RCPG Submission to the Joint Committee on the draft Care & Support Bill
January 2013

Introduction

The Royal College of General Practitioners (RCPG) welcomes the opportunity to submit evidence to the Joint Committee’s inquiry on the draft Care and Support Bill. This written submission accompanies oral evidence due to be provided by RCPG Vice Chair Professor Nigel Mathers to the Committee on 23rd January 2013.

The RCPG is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 46,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

The College’s response to the ‘Care and Support’ section of this consultation is informed by our members’ experience both as providers of front line NHS care and (following the passage of the Health and Social Care Act) as commissioners of care. The nature of the GP role – and the ‘whole person’ approach that underlines patient care in general practice – brings our members into regular contact with social care professionals and with patients whose needs do not fit easily into ‘NHS’ or ‘social care’ organisational silos. GPs also play a central role in supporting carers – just over one in ten patients who visit their GP is a carer.

Our response to the aspects of the Bill that relate to the establishment of Health Education England draw on our experience as a professional body closely involved in the delivery of postgraduate medical education throughout the UK. The comments on the section of the draft Bill relating to the establishment of the Health Research Authority (HRA) reflect the expertise located within the RCPG’s Clinical Innovation and Research Centre (CIRC).

Executive Summary – Key RCPG Messages

- The RCPG strongly supports greater integration of health and social care, and we welcome the duties set out in the draft Bill requiring local authorities to promote integration, cooperation and prevention. However, translating the legal duties in the draft Bill into action and ensuring that it delivers a more integrated patient and service user experience of health and social care will be hugely challenging.

- GPs sit at the interface between health and social care, and can in the right circumstances play a vital role in working with patients, social care professionals and others to join up services and improve outcomes.

- The RCPG supports the provisions contained in the Bill relating to assessment of needs for care and support for both individuals and their carers. It will be important that GPs are aware of and able to access copies of assessments relating to their patients (subject to appropriate procedures for patient consent).

- It is currently not clear how care and support plans put in place by local authorities under the
provisions contained in the draft Bill will be implemented in an integrated way where the individual receiving care and support has both health and social care needs, and is receiving support from the NHS.

- As individuals with both health and social care needs may be eligible for both a personal budget and a personal health budget, we strongly recommend that the Committee look at how we can ensure that the two are properly integrated and coordinated.

- The RCGP welcomes the establishment of HEE and LETBs as statutory bodies. However, we feel that the draft Bill does not currently do enough to incentivise the development and delivery of a long term approach to workforce planning.

- There is a need for further detail on future plans for funding arrangements for education and training, including how and when the Government intends to take forward the proposed health education and training levy.

- There is a need for a new focus on primary care based research, building on the significant contribution GPs already make to health research supported by the RCGP’s Clinical Innovation and Research Centre (CIRC).

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**Part 1 – Care and Support**

**Promoting integration of care, cooperation and prevention**

The RCGP strongly supports greater integration of health and social care, and we welcome the duties set out in the draft Bill requiring local authorities to promote integration, cooperation and prevention. Alongside the duties on NHS bodies contained in the Health and Social Care Act, the introduction of a statutory duty on local authorities to promote integration is a positive step towards creating the right framework within which integrated care can flourish.

However, translating the legal duties in the draft Bill into action that delivers a more integrated patient and service user experience of health and social care on the ground will be hugely challenging. The RCGP explored some of the challenges and opportunities to delivering integrated care in a report published in June 2012,¹ and has undertaken further policy development work looking in detail at how general practice and social care can work together more effectively. Key points highlighted by this include:

- Exploring new ways of providers working together can be an important driver for the development of more integrated. For example, we have highlighted the important role that greater use of care planning, working in multi-disciplinary teams and establishing GP Federations can play. There is a clear need to focus on communication processes at a provider level in particular. Co-locating social care professionals within GP practices – or alternatively attaching social care teams to a group of practices – can make a huge different to patient care. Greater use of regular multi-disciplinary team (MDT) meetings to jointly anticipate and plan care delivery can cut through communication barriers.

