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Dear Angiolina

RCN Scotland response to the Scottish Government proposals on the integration of adult health and social care in Scotland

Our work has shown that better integrated working is driven by a shared motivation for improving the wellbeing of service users, by trusting local relationships and by strong, transparent leadership. It is people and their relationships, not organisational structures, which are at the heart of successful integration¹.

The RCN represents 39,000 nurses, nursing students and health care assistants in Scotland, as both a trade union and professional body. As you know, we have been working with the Scottish Government and other partners to contribute constructively to the debate on the future of integrated care on behalf of our members. We hope that this response to the Scottish Government's consultation on legislation to integrate adult services will continue to demonstrate our positive and solution-focused approach to reform.

Our submission is informed by the RCN's ongoing research into integration; our position paper, *The RCN Principles for Delivering the Integration of Care*; 253 responses to an online survey of nurses on the consultation proposals; detailed debates with nurse leaders from across Scotland; our learning from involvement in various Government events and groups, and our experiences in engaging in detail with local integration activity in areas such as Highland.

As is acknowledged in the consultation document, the scope of the proposals is limited, primarily, to the technical aspects of legislation. However, it is sometimes only by being clear what the Government is committed to progress through non-legislative routes that it is apparent what should be included on the face of a Bill. The fullness of a comprehensive Government narrative vision on the future of integrated care is not yet available. Bearing this in mind, we have tried to keep a proportionate approach to our additional legislative suggestions, whilst acknowledging our concerns at some significant omissions from the proposals.

¹ RCN, *Principles for delivering the Integration of care* (2012)

However, we have also touched on a number of important areas where we think the Government could usefully set out its more general future plans before the draft Bill is published. The issues we wish to raise do not always fit neatly into the questions posed in the consultation. As such, in order to give a comprehensive response, we have addressed each chapter in turn but have not followed strictly the scope and flow of the set questions.

If you wish to discuss any of the issues raised in this response in more detail, please contact Rachel Cackett, RCN Policy Adviser at Rachel.Cackett@rcn.org.uk or 0131 662 6180.

The case for change

The RCN in Scotland is supportive of the principle of ensuring better integration between services to deliver high quality care and improved outcomes for the people of Scotland. We have included the RCN's vision statement on integration, from our recent *Principles* document, at Annex 1 as a reminder of our position in the context of this response.

The scope of proposed legislation

It is our understanding that the Scottish Government's rationale for creating separate governance arrangements for adult and child health and social care is that the adult legislative proposals are designed to overcome specific problems around inappropriate admissions and delayed discharges for older people². The RCN is not convinced that this is a sufficiently strong argument to split apart governance arrangements – and very possibly existing good integrated working arrangements - across the age ranges.

Firstly, the Bill proposals are not limited to older adults, even if the initial indicators on which Health and Social Care Partnerships (HSCPs) will be performance managed are. Not all issues around improving integrated care for the wider adult population are focused on the community / acute interface. Secondly, if a legislative governance arrangement is set up to overcome a particular problem in current operational activity – and it is successful in doing so – the rationale for that governance model will quickly become redundant. Thirdly, as neo-natal interventions become more sophisticated, the numbers of babies surviving into childhood with highly complex healthcare needs are rising. This also raises significant issues in negotiating the community / acute interface for the benefit of the child and their family. Finally, and crucially, if the message is clear that integrated services are best delivered through full joint ownership and governance of planning and service delivery across the NHS and local government, we do not see why this gold-standard is only appropriate for one part of the full age spectrum.

Whilst we appreciate that joined-up children and young people's services go beyond the scope of health and social care alone, we would note that so do those for adults. For example, the current guidance from the Joint Improvement Team on developing new Joint Strategic Commissioning Plans includes the requirement to involve housing.

The imbalance in approach across age groups is exacerbated by the Children and

² Verbal response by the Scottish Government to an RCN question at the Adult Health and Social Care Bill Advisory Group (28 August 2012)

Young People's Bill consultation providing insufficient detail on proposals for integrating service planning, commissioning and delivery. This does appear to be a late inclusion to the focus of that Bill with, as yet, far less consideration given to the detail of integrated governance and practice than has been available through the 18 months' of debate that preceded the adult Bill proposals. We suggest that integrated care should be implemented through a single Bill to ensure parity of approach across age ranges and mitigate the fragmentation of holistic service provision within families.

However, we are also mindful of the legitimate concerns of our members, and others, that any approach to change must be proportionate. Whilst some parts of Scotland are well advanced in the field of integrated working and may cope relatively well with a whole systems approach to reform, others will need more time to develop working relationships and new approaches.

