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# RESPONSE TO THE SCOTTISH GOVERNMENT'S 'A NATIONAL CARE SERVICE FOR SCOTLAND' CONSULTATION.

## Summary

The RSE welcomes the opportunity to respond to the Scottish's Government's consultation on a National Care Service (NCS) for Scotland. Changes to the culture, planning and provision of social care are urgently needed, and there is much in the consultation that we welcome.

We are concerned, though, that the consultation paper focuses on organisational restructuring without addressing transformative cultural change which prioritises person-centric services matched to individual's specific needs, broadens definitions of what constitutes care, and encourages feedback and learning through processes of continual improvement.

The NCS would benefit from a mixed governance model, which ensures national standards, terms and conditions, and training for staff whilst providing a locally controlled, individually responsive, and flexible service.

Proposals for the NCS should take account of the impact of socioeconomic deprivation, urban-rural geographic inequalities, and the needs of remote and island communities – the uneven impacts of which have been exacerbated by the COVID-19 pandemic – to design a more equitable service which values all people through the creation of a tailored care service which is attuned to local and individual requirements.

Greater clarity is required around the resourcing, budgetary, and contractual arrangements of the NCS, and proposals for reformed Integrated Joint Boards (IJBs), or Community Health and Social Care Boards (CHSCBs).

The consultation paper does not address the ethical and legal ramifications of patient confidentiality and privacy in the sharing, and use, of patient data. A balance should be struck between harnessing the value of 'big data' to revolutionise healthcare via data-driven solutions, and more holistic approaches which value data gathered through relationship-based care, including patients' values, feelings, and local circumstances. This should be underpinned by genuine public engagement, an appreciation of the lived experiences of individuals, and the use of routinely available data to predict future trends.

We believe that addressing the above issues will be vital to ensure a thriving ecosystem of local care services, in accordance with the recommendations outlined within Derek Feeley's Independent Review of Adult Social Care.[1]

1 Scottish Government (2021) Independent Review of Adult Care in Scotland [online]
Available at: https://www.gov.scot/publications/independent-review-adult-social-care-scotland/documents/

## Introduction

1 The Royal Society of Edinburgh (RSE), Scotland's National Academy, welcomes the opportunity to provide its views on the Scottish Government's consultation on 'A National Care Service for Scotland'. Our response was facilitated through an RSE working group which included RSE Fellows and members of the Young Academy of Scotland with significant and wide-ranging practitioner and research experience in the health and social care sector and academia. Our response focuses on the following key sections of the consultation: (1) ways to reduce inequality in provision of, and access to, care (pp. 19 and 92 of the consultation); (2) integration and coordination across the health and social care system (pp. 92); (3) the development and scope of the National Care Service (pp. 48-86); (4) reformed Integration Joint Boards or Community Health and Social Care Boards (pp.89-94); (5) the commissioning of care (pp. 95-105); (6) regulation of care (pp. 106-118); and (7) valuing people who work in social care (pp. 119-132).

### *Reducing inequality in provision of, and access to, care through development of a National Care Service that is fully integrated and coordinated across the health and social care system*

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

**Q21. Are there any other services or functions the National Care Service should be responsible for, in addition to those already set out?**

**Q22. Are there any services or functions listed that the National Care Service should not be responsible for?**

**Q31. Are there any other ways of managing community health services that would provide better integration with social care?**

*a) The importance of locality and geographical context*

2 The context of health and social care delivery should be embedded in the design of the NCS, to account for local variation in health and social care needs and enable the provision of a locally situated, geographically flexible, and responsive service which accounts for individual attributes, local differences in population health, and wider determinants of health (at community and regional scales). As such, the NCS should acknowledge how deprivation and geography impact service provision, set against a backdrop of falling life expectancy in Scotland principally driven by COVID-19.[2]

3 In response, we suggest rural and island 'proofing' the NCS by tailoring services to local geographies and socio-economic conditions, to help overcome disparities in service offerings and the 'postcode lottery' that can stymie access to service provision. This need is highlighted by the limited impact of brokerage models of Self-Directed Support (SDS) solutions in rural regions of Scotland.[3] The NCS should be informed by lessons learned from the relative uptake of Options 1, 2 and 3, which highlights rurality as a limiting factor in terms of implementing each option.[4] Rural England's Rural Proofing for Health Toolkit, developed to help organisations address the needs of their local rural populations during the development/reviewal of strategies, initiatives, and service delivery plans, provides a framework to achieve this.[5]