- GPs sit at the interface between health and social care, and can play a vital role in working with patients, social care professionals and others to join services up and improve outcomes. Groups that would particularly benefit from greater joint working between GPs and social care include (but are not limited to) those with learning

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disabilities, those living with dementia, those living in care homes who may have poor access to health services and those being supported by re-ablement services following hospital discharge. Increasingly health and social care services are delivering care to individuals with multiple long-term conditions and complex needs. We have developed two case studies providing examples of integrated working between social care and general practice, copies of which we have attached along with this submission. However, there is significant scope for further development in the way GPs and social care professionals work together. A programme of shared work between general practice, social care and policy makers is needed to develop tools to engage and support both professions in this agenda. We believe this will be essential to achieving the Government’s aims as set out in this draft Bill and the White Paper.

- It is hoped that Health and Wellbeing Boards will play a major role, through Joint Strategic Needs Assessments and other processes, in encouraging a more joined up approach between the NHS and local authorities. In some areas, collaboration between the NHS and social care will extend to formal budget pooling arrangements. Under the right circumstances, pooled budgets can help deliver better outcomes more cost effectively. However, in practice different organisational structures and methods of funding care can prove a barrier to full collaboration and mutual trust. An approach based on financial transparency and jointly agreed outcomes will be essential to ensuring that the draft Bill’s provisions around co-operation and integration deliver meaningful change in practice, and we would welcome the Committee’s consideration of how this could be reflected in the legislation or accompanying guidance.

Other comments we have on these provisions of the Bill include:

- It will be vital that robust processes are put in place to plan, monitor and evaluate activity taking place in fulfilment of these duties (particularly the duty to promote integration) and RCGP would support measures to strengthen the Bill to reflect this (e.g. specifying how local authorities will be expected to demonstrate that they are successfully promoting integration).

- It is also notable that the draft Bill uses the term “integration” but does not provide a definition of what this term means in practice. Whilst RCGP would not advocate attempting to include a definition within the Bill itself (given the range of different interpretations and the need for a flexible approach which allows for innovative thinking) clear guidance and support will need to be developed. Judgements about whether integration is being effectively promoted should be informed by the views of both patients and professionals.

Assessing the needs of individuals and their carers

RCGP supports the provisions contained in the Bill relating to assessment of needs for care and support for both individuals and their carers (see separate section specifically on carers below). Promoting self care and empowering individuals to feel in greater control of their lives should be at the heart of a more integrated approach to health and social care provision.

As the first point of contact for many people whose needs cut across health and social care, GPs will have an important role to play in both identifying those who may benefit from an assessment and supporting patients and or/ carers who have received a social care
assessment who also have health needs. With this in mind, we would like to see further exploration of:

- How local authorities will share information about/raise awareness of assessment processes with GPs and other health professionals and what additional information and support will be available about these to individual patients and their carers.

- How the results of assessments will be shared. Part 1 of the draft Bill states in clause 12 subsection (1)(e) that regulations will specify persons to whom the local authority must give a copy of the assessment. It will be important that GPs are aware of and able to access copies of an assessment relating to their patients (subject to appropriate consent procedures).

- The financial implications of an increased uptake in social care support services as a result of the provisions contained in the draft Bill. These need to be carefully considered.

Supporting carers

RCGP welcomes the extra focus on the health and wellbeing of carers and the new entitlement of carers to public support. By consolidating existing requirements into a single duty to assess carers’ needs on a similar basis to that for users, the Bill should enable carers to understand much better what help they can expect to receive from local authorities.

Carers play an indispensable role in providing care and support to millions of people. Maintaining carers’ health and wellbeing is an important priority in its own right and also contributes to improved patient outcomes. With 2.3 million new carers each year, this is an issue of growing and urgent importance for the health and social care system as a whole.