We ask the Scottish Government to consider if there is merit in exploring whether the Bill can be drafted without reference to age groups in its title or on the face of primary legislation, but that the age-scope of the Bill is set, by Ministers, through regulation. This could allow for a phased approach to the duties under the legislation, enacting duties for adult services through early regulation, and widening the scope through amended regulation at a later date.

Given the experimental nature of what is being proposed through these significant changes, such an approach could also allow a full report on the success of the first stage of reform to be laid before Parliament before wider developments are enacted. We suggest that a review date on the scope of age-related regulations should be announced during the passage of the Bill, so that Partnerships can be clear about anticipated timescales for future development. We are also clear that the Bill should not hinder those HSCPs who wish to include children and young people's services in the scope of their work from the start.

Outline of proposed reforms

Clarifying the vision for staff and the public

Understandably, given the context of the consultation, the framework for integration presented is focused almost exclusively on technical legislative proposals. However, to ensure that the public and staff groups are fully engaged in the proposals for significant change, and to ensure that the chosen legislative approaches are indeed fit for purpose, we would like to see the Government set out a far clearer vision for the future of integrated care, building on the short 20:20 vision produced by the current Government and focusing on painting a detailed picture of the impact of delivering the proposed outcomes and emphasising the ethos and culture expected of both those accountable for and those delivering services.

Embedding quality and safety across all services

Below we propose a number of ways to embed quality, clinical and social care governance and staff governance into the legislative framework for the new partnerships, as we believe these are key omissions from current proposals. However, if significant latitude is to be given to local partnerships to set the detail of services and user pathways through them, we would like to emphasise the importance of ensuring that up-to-date and comprehensive minimum standards for integrated care are set nationally and that Partnerships are under a duty to abide by

them. We ask the Scottish Government to be mindful of such an approach in the upcoming review of National Care Standards.

In this context we would highlight the pressures that are likely to arise as one person's localism becomes another's postcode lottery in terms of a health service that is still funded by and accountable to national government. We would not wish to see significant and unjustified variation in service quality or availability become a feature of our highly-prized universal healthcare provision.

Finally, on a practical legislative note, we would like to see the limits on the delegation of health functions to local authorities (e.g. for invasive treatment), currently contained in secondary legislation to the 2002 Community Health and Care (Scotland) Act, remain in place. Indeed it may be an opportune moment to review this wording to ensure it is clear, comprehensive and relevant.

Addressing information barriers

Our members have repeatedly raised concerns that difficulty in sharing client information between partners is a significant and ongoing barrier to integration. We appreciate that the Scottish Government is developing an integrated IT strategy to better support the technical aspects of integrated information management. However, in terms of how client data should be handled responsibly to support integrated care, we ask the Scottish Government to review the recommendations of Dame Fiona Caldicott's English review of information governance when they become available, and to consider what implications these might have in a Scottish context, both for the Bill and wider ways of working.

Additional HSCP duties for consideration

When we surveyed our members on the current proposals for integration, we additionally asked whether HSCPs should be under specific legal duties to prioritise health improvement, early prevention and / or reducing health inequalities. Responses to these proposals were very positive. 83% supported legislative duties in health improvement; 86% supported duties in early prevention, and 85% supported HSCPs facing a legal obligation to reduce health inequalities. We urge the Scottish Government to consider how HSCPs could be obliged through legislation to demonstrate that their plans and services are configured to support health improvement, early intervention and a reduction in health inequalities.

Benchmarking a draft Bill's proposals

As the Government's wider vision and details of the proposals become clearer other omissions from the framework will almost certainly become clearer too. As well as testing legislation against the narrative vision we hope will be produced, we would also suggest that the Bill, during the process of drafting, could be usefully measured against the RCN *Principles for Delivering the Integration of Care* and the very useful Joint Improvement Team document, *Barriers to Partnership Working*³. This will help ensure that the full scope of legislative levers, which will support effective joint working, are included in the Bill before publication.

³ Joint Improvement Team, *Barriers to Integrated Working. Health, Social Care and Housing Partnership Working* (2009)

National outcomes for adult health and social care

The draft outcomes and HEAT

The draft national outcomes for adult health and social care included in the appendix to the consultation document are a sound basis on which to proceed to develop further indicators for HSCPs to deliver against. The RCN is happy to support these as a complete set of interlinked measures for HSCPs to work towards. We would like to see commitment to a national review process of these outcomes and indicators, as integration activity develops, to ensure they are truly fit for purpose. In addition, if the age scope of legislation were to be phased within a single piece of integration legislation, outcomes for children and young people, such as those already in existence under GIRFEC, would also need to be included over time.