2 See for instance the Centre for Research on Environment, Society and Health's (CRESH) research on deprivation [online] Available at: https://cresh.org.uk/; S Curtis, J. *et al.* (2019) Changing labour market conditions during the great recession and mental health in Scotland 2007-2011: an example using the Scottish Longitudinal Study and data for local areas .Social Science & Medicine, 227:1-9, [online] Available at: https://link.springer.com/chapter/10.1007/978-3-030-70179-6_6; National Records of Scotland (2021) Healthy Life Expectancy decreases [online] Available at: https://www.nrscotland.gov.uk/news/2021/healthy-life-expectancy-decreases; further information on the role of COVID-19 in relation to life expectancy in Scotland is available online: https://www.bbc.co.uk/news/uk-scotland-58663991

3 Brokerage is one aspect of an independent support approach within SDS where social services provide impartial information, advice and support for people to help them plan and organise their own support arrangements, and make maximum use of community resources and informal support, helping people find creative solutions to meet their needs. For more information see: Smith, L. (2018) ESSS Outline: SDS Brokerage in rural Scotland [online] Available at: https://www.iriss.org.uk/sites/default/files/2018-04/iriss-esss-outline-sds-brokerage-rural-scotland-2018-1-24.pdf

4 Option 1 involves the individual or carer choosing and arranging support and managing the budget as a direct payment; Option 2 involves the individual choosing the support and the authority or another organisation arranges the chosen support and manages the budget; Option 3 involves the authority choosing and arranging the support. More information on SDS options is available online at: https://www.audit-scotland.gov.uk/report/self-directed-support-2017-progress-report.

5 Rural England (2020) Rural proofing for health toolkit [online] Available at: https://ruralengland.org/rural-proofing-for-health-toolkit/

### *b) Drawing on lived experiences*

**4** To dismantle assumptions around service delivery, and counter concerns around the limited scalability of healthcare improvement science solutions (such as hand hygiene compliance in clinical settings), experientially informed, locally rooted care solutions should be developed. Crucially, these should be informed by ethnographic accounts of receiving care, and any associated barriers.[6] Local solutions, such as the Glasgow-wide Creative Communities: Artists in Residence scheme which underscores the importance of creative activity to palliative care, the RSE Post-Covid-19 Futures Commission's (PCFC) participatory film-making project 'Inclusive services: people-centred support' which provides experiential accounts of users and facilitators of people-centred community support and services, and the success of the Scottish Violence Reduction Unit could be broadcast as examples of good-practice solutions to help normalise a mind-set where staff experimentation leads to positive change.[7]

**5** Relatedly, the importance of groups such as Voluntary Health Scotland and the Cross Party Group (CPG) on Health Inequalities in facilitating cross-sectoral discussion on issues relating to health and health policy – with a specific focus on communications between governments and NGOs – should be embraced as a mechanism of positive change.[8] Indeed, this provides an opportunity to highlight the value of non-medical interventions grounded in lived experiences. Crucially, this proposal to engage the third sector is underpinned by research underscoring the relationship between engagement with community cultural assets (for example visiting museums or heritage sites), and well-being (greater levels of life satisfaction, improved mental health functioning, and reduced mental distress), which is moderated by local deprivation.[9] This highlights the importance of place-based funding schemes that focus investment on areas of higher deprivation to improve engagement rates with community cultural assets.

**6** The creation of a NCS with an enriched preventative care package provides an opportunity to champion and expand on this agenda, by embracing system complexity, non-clinical programmes, and opportunities for in-depth consultations with service users to understand their experiential accounts.[10] Indeed, the *'Greater Manchester: A Creative Health City Region'* Social Glue project underscores the importance of cultural participation in health, and the role city-regions – as a new tier of government administration - can play in facilitating a cultural evolution which embraces creativity.[11] Indeed, the Social Glue report unpacks a range of projects which illustrate how heritage, culture, creativity, health, wellbeing, and care are inextricably linked, and have the potency to transform people's lives by tackling inequality and amplifying a sense of place. In doing so, this provides a means of humanising clinical environments, reaching explicit health outcomes and widening participation. Relatedly, the Culture, Health & Wellbeing Alliance's 'Prescribe Culture', a heritage-based, non-clinical mental health programme, and the Scaling-up Health-Arts Programme (SHAPER), provide further complementary examples that could be drawn from.[12]