GPs already play an important role in identifying and supporting carers and the Quality Outcomes Framework (QOF) includes an indicator (Management 9) which relates to referrals of carers for social services assessment. RCGP is working with GPs on the ground to promote the identification of, and support for carers. In partnership with the Princess Royal Trust for Carers (now the Carers Trust) we have produced a Carers Action Guide, which provides extensive information about the role that GPs can play in ensuring the needs of carers are met. This provides a self-assessment checklist and guidance on developing patient care plans for carers. Following the publication of the guide, the College has introduced a programme of activities and educational support (including workshops, e-learning, focus groups, published materials, and the setting up of UK-wide awards to recognise good practice) to help GPs and their practice teams improve the support they can give to carers.

The draft Bill supports the above work by simplifying the legal framework around carers’ entitlements, but as set out in the section on ‘Assessing the needs of individuals and their carers’ above, clarity is needed on how information will be shared with GPs and other health professionals. Furthermore, the draft Bill does not contain a specific definition of ‘carers’ – if this is not mentioned explicitly on the face of the Bill reference should be made to how an agreed definition will be reached – e.g. through specific guidance to which local authorities must have regard.

Care Planning

RCGP supports clause 24 in Part 1 of the draft Bill that enshrines a statutory duty on local authorities to produce a care and support plan for people with assessed eligible needs. The
College has long championed the role that care planning can play in empowering those with health and/or social care needs to manage their own care, and there is considerable evidence to suggest that a care planning approach leads to improved patient experience and outcomes, while some (but not all) studies have found an association with lower levels of hospital utilisation.

However, it is not clear how care and support plans put in place by local authorities under the provisions contained in the draft Bill will be implemented in an integrated way where the individual receiving care and support has both health and social care needs, and is receiving support from the NHS. Some individuals may already have a separate care plan in place to support their health needs, involving their GP and other health professionals. As with assessments, it will be important that GPs and other professionals working in the NHS are able to access care and support plans put in place by local authorities where they, in partnership with the patient or carer to whom the plan relates, agree this is appropriate.

Personal Budgets

Whilst the provision of personal budgets in social care lies outside the expertise of the RCGP, the College has been actively contributing to the debate around the introduction of personal health budgets in the NHS in England, publishing both a position statement and guidance.

As individuals with both health and social care needs may be eligible for both a personal budget and a personal health budget, we would strongly recommend that the Committee look at how we can ensure that the two are properly integrated and coordinated from the point of view of the patient/service user and their carers. Further thought is needed about how this would work in practice, but clearly the possibility that an individual may have multiple care plans, with multiple budgets and more than one coordinator of care could result in a fragmented experience.

Discharge of hospital patients with care and support needs

Hospital discharge is an important issue. An integrated approach that joins up different parts of the health and social care system and ensures that patients move back into the community with the care and support they need in place and their carer well informed has the potential to deliver better outcomes and avoid unnecessary readmissions to hospital. The second RCGP case study attached with this submission – a multi-disciplinary re-ablement service in Taunton – contains a model of good practice in this area. This initiative is driven by close partnership working between groups of GP practices, NHS Somerset and Somerset County Council and has delivered positive outcomes for patients including reducing unnecessary hospital admissions. In addition, the RCGP’s Clinical Innovation and Research Centre (CIRC) has produced a guide on re-ablement with the Social Care Institute for Excellence (SCIE).

The Bill largely addresses aspects of hospital discharge from the point of view of improving communication between hospitals and local authorities at the point of discharge. Further consideration is needed as to how the proposed ‘assessment notices’ fit into a wider debate which we believe is needed around how information about discharges is shared between hospitals, social care, primary care and others (such as, for example, mental health

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2 Insert refs to Integration of Care paper and Care Planning paper
3 Ref pos statement and guidance
services). GPs should be able to access information about their patients’ discharge and, where appropriate, be involved in discharge management.

**Safeguarding**

Between July 2011 and October 2012 the Department of Health consulted on whether a new intervention power is needed by local authorities to support their safeguarding role. It was proposed that a new power of entry could be introduced enabling local authorities to speak to someone with mental capacity who they think could be at risk of abuse and neglect, where a third party is preventing them from doing so. This power is already available to social care and health workers Scotland. It is currently unclear however if additional provisions in law will be enacted. The RCGP supports this intervention power to safeguard vulnerable adults, particularly in the light of the findings of the Department of Health’s final report on Winterbourne View in December 2012.

