Health and Sport Committee

Inquiry into NHS Corporate Governance (Phase Three of the enquiry into NHS Governance – Creating a Culture of Improvement)

Submission from RCGP Scotland

The Royal College of General Practitioners (RCGP) is the professional membership body for family doctors in the UK and overseas. It is committed to improving patient care, clinical standards and GP training. Its objectives, in concern for care for patients, are to shape the future of general practice, ensure GP education meets the changing needs of primary care throughout the UK, grow and support a strong, engaged membership, and to be the voice of the GP.

The College in Scotland came into existence in 1953 (one year after the UK College), when a Scottish Council was created to take forward the College’s interests within the Scottish Health Service. RCGP Scotland currently represents around 5,000 GP members and Associates in Training throughout Scotland. In addition to a base in Edinburgh, the College in Scotland is represented through five regional faculty offices in Edinburgh, Aberdeen, Inverness, Dundee and Glasgow.

In responding to this consultation, RCGP Scotland has sought and collated the views of its membership and those of its Patient Partnership in Practice Group (P³).

1) Do you trust NHS Boards to make decisions that are in the best interests of the public?

RCGP Scotland recognises the difficult financial climate in which NHS Boards are currently making decisions and the challenges that come with having to balance the delivery of services with the demographic and financial problems that Boards face in meeting the needs and expectation of the population that they serve.

However, there is some concern ‘on the ground’ that, due to such considerable focus placed by NHS Boards on the delivery and funding of secondary care, support for primary care, in some instances is inadequate. Failure to appropriately fund primary care, where 90% of patient consultations occur, inevitably impacts on the delivery of services that are in the best interests of the patients, consequently exacerbates pressure on secondary care and ultimately has a negative bearing on tackling health inequalities in both urban and remote and rural areas. There is also a feeling amongst RCGP members that some Boards, due to insufficient interaction, may not fully understand the intricacies of general practice, including
the importance of the profession in tackling fundamental health inequalities, which Health Boards clearly express as a priority.

When considering how best to align service delivery to patients’ considered needs and best interest, from a patient perspective it is incredibly important that patients are able to input into NHS Boards’ decision making process. This extends to innovation and review at Scottish Government level. There is a feeling amongst patients that although they do have the ability to input into some Health Board processes, this involvement is felt to be ‘tokenistic’ and ‘piecemeal’. Patients feel that many NHS Boards take decisions without carrying out sufficient consultation with the public and when consultation events do take place, these are often to inform reactionary decisions to significant events in local communities, for example in the case of secondary care ward closures. Such a lack of sufficient consultation would possibly be against statutory obligation and certainly outside of its spirit. It is very difficult for decisions to be take in the best interest of the public if the public do feel able to adequately contribute to the decision-making process.

2) Are NHS Board decisions open and transparent?

In terms of the openness and transparency of NHS Boards’ decisions, there are some mechanisms in place to allow for this. For example, NHS Boards’ meeting minutes are publicly available online. However, often these are over 500 pages long, which makes the papers difficult to read fully and may not be appropriate to all patients’ abilities. So, perhaps it could be said that although there are mechanisms in place for openness and transparency, accessibility is still a major problem. Many sessions of NHS Boards are held in secret, which due to the nature of much of the work is understandable. Often the most sensitive of decisions are those which will have the biggest impact on the public, however, such as ward closures, and appropriate public awareness of the mechanisms of such decisions should be facilitated.

From a general practitioner perspective, NHS Boards often feel very distant from the work of general practices. This feeling stems, in part, from the concern already expressed with regard to the focus of NHS Boards on secondary care rather than primary care.

In terms of those sitting on NHS Boards, although their names are listed and this information is publicly available, there is little public information around the reasoning behind their appointments, which would outline, for example, whether or not the Board has vital GP representation. There is some concern, expressed by RCGP members, over the lack of GP representation on NHS Boards and providing clarification on the rationale behind appointments may serve to help resolve this issue.

NHS Boards should be as accountable as possible to the population that they serve and CEL 4 (2010) is in place, along with legislation, to ensure that the public is involved in designing, developing and delivering the health care services Boards provide. The biggest change to general practice since 2004 came in late 2017, with
the publication of the draft new General Medical Services (nGMS) GP Contract 2018. This was developed and negotiated without specific patient or public engagement and input, despite the considerable change that it brings to the way in which patients will access their GP and other primary care services through Boards. The aims of 2015’s ‘National Conversation’ were relatively unspecific and so insufficient for this work.

RCGP Scotland is pleased to note that the Scottish Government has commissioned a series of public engagement events, delivered through the Health and Social Care Alliance, to help inform the public of what the agreed changes in service delivery will mean for patients and to gather their views on it. This engagement is, however, limited by the very nature of its delivery, and concern exists as to how most patients will come to be aware of the coming changes to service. We recognise that many patients will notice a considerable change in the way in which they access services and are concerned about the impact that explaining such changes to patients will have on GPs’ already stretched workload. It is of concern that a significant portion of each ten minute GP appointment could be taken up with the task. It is vital that Health Boards recognise their duty to communicate the changes contained within the new GP contract in a way that is easy to understand and accessible once the changes contained within Phase One of the nGMS contract begin to be implemented.

3) How accountable do you feel NHS Boards are?

With the integration of Health and Social Care in Scotland, the governance structures and delivery mechanisms of health care at a local level are considerably complex. This leads to a lack of transparency and public knowledge with regards to the upwards accountability of NHS Boards in terms of their reporting structure to Scottish Government and the criteria behind this reporting.

From a general practice perspective, NHS Boards often do not feel accountable as they have limited interaction with the GP community. There is a sense amongst some GPs that Health Boards only become involved with general practice when there is pressure on the services or a perception of increased risk. In light of the planned changes to general practice and primary care, the interface between Boards and primary care delivery must be fit for purpose.

There does not seem to exist an agreed definition of accountability within Health Boards and little is known publicly about the processes and standards that are in place for various aspects of health care delivery. Making such standards openly available and appropriately promoted will ensure that NHS Boards are more accountable to the public.

NHS Boards should be more accountable to their patients than was the case previously, as a result of the relatively recent establishment of Integrated Authorities (IAs). Some measure of local, democratically elected political representation is welcome. That democratic representation, however, and the role
of patients, must allow for a two-way flow of information and decision making, rather than a top-down approach from Scottish Government and others.

Boards must strive to be truly representative of the patient body and guard against the influence of particular interest groups, with decisions transparent to their patients and public. The responsibility of Health Boards under Freedom of Information legislation is a welcome level of accountability.

4) How effective are NHS Boards at delivering health services and improving the health of their population?

RCGP Scotland recognises the financial and demographic challenges being faced by NHS Boards. Of course, there is variation in approach to improving public health across the country. In order to adequately assess the effectiveness of Health Boards, comparable evidence must be collected from Boards across the country in terms of the activity that they are undertaking to improve population health and the outcomes of that work. Health Boards should be held more accountable for Scotland’s health outcomes and clearly state their professional response to poor outcomes, justified by the evidence base.

Of course, NHS Boards in isolation cannot adequately improve population health. For instance, related factors such as housing standards and educational opportunities also have a major role to play in improving the health of the population.