6 White *et al.* (2012) Utilising improvement science methods to improve physician compliance with proper hand hygiene, Pediatrics, 129(4) [online] Available at: https://pubmed.ncbi.nlm.nih.gov/22392176/

7 Glasgow Life (2021) Creative Communities: Artists in Residence [online] Available at: https://www.glasgowlife.org.uk/arts-music-and-cultural-venues/creative-communities-artists-in-residence; Royal Society of Edinburgh (2021) Inclusive services: people-centred support [online] Available at: https://www.rsecovidcommission.org.uk/inclusive-services-people-centred-support/;; further information on the Scottish Violence Reduction Unit is available at: http://www.svru.co.uk/

8 For further information visit the VHS website, available at: https://vhscotland.org.uk/; for further information, including a backlog of resources, visit the CPG on Health Inequalities website, available at: https://www.parliament.scot/get-involved/cross-party-groups/current-and-previous-cross-party-groups/2016/health-inequalities.

9 Mak, H. W., Coulter, R. and Fancourt, D. (2021) Associations between community cultural engagement and life satisfaction, mental distress and mental health functioning using data from the UK Household Longitudinal Study (UKHLS): are associations moderated by area deprivation?, BMJ open, 11(9) [online] Available at: https://bmjopen.bmj.com/content/11/9/e045512.

10 This interlinks with the wider growth of interest in social prescribing, a practice dependent on an understanding of local experiences and requirements. See for example: McHale, S. *et al.* (2020) Green Health Partnerships in Scotland; Pathways for Social Prescribing and Physical Activity Referral. *International journal of environmental research and public health*, 17(18) [online] Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7560024/.

11 Manchester Institute for Arts, Health & Social Change (2021) A Social Glue. Greater Manchester: A Creative Health City Region [online] Available at: https://www.miahsc.com/a-social-glue

12 Baxter, R. (2021) Guest Blog: Prescribe Culture [online] Available at: https://www.culturehealthandwellbeing.org.uk/news/blog/guest-blog-prescribe-culture-ruthanne-baxter; for further information visit the SHAPER website, available at: https://www.ucl.ac.uk/ion/news/2019/oct/worlds-largest-study-impact-arts-physical-and-mental-health

**Q12. 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?**

7 This section of the consultation effectively sets out the problems in extracting and using health and care data in the community. Proposals for a nationally consistent, integrated, and accessible electronic social care and health record are laudably ambitious, but should be accompanied by appropriate assurances around patient confidentiality and privacy to ensure person-centred data and information can be shared safely and securely. Plans for GP data extraction for planning and research (GPDPR) in England underscore how ceding individuals' right to opt out of the sharing of their data for the 'public benefit' constitutes a trade-off fallacy, or false dichotomy, which disempowers individuals and unnecessarily risks GPs' covenant of trust.[13] These concerns are further compounded by a need to overcome issues of limited interoperability between data sets, inequity in data provision, and information gaps which may negatively impact the NCS' ability to 'Get it Right for Everyone' and facilitate a person-centred, human-rights focussed model of care across Scotland. An alternative approach to data-sharing might look to adopt or trial an e-Scotland approach, drawing from the success of the e-Estonia approach to health care records, as the basis for a fully integrated health and social care record.[14] Crucially, this would enable the NCS to break out of a 'failure-demand cycle' of care by using routine data to interpret emergent trends and design appropriate solutions, to for example, discourage a shift from in-house primary care to out-of-hours care.