**Part 2 – Health**

**Health Education England**

**a) Workforce planning**

RCGP welcomes the establishment of HEE and LETBs as statutory bodies. However, in the RCGP’s view the draft Bill does not currently do enough to incentivise the development and delivery of the long term approach to workforce planning that will be necessary to ensuring health and social care services effectively anticipate and meet the needs of patients in future. For example, the expectation that more care is likely to move from large hospitals and into the community in the coming years has implications for primary care workforce capacity, and the Centre for Workforce Intelligence (CfWI) recently concluded in its report on the ‘Shape of the Medical Workforce’ that “the current growth in general practice is not strong enough to meet the predicted need.”

The College believes that a clear vision is needed for the future of education and training in primary care (an issue explored in more detail in our Sept 2012 consultation on the ‘2022 GP’ and that HEE have clear responsibilities and powers in this area.

The Committee should consider as a priority how this aspect of the draft Bill can be strengthened, including looking at the following:

- The potential inclusion of a specific duty on HEE to develop and deliver a long-term approach to workforce planning and to ensure that there is comprehensive national oversight of standard setting, monitoring of training numbers and quality assurance across the system.

- Clarity is needed on the role of the Centre for Workforce Intelligence in gathering data and providing evidence-based advice to HEE and LETBs. RCGP strongly supports the work of the CfWI and feels its work is particularly relevant to achieving the goals of this legislation, particularly given that its work spans both the health and social care workforce and provides a long-term perspective. The Centre needs to be provided with adequate resources and appropriate powers (e.g. obliging healthcare providers to provide information on their current and anticipated workforce needs).

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6 2022 GP ref
HEE must have sufficiently robust powers to ensure that local education and training plans developed by LETBs align with national priorities. We support amending Clause 64(5) to say that LETBs must obtain approval for local education and training plans from HEE regardless of whether they have met the establishment criteria. Careful consideration is needed to ensure that the right checks and balances are in place to empower LETBs to develop a strong local leadership role whilst ensuring that long term national goals are also advanced and that HEE is able to intervene in their running if necessary.

b) Ensuring a well-balanced multi-professional approach

RCGP remains concerned (as other organisations have also touched on in their response to the draft Bill) that HEE and LETBs may not develop in a way that enables all health and social care professionals to have an appropriate voice in decisions that will ultimately have important implications for the shape and quality of future care provision. Although we recognise that there are inevitable challenges to ensuring that all health and social care professionals feel adequately represented, we remain concerned the disparate nature of primary care will lead to LETBs in particular being dominated by secondary care. We would urge the Committee to consider what amendments could be made to the draft Bill to ensure that it refers explicitly to regulations or guidance relating to LETB representation and the need to ensure there is an adequate balance, in broad terms, between secondary and primary care.

c) Funding education and training

As the Government’s previously stated aim of introducing a new health education and training levy is not dealt with in the draft Bill we will not comment at length on it here. However, there is a need for further detail on future plans for funding arrangements for education and training, including how and when the Government intends to take forward the proposed levy. We remain concerned that the introduction of such a levy could have significant unintended consequences.

d) The role of education and training in delivering integration

The Committee has raised the question of whether the education and training provisions contained in the Bill should do more to support the Government’s aspirations around integration. We note that in oral evidence to your Committee on 13th December 2012 Jamie Rentoul, Director for Workforce Development, Department of Health, stated that HEE’s duties relating to integration would stem from objectives set by the Secretary of State rather than the draft Bill itself. There may be advantages to including a more explicit reference to integration on the face of the draft Bill to help to embed this into the future work of HEE; however we feel more discussion is needed to explore what practical actions HEE would propose to take to promote integration through the education and training system.