However we remain unclear about the relationship between these shared outcomes and existing HEAT targets which, it seems apparent from the consultation document, will remain. Whilst there is a clear rationale for maintaining a set of performance measures for those parts of the acute sector which will not fall within the joint governance arrangements of the HSCP, a whole systems approach to reform, which includes journeys in and out of hospital, will require a coherent performance management framework across the whole sector.

In addition, the Scottish Government should not underestimate the pressure on NHS board decision making around service design and delivery – and ultimately funding priorities - by the requirement to be directly accountable to the Cabinet Secretary for compliance with HEAT targets, such as those which stipulate maximum waiting times. Attempts to shift the balance of health funding towards community-based provision will be challenged if the current approach to HEAT remains unaltered. These targets must be reviewed in light of the developing proposals around an outcomes-focused approach for the entirety of health and social care services.

Clarity of responsibility between CPPs and new HSCPs

This section of the consultation document also underlines our ongoing concerns about confusing lines of responsibility between Community Planning Partnerships, with a remit for health and wellbeing, and future Health and Social Care Partnerships. We certainly agree that ongoing Single Outcome Agreements and the work of the HSCP to deliver their strategic commissioning plans must be fully aligned. However, the Scottish Government must clarify in their narrative vision for integration, and where necessary in legislation, the separate lines of responsibility and accountability held by CPPs and by HSCPs around care. We are mindful that it would be in no-one's interest to create near-parallel systems to be negotiated in terms of prioritising, commissioning, accountability and reporting. The findings of the CPP review, when available, should be compared to the Audit Scotland review of CHPs, to inform the wording of the draft Bill and ensure a fully joined-up approach to collaborative public service delivery between the NHS, local government and their partners.

Future directives for health

Linked to the issues of directive or enabling approaches to performance, we also note that it is current practice for the Scottish Government to use Chief Executive Letters to direct the activity of NHS boards without the need for, say, regulation. For example, among other things, CEL 32 (2011) directs NHS boards to ensure they are

using the nursing and midwifery workforce and workload planning tools⁴. CEL 23 (2010), as another example, sets out directives for the NHS around the mandatory induction standards and codes of conduct for Health Care Support Workers. We do not believe there is a similar approach taken to local government.

The RCN is unclear how such directives and guidance will take effect, either under the new joint partnership arrangements with local government, or if and when staff are transferred from NHS employment (as is the case for some child health staff in Highland). Given the importance to healthcare quality and safety of much of the guidance currently published through CELs, we ask the Government to consider what additional measures, if any, should be included in primary and secondary legislation to replace levers that may be lost if CELs have no influence over partnership activity or the expenditure of integrated health and social care budgets.

Developments to scrutiny and improvement support

Delivering against these outcomes will require a significant focus on continuous improvement and scrutiny, as well as on available sanction if partnerships are failing.

We are aware that scrutiny and improvement functions are currently spread across a number of different Government departments and other organisations. The Joint Improvement Team provides support to current partnerships; the Improvement Service provide advice, consultancy and support to local government; Healthcare Improvement Scotland and the Care Inspectorate both have inspection, scrutiny and improvement functions across health and social care; the QuEST delivery support team in Scottish Government provides support and interventions around key areas of NHS performance improvement; various Managed Clinical Networks and Scottish Government-sponsored Collaboratives engage clinicians in continuous improvement activity. This is not an exhaustive list.

Both performance scrutiny and improvement support will be essential to ensure quality performance in the delivery of care to meet desired outcomes. Networks of support within and beyond partnerships will also be important for practitioners to ensure that new approaches to care are well-evidenced and efficient. To ensure practitioners can benefit from improvement support and clearly understand scrutiny arrangements in an integrated care landscape, we ask the Scottish Government and CoSLA to review the plethora of scrutiny and improvement bodies currently in existence and ensure that they are able to deliver integrated functions to integrated teams. We note again that the RCN believes it makes sense to move towards the creation of one body to oversee the scrutiny and improvement of health and social care as recommended in the Crerar review⁵ and set out in the Public Services Reform Act. This could usefully be supplemented by an integrated care Collaborative to support practitioners on the ground.