## Governance Models

### *Reformed Integration Joint Boards (IJBs): Community Health and Social Care Boards*

**Q4. What would be the benefits of Community Health and Social Care Boards managing GPs' contractual arrangements?**

**Q30. What would be the risks of Community Health and Social Care Boards managing GPs' contractual arrangements?**

8 Greater clarity around the proposal for Community Health and Social Care Boards (CHSCBs) to manage GPs' contractual arrangements would be welcomed. GPs' contracts were recently negotiated and agreed by the British Medical Association and Scottish Government, and it is not clear if the proposal in the consultation document is that this agreement would be replaced by a local negotiation by the CHSCBs. The RSE suggest that such a change would be inadvisable. It comes at a time when health and care services are under significant strain as a result of the COVID-19 pandemic, which is generating serious issues around burn-out and staff retention.[15] General Practice is a key component of the NHS, GPs act as gatekeeper to hospital services and primary care delivers around 90% of health care. Any change to this function or proportion of health care activity would have a significant impact on hospital services, and may discourage younger GPs who value flexibility in moving between specialties. As such, any change to GP contractual arrangements should be discussed with the British Medical Association (BMA) Scotland and Royal College of General Practitioners in Scotland (RGCP).

9 When GP clusters were created in 2017, part of their role was perceived as encouraging involvement in community facing activities (extrinsic) as well as clinical/practice activities (intrinsic).[16] The effectiveness of GP clusters has been limited for a variety of reasons, including capacity and support. A more productive approach to maximising the value that GPs and their teams can add may be to take a fresh look at the how GP clusters can be strengthened under the new arrangements.[17]

13 See for example: BJGP Life (2021) Confidentiality, Privacy and General Practice. GPDPR and the Brave New World of 'Big Data' [online] Available at: https://bjgplife.com/2021/08/04/confidentiality-privacy-and-general-practice-gpdpr-and-the-brave-new-world-of-big-data/; and Cheung, S. (2021) Disambiguating the benefits and risks from public health data and the digital economy, Big Data & Society [online] Available at: https://journals.sagepub.com/doi/10.1177/2053951720933924

14 For further information, visit the e-Estonia website, available at: https://e-estonia.com/solutions/healthcare/e-health-record/

15 BMA (2021) Rest, recover, restore: Getting UK health services back on track [online] Available at: https://www.bma.org.uk/media/3910/nhs-staff-recover-report-final.pdf

16 Scottish Government (2017) Improving Together: A National Framework for Quality and GP Clusters in Scotland [online] Available at: https://www.gov.scot/publications/improving-together-national-framework-quality-gp-clusters-scotland/pages/4/

17 The Lothian Deprivation Interest Group – a group of primary health care workers who promote high quality primary care for socially excluded groups and communities experiencing high levels of multiple deprivation – are well-placed to provide specific recommendations on how funding mechanisms might be improved to address inequalities in some of the most deprived areas in Scotland; see also Watt, G. (2012) General Practitioners at the Deep End: The experience and views of general practitioners working in the most severely deprived areas of Scotland, Occasional paper (Royal College of General Practitioners), [online] Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3627459/

**Q27. 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?**

**Q58. *"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?**

**10** The RSE has concerns that the introduction of CHSCBs represents a pre-occupation with organisational restructuring to the detriment of a wider culture change. This risks repeating the previous IJB's unsuccessful attempts to unify health and social care, or to resolve underlying budgetary issues. A more radical restructuring of the units of change involved would help to implement a culture of doing things differently, whilst accounting for variation across Scotland. In doing so, the Scottish Government could draw from the Scottish Longitudinal Study (SLS) to design a service which accounts for the distinctive experience of rural/island communities, whilst building in capacity for compassionate, collaborative high-level leadership.[18] Drawing from examples of innovation in New Zealand and Sweden could also aid the implementation of a system which integrates the health and care system and acknowledges the pivotal role grassroots organisations play in facilitating change.[19]

**11** It is unclear whether CHSCBs will move away from locally elected councils, and reduce democratic accountability to the detriment of a collective, outcomes-based approach to social care. Relatedly, proposals for a NCS CEO, alongside an NHS CEO, risk reinforcing a split between health and social care, unless this duality in roles and responsibilities is required to ensure an equitable split of resources. The RSE would welcome further information on both points.

## The Commissioning of Care

**Q70. Would you remove or include anything else in the Structure of Standards and Processes?**

**12** Further information on what a human rights model of care would entail, including how it will differ from the current situation in Scotland, would be welcomed. Whilst a user-led human-rights based approach which places a clearer focus on individual autonomy, coproduction, and expressed needs is a step in the right direction, if not carefully designed, it risks serving as a legal instrument which moves democratic decision making to the courts and the judiciary, and away from legislators. More work could be done to unpick issues of finance and bureaucracy, and ensure those in receipt of care have access to independent specialist and generic advocacy support they require.

