeing before the pandemic and this pressure has been heightened further by the crisis. The workforce and people using services deserve staffing levels that are safe, and this must be one of the most important considerations when reforming social care.

Workforce planning in social care should ensure compliance with the requirements of the Health and Care (Staffing) (Scotland) Act 2019. This Act provides the tools to facilitate safe staffing levels in adult social care. This legislation sets out a legal requirement on all care providers to ensure suitably qualified staff in sufficient numbers are in place to ensure good outcomes for service users. It also requires the Scottish Government to report on the steps they are taking to support staffing levels in care services to meet this legal requirement. The legislation also provides the Care Inspectorate with the power to develop, in conjunction with the sector and stakeholders, a staffing methodology to determine (based on the needs of residents and a variety of other factors) the number and skill mix of staff that are required to ensure the best outcomes for recipients.

The Health and Care (Staffing) (Scotland) Act 2019 is an opportunity to help ensure that care homes are supported to deliver safe, quality care to residents with increasingly complex health needs. Implementing this legislation is urgently needed to address the workforce crisis in the sector and to ensure care homes are better equipped to meet the needs of residents.

Access to robust nursing workforce data for social care must be improved. The best available data are SSSC estimates, which show that, despite increasing clinical needs of residents, the number of registered nurses working in care homes has fallen by nearly 10% since 2015.

The need for improved data is urgent, and without it, it is not possible to plan for workforce in the social care sector. Planning must be informed by data about people using services now and what projected need is going forward; data about providers and the market, and data about the current social care workforce, including projected exit from that workforce, across all professions in social care.

Responsibility for workforce planning must sit with the National Care Service or another national agency to enable a sufficient overview, but paying heed to local issues and requirements. Siting this responsibility with a national agency would also ensure that the quality of workforce planning was not adversely affected by variations in providers' capacity to undertake their own workforce planning.

Workforce planning must result not only in recruitment and professional development plans, but also in ensuring that sufficient training provision is in place in further and higher education to meet future workforce needs. This includes sufficient nursing student places, recognising the geographical variation in changing requirements.

Q91. Do you agree that the National Care Service should set training and development requirements for the social care workforce?

Q92. Do you agree that the National Care Service should be able to provide and/or secure the provision of training and development for the social care workforce?

Questions 91 and 92 are related and we have answered them together.

RCN members tell us that disincentives to working in adult social care are the lack of opportunity to undergo training at work, as well as a perception that there are few opportunities for career progression. These lead to recruitment difficulties and staffing shortages so must be addressed by the new frameworks that result from this consultation. Reform of adult social care must include improved career pathways, funding for learning and development opportunities and increased opportunities for social care staff to gain experience in healthcare settings and vice versa.

RCN Scotland welcome proposals to improve the consistency of training requirements and quality for social care staff. We are clear that all social care staff must be able to access training during their working hours, that this should be compulsory, and that they should be paid for it.

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Royal College of Nursing Scotland

Published: November 2021