Options for sanction and mediation

We are not clear from the proposals exactly what sanctions will be written into the Bill with regard to failing partnerships. However, given that the option to walk away from the table, which has been used previously in some areas of Scotland, will no longer be available to NHS boards and local councils we do believe that there would

⁴ See: http://www.sehd.scot.nhs.uk/mels/CEL2011_32.pdf and http://www.sehd.scot.nhs.uk/mels/CEL2010_23.pdf

⁵ See: <http://www.scotland.gov.uk/Publications/2007/09/25120506/19>

be merit in considering what mediation and contingency arrangements should be written into the legislation. In addition, we would welcome clarity on how these proposals fit with the ministerial powers of intervention in failing health services set out in the National Health Service Reform (Scotland) Act 2004.

The future of major service change arrangements

We note that the consultation suggests that the current process for the NHS, in which 'decisions for major service change ultimately [sit] with Scottish Ministers' will come to an end under these proposals. First, we assume that this will not be the case for all of the acute sector – a significant proportion of which will remain outwith the joint governance arrangements in the Bill. Second, we ask what the status of *CEL 4 (2010): Informing, engaging and consulting people in developing health and community care services* will be under these new proposals and what, if anything, will be done to update the guidance to make it appropriate to changed circumstances.

Governance and joint accountability

The RCN is concerned that in the focus on political and financial accountability within the proposals to date – which has perhaps come about as a result of an insufficient person-focused narrative vision about integrated care - the consultation has omitted to emphasise the need to establish an equally strong statutory basis for quality and safety through clinical / social care governance, and for staff governance.

Clinical and social care governance and professional leadership

At essence, clinical / social care governance is a means of providing assurance of public protection, service quality and the delivery of improved outcomes. This proposed legislation provides a timely opportunity to ensure the emphasis on quality of care, as embedded in the Scottish Government's *Healthcare Quality Strategy*, is reflected in a legislative focus on professional leadership and governance within the new structures that are proposed.

All HSCP structures must be set up to clearly include a duty to address issues of clinical and social care governance. Our preference is for this obligation to be contained within primary legislation to ensure that the emphasis on political and financial governance is balanced by an agreed ethos of governance for care standards, scrutiny and continuous improvement. There are examples of existing integrated CHCPs addressing these important issues. For example, East Renfrewshire has a Care Governance Committee as a formal subcommittee of the CHCP, chaired in rotation by an elected member and non-Executive NHS director and with full membership from professional, staffside and patient representatives. There is merit in considering these existing arrangements and we would be supportive of moves to include such committees within the outline integrated structures set within the Bill.

To ensure the quality and safety of care provided under any new structure, the RCN would wish to see statutory partners, whether transferring staff or not, under a duty to demonstrate that they have established clear professional leadership and accountability structures, including access to professional supervision and support to ongoing training and development for staff, agreed with staffside and professional representatives. Our experience to date has shown that partners attempting to

integrate services have sometimes considered these crucial care quality issues rather late in the day when faced with the pressures to agree, for example, complex financial arrangements. Delivery of these structures should be reviewed regularly. Details of agreed professional structures could be included as a minimum standard for partnership agreements, with these standards set out in secondary legislation. However, if this route were taken, we would ask the Scottish Government to indicate their commitment to such an approach early in the development of primary legislation.

In addition, all partners engaged to deliver services under the Joint Strategic Commissioning arrangements should be placed under a duty to contribute to integrated workforce data collection and planning to ensure the ongoing sustainability of the professional workforce as staff are, potentially, increasingly spread across different employers. This would help to ensure that existing difficulties in this area (for example, the lack of available practice nurse data from independently contracted GPs to inform plans to educate the future nursing workforce) would be resolved and not be exacerbated in a new, more integrated landscape.

Given the substantial level of governance authority to be delegated wholly to Health and Social Care Partnerships, we remain unconvinced by the distinction between voting members and professional advisers in the proposed partnership committee structure. Furthermore the scope of the advisers to the committee in current proposals is wholly insufficient to ensure the full breadth of professional expertise required to deliver safe, high quality and efficient care.

HSCPs will have an important responsibility in ensuring the safety and quality of the services commissioned to deliver on national outcomes, and assuring NHS board chairs, council leaders, the Cabinet Secretary and the public of this. This assurance will become ever more important as increasing levels of current 'acute' interventions and greater levels of complex clinical care are delivered within the community settings for which HSCPs will have responsibility for delivery. Professional governance will be key.