**13** Mindful of the costs of previous UK healthcare reforms, such as the Lansley Reform, greater clarity around the NCS's budgetary scope would be appreciated to provide assurance that more targeted, equitable spending arrangements are put in place which account for local variation and cuts in local government or third sector funding, provide relevant expertise to run organisations, and provide the support of advocacy/independent specialists.[20] Similarly, further information on the distribution formula determining the direct allocation of budgets by the NCS is required to provide assurance that a more holistic, preventative model of care is established which moves beyond accounting for the 'direct costs or savings of providing care' and acute/crisis support to consider how to improve people's experience of care and the outcomes they achieve.[21]

18 Further information on the SLS is available online, at: https://www.lscs.ac.uk/projects/scottish-longitudinal-study/ ; for further information on leadership see: West, M. (2016) If it's about NHS culture, it's about leadership [online] Available at: https://www.kingsfund.org.uk/blog/2016/01/if-it%E2%80%99s-about-culture-it%E2%80%99s-about-leadership

19 Timmins, N. and Ham, C. (2013) The quest for integrated health and social care: A Case Study in Canterbury, New Zealand [online] Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/quest-integrated-care-new-zealand-timmins-ham-sept13.pdf; Øvretveit, J., Hansson, J. and Brommels, M. (2010) An integrated health and social care organisation in Sweden: creation and structure of a unique local public health and social care system. *Health policy*, 97(2-3) [online] Available at: https://www.sciencedirect.com/science/article/abs/pii/S0168851010001363

20 Timmins, N (2012) Never Again? The Story of the Health and Social Care Act 2012 [online] Available at: https://www.instituteforgovernment.org.uk/sites/default/files/publications/Never%20again_0.pdf

21 This model of care could draw on the findings of the RSE's Post-Covid-19 Futures Commission. The PCFC's findings are available online at: https://www.rsecovidcommission.org.uk/coming-out-of-covid-19-reimagining-scotland/.

**14** The inequity which currently exists between the provision of social care, primary care, and hospital care risks an over-medicalisation of care, whereby patients may be over-diagnosed and over-treated. The Lancet Commission on the Value of Death underscores how over-treatment at the end-of-life results in expenditure being concentrated in hospitals, reinforcing the dominance of a curative medical model as the 'pre-eminent driver of health service priorities', marginalising supportive and palliative care services, which are often relegated to third sector/charitable organisations.[22] In response, comprehensive multidisciplinary input and support is required to reduce rates of institutionalisation, and increase rates of return to independent living for people wishing to live at home.

**15** COVID-19 has significantly accelerated digital transformation.[23] Technological healthcare solutions should be developed which are matched to individuals' specific needs. The Scottish Government's Technology Enabled Care (TEC) Remote Health Pathways provide a good example of an asynchronous treatment model which empowers the user/patient by encouraging self-directed care without relying on health or care professionals and patients being available at the same time.[24] This health condition management solution improves individuals' understanding of their conditions, encourages individuals to take ownership for their health and wellbeing, reduces time taken up by unnecessary appointments and travelling, and improves the availability of information to assist diagnosis and early intervention, subsequently supporting health and care planning. The model has been successfully applied to a number of scenarios, including the remote monitoring of patients diagnosed with COVID-19, blood pressure monitoring, and asthma treatment. The wider success of the Near Me GP consultation service, which recently surpassed one million virtual consultations, further underlines the importance of innovative technological solutions as part of a mixed portfolio of health and care offerings.[25] Nonetheless, the continued success of digital solutions depends on tackling inequalities in digital literacy, financial hardship, and internet connectivity by drawing on communities of practice built up through development of technological solutions.