Establishment of the Health Research Authority

The RCGP welcomes the establishment of the Health Research Authority (HRA) and strongly supports the aspects of its proposed remit that relate to standardising and coordinating the regulation of health and social care research. We feel the following issues merit further consideration by the Committee:

- **Investing in primary care research:** UK expertise in research in general practice and primary care is exceptional, long-standing and internationally renowned. The needs of general practice are associated with challenging research agenda
spanning: preventive medicine, early diagnosis, acute and chronic disease management, personalised care, and the understanding of beliefs and behaviours relating to health and illness. These areas of focus are of increasing importance to the future development of healthcare in the UK, with its emphasis on healthy living and pro-active disease management. The expectation that in the coming years we will see a movement of more patient care into the community means that UK capacity for general practice research needs to be expanded. The RCGP’s CiRC has launched ‘Research Ready’ – an online self-accreditation tool covering the minimum requirements of the Research Governance Framework for undertaking primary care research in the UK, developed in conjunction with the NIHR Clinical Research Network and the Primary Care Research Networks (PCRN). This programme will become increasingly important as responsibility for research governance shifts from PCTs to the practices themselves from April 2013. The RCGP intend to work with HRA to review the criteria for Research Ready programme in the context of the new education and training system established by the draft Bill to ensure that it provides the best support possible to practices on the ground.

**Strengthening links between education and research:** Only 1 in 225 general practitioners in the UK are clinical academics (compared to approximately 1 in 16 consultants in all hospital specialties) and the current number of academic general practice training posts is insufficient to sustain existing capacity.7 With this in mind, the College’s case for enhanced and extended GP training8 sets out the aspiration that an additional year of training would enable GPs to develop "improved academic skills for evidence-based practice, innovation, quality improvement, education and research". The formation of HEE and LETBs presents an opportunity to strengthen links between education and research. A commitment to promoting effective and efficient research governance should be reflected in the priorities and outcomes set by HEE and implemented by LETBs in their education and training plans, and LETBs will need to foster strong relationships with Academic Health Sciences Networks as well as local authorities.

- **The HRA’s relationship with NIHR:** The relationship between the HRA and the National Institute for Health Research is of paramount importance in maintaining high standards of responsive research. Our understanding is that the HRA will take on the functions of the National Research Ethics Service (NRES) and the Integrated Research Application System (IRAS) and hence its processes will have a direct effect on the speed of the delivery of research. We would like the NIHR and the HRA to work closely together to ensure the processing of research ethics proposals take place as efficiently as possible. We understand that the NIHR is, though its research governance frameworks, aiming to improve start up times for research trials to achieve an ambitious 70-day benchmark for start up. The HRA will need to play a complementary role in support of this.

- **The HRA’s relationship with the NHS Commissioning Board and CCGs:** The RCGP recognises the importance of formalising the commitment to research at all levels of the NHS and Local Authorities, especially with establishment of the NHS Commissioning Board and Clinical Commissioning Groups (CCG). RCGP has concerns about what obligations private companies will be under to maintain and support research if they win contracts to provide services to patients from CCGs or the NHS Commissioning Board. We would encourage the Committee to explore how

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7 The Academy of Medical Sciences (2009) Research in general practice: bringing innovation into patient care Workshop report
the relationship between HRA and the new commissioning structures in England will work in practice.

- **HRA leadership on excluded research groups and under-researched areas:** The RCGP’s CIRC has identified that issues of capacity may result in certain groups of people being excluded from research, including young people aged 10-21 years with mental health illness, people with a learning disability and the frail elderly. There is also a considerable deficit in research into the health of people with rare diseases. The RCGP CIRC looks to the HRA to provide leadership on these issues.

- **Promoting more efficient and effective translation:** There remains a translational gap between the completion of a research project and final publication, meaning that often the research team has dispersed with little focus on translation of research into healthcare benefits. This delay in realisation of benefits remains a wasted opportunity to improve people’s health and wellbeing. As health research is a complex process, the RCGP looks forward to working in partnership with HRA to promote the implementation of new knowledge into clinical practice.

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