**16** A revised governance approach could also address lags in the construction of key healthcare infrastructure – for example how the current introduction of 'super hospitals' runs contrary to the emergent need for local provision – by implementing a 'place standard' for urban design. This would instil an appreciation of the intersection between public health and urban planning, a key element of the Scottish Government's 'Place Standard', which acknowledges how our wellbeing is shaped by the places we live, work, learn, and visit.[26] Examples such as Humanitas, a Netherlands-based residential and care centre predicated on the co-habitation of students and elderly residents, could be replicated in Scotland.[27] The effective design of these buildings – based on a foundational understanding of the importance of community integration to healthcare – underscores the importance of improved wellbeing enabled by intergenerational collaboration and effective building design. Similarly, implementing an anticipatory approach could also help to mitigate against the perpetuation of public health crises (for example how the built environment of care homes enabled COVID-19 clusters to emerge).[28] This desire to ensure care homes are fit for the future interlinks with the RSE's engagement with studies aimed at improving palliative and end-of-life care in care homes, including electronic care planning via the Care Home Innovation Partnership (CHiP)[29] The RSE has also explored how the built environment impacts our quality of life, health and wellbeing as part of the Curious Programme, and would welcome the opportunity to discuss this further with Scottish Government representatives.[30]

22 Further information on the Lancet Commission on the Value of Death is available online, at: https://commissiononthevalueofdeath.wordpress.com/2019/01/07/the-commentary-that-launched-the-lancet-commission-on-the-value-of-death/.

23 McKinsey & Company (2020) How COVID-19 has pushed companies over the technology tipping point – and transformed business forever [online] Available at: https://www.mckinsey.com/business-functions/strategy-and-corporate-finance/our-insights/how-covid-19-has-pushed-companies-over-the-technology-tipping-point-and-transformed-business-forever.

24 Further information on TEC Remote Health Pathways is available online, at: https://tec.scot/programme-areas/remote-health-pathways

25 Scottish Government (2021) Coronavirus (COVID-19) – Near Me video consulting service: evaluation 2020 [online] Available at: https://www.gov.scot/publications/evaluation-near-video-consulting-service-scotland-during-covid-19-2020-main-report/documents/

26 Scottish Government (2020) Place Standard tool: Strategic Plan 2020-2023 [online] Available at: https://placestandard.scot/docs/Place_Standard_Strategic_Plan.pdf

27 Harris, J. (2016) Here's why some Dutch university students are living in nursing homes [online] Available at: https://theconversation.com/heres-why-some-dutch-university-students-are-living-in-nursing-homes-68253

28 Burton *et al.* (2021) Evolution and impact of COVID-19 outbreaks in care homes: population analysis in 189 care homes in one geographic region [online] Available at: https://www.medrxiv.org/content/10.1101/2020.07.09.20149583v1

29 Royal Society of Edinburgh (2021) Invited perspective: care homes and the 21st century [online] Available at: https://www.rsecovidcommission.org.uk/invited-perspective-care-homes-and-the-21st-century/

30 Royal Society of Edinburgh (2021) Making space to thrive [online] Available at: https://www.rse-curious.com/making-space-to-thrive/

## The Regulation of Care

### Q73. Is there anything you would add to these core principles?

### Q74. Are there any principles you would remove?

### Q75. Are there any other changes you would make to these principles?

**17** We recommend that regulators avoid adopting a purely outcomes-focussed approach to care, which relies on unhelpful barometers for measuring the success of service provision, such as whether care is being provided, and whether it is meeting minimum standards. The NCS could go beyond this more defensive approach to regulation by drawing from the concepts of anticipatory complex systems and regulatory sandboxes to encourage innovation which harnesses the benefits of big data and artificial intelligence in local settings. [31] This could enable a proactive, anticipatory approach to regulation, which could be supported through the commissioning of research in collaboration with Higher Education Institutions.

**18** The absence of Public Health Scotland and local departments of Public Health within proposals for the NCS is a surprising oversight, particularly in relation to their contribution to public health data and intelligence.

## Valuing People who work in Social Care

### Q88. What do you think would make social care workers feel more valued in their role?

**19** The success of positive, supportive routes into the healthcare profession will depend on a broader culture shift which recalibrates the consultation's current focus on structural issues in favour of an NCS which places those who receive or provide care at the centre. There is an opportunity to mirror opportunities currently provided to NHS staff, without adopting its organisational structure, such as the Scottish Quality and Safety (SQS) Fellowship Programme and the Scottish Improvement Leader Programme (ScIL).[32]

**20** Trainee doctors' experiential accounts provide a thermometer for patient care in the healthcare sector. A similar model should be considered for the social care workforce. At a national level, education providers should learn from this data to improve training to ensure staff feel valued, have access to the appropriate training resources, and can raise concerns as appropriate (at a national anonymised level, as well as within areas of specific, local concern). The NCS should also avoid implementing standardised graduate training packages, which risk implementing a transactional model of care, at odds with an ethos of local, relational, and co-produced care packages which are designed in collaboration with care users, enabling individuals to tailor their training to local care requirements and personal ambitions.

31 For further information on complex systems see: Staiger et al. (2017) A conceptual framework for applying the anticipatory theory of complex systems to improve safety and quality in healthcare, Anticipation and Medicine [online] Available at: https://link.springer.com/chapter/10.1007/978-3-319-45142-8_2; and Curtis., S. (2021) Emergent global pandemic risks, complex systems and population health, in Andrews, G. et al. (Eds) COVID-19 and Similar Futures, Geographical perspectives, issues and agendas, [online] Available at: https://link.springer.com/chapter/10.1007/978-3-030-70179-6_6; for further information on regulatory sandboxes see: Leckenby, E. et al. (2021) The Sandbox Approach and its Potential for Use in Health Technology Assessment: A Literature Review, Applied Health Economics and Health Policy, [online] Available at: https://link.springer.com/article/10.1007/s40258-021-00665-1

32 Further information on the SQS Fellowship Programme is available online at: https://learn.nes.nhs.scot/814/quality-improvement-zone/learning-programmes/scottish-quality-and-safety-sqs-fellowship-programme; further information on the ScIL Programme is available online at: https://learn.nes.nhs.scot/813/quality-improvement-zone/learning-programmes/scottish-improvement-leader-programme-scil

**Q89. How could additional responsibility at senior/managerial levels be better recognised?**

**Q90. 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?**

**Q92. Do you agree that the National Care Service should set training and development requirements for the social care workforce?**

**Q93. 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?**

**21** There was much rhetoric around valuing the role of carers during the early-to-mid stages of the COVID-19 pandemic. The RSE welcomes proposals for the NCS to move beyond this through provision of advocacy services, training and development opportunities to individuals working in social care, which is seen as a positive step towards providing care workers with the recognition they deserve. However, more can be done to attract and retain care workers through adequate job security and appropriate levels of remuneration, particularly given increasingly inflexible immigration frameworks.

**22** Definitions of care, and indeed the provision of care, should be broadened to acknowledge the important role played by informal carers and wider communities who utilise public resources, and provide a potential solution to GP referral bottlenecks. This more holistic interpretation of care would draw from local community assets by implementing a mixed-model of care, which combines top-down governance offerings, such as terms and conditions for staff, clearly defined career pathways, and guaranteed workplace conditions with improved localised care offerings, staff autonomy, and community-centred care. In doing so, this would facilitate a more creative approach to care which draws from cost-effective community-centred activities such as intergenerational reading projects.[33] The NCS should commission pilot studies in collaboration with local organisations and Higher Education Institutions to uncover, cascade, and implement best practice examples.

**23** Research estimates that there are approximately 700,000 unpaid carers in Scotland, in comparison to 125,000 workers in care at home, housing support, and care homes.[34] Denmark's approach to formalising the care sector by offering routes to professional qualifications, accreditation and career progression provides an example of good practice which has a high degree of clinical relevance. This also provides the opportunity to empower care workers by giving them the appropriate recognition they deserve and validating the support they provide. This provides a meaningful opportunity to tackle inequality amongst a predominantly female workforce, with large BAME representation.[35]

**33** For example, the Exeter Care Homes Reading Project looks to strengthen intergenerational connections to improve the quality of life, dignity, and happiness of those involved. Further information on this is available at: https://readingproject.exeter.ac.uk/

**34** Audit Scotland (2021) Social care reform questions remain [online] Available at: https://www.audit-scotland.gov.uk/report/social-care

**35** Scottish Government (2016) Social Work and Social Care Statistics for Scotland: A Summary [online] Available at: https://www.gov.scot/publications/social-work-and-social-care-statistics-for-scotland-a-summary/

## *Additional Information*

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