Nurse leaders are not the only professionals who need to be engaged in the governance of quality care but, given their roles and responsibilities, they are certainly one of them. The recent Joint Declaration on Nursing, Midwifery and Allied Health Professional (NMAHP) Leadership in Scotland⁶ states:

- *NMAHPs will take responsibility for effective management of public resources. They will play a central role in strategic decision making locally and nationally developing solutions that are quality improving and cost reducing and ensuring that in line with their professional obligations, any clinical risks are fully and openly considered.*
- *NMAHPs will be a dynamic, modern, informed, engaged, competent and compassionate workforce who will drive quality in healthcare settings.*
- *NMAHP practice will be a byword for care, compassion, excellence, innovation and professionalism throughout Scotland and internationally.*
- *NMAHP practitioners will be outstanding exponents of partnership working, professional expertise and leadership in their fields.*
- *NMAHPs will work across boundaries to facilitate health and wellbeing for individuals, families and communities at all stages of life.*

⁶ NHS Scotland, *A Joint Declaration on NMAHP Leadership from Scotland's Chief Nursing Officer, Chief Health Professions' Officer and Nursing, Midwifery and Allied Health Professions Leaders* (2010)

NHS territorial boards have been constituted to include healthcare practitioners such as the nurse director (since 2002) and the medical director (since 2003) to underline the importance of clinical engagement and advice in service development and decision-making. A commitment to clinical engagement is shared in the current integration consultation. A full voting role was afforded to nurse directors on NHS governance bodies to:

- To share collective responsibility for governance across the local NHS system
- To ensure that nurse leadership is seen as integral to the corporate management of each NHS Board area
- To focus the contribution of nursing expertise available to the NHS Board
- To provide an effective conduit through which other nurse leaders within the local NHS system can influence the work of the NHS Board
- To bring their expertise to the Board in a number of areas such as clinical quality; patient responsive services and health promotion⁷

We appreciate the former Cabinet Secretary for Health and Wellbeing re-affirming her commitment to the place of Nurse Directors on NHS Boards in discussions with the Director of RCN Scotland⁸.

South of the border, where Clinical Commissioning Groups are being established, the Westminster Government and the RCN have been clear of the importance of nursing to the success of these new bodies. Whilst CCGs are certainly not identical to Scottish proposals, they contain significant parallels.

*An effective lead nurse role provides emerging [Clinical Commissioning Groups] with an essential focus for quality, safety, effectiveness and efficiency and contributes not only towards successful authorization but also towards ongoing improvement.*⁹

The RCN contends that if the Scottish Government accepts that a nurse director with voting rights (among other professional leaders) is central to the work of the NHS board of governance, this should be matched by an equivalent statutory presence on the HSCP partnership committee, given this group will have delegated governance responsibility for significant amounts of healthcare delivery. 94% of respondents to a recent RCN survey on the Bill proposals agreed that a nurse leader should be represented on the governance group. This approach would also help to support integrated strategic clinical and workforce decision making at community and acute level between the HSCP and the NHS Board – a key element of ensuring integration between hospital and community healthcare within the proposals.

We do appreciate that this approach is not mirrored in existing governance arrangements for local government. However, if the governance function of the partnership committee is to oversee delivery of the client-focused national outcomes in a complex health and care landscape – and the Scottish Government and COSLA are committed to putting practitioners at the heart of these arrangements – we are sure that national leaders will find constructive and innovative ways to integrate effective governance, despite these differences in current approach.

On a practical note, the intention to establish 32 HSCPs will leave those NHS boards directors – including nurse directors – covering multiple local authority areas,

⁷ Scottish Executive, *Guidance to NHS Boards: Appointment of Nurse Directors* (2002)

⁸ Meeting between Theresa Fyfe and Nicola Sturgeon MSP (16 October 2009)

⁹ RCN, *Towards Authorisation – the Lead Nurse Contribution to Clinical Commission Groups* (2011)

stretched in terms of capacity to serve effectively on partnership committees. Whilst we wish to see a nurse leader take a full seat on each partnership committee, alongside their colleagues in other health and social care professions, it would be prudent, given the number of partnerships within some NHS Board boundaries, for the NHS Executive Nurse Director to have the power to delegate this responsibility to a senior nurse within the board. We would support regulations to the Bill setting out the expected competencies of any nurse fulfilling this delegated role.

Staff Governance

NHS Scotland is rightly proud of its work to develop positive industrial relations through a Partnership approach between the Scottish Government, NHS employers and trades unions. The recent evaluation of the Scottish Partnership approach by Nottingham University stated that it has “matured into the most ambitious and important contemporary innovation in British public sector industrial relations”¹⁰. The foundations of the last thirteen years’ work in Scotland give us a basis to improve integrated care through an emphasis on respect and collective responsibility.

Moves to increase the pace of local change and institute significant reform to the ways in which staff are expected to work increases the need for sound relationships, established within structured supports, between employers and staff representatives. Staff are the greatest asset the public sector has and successful change will be reliant on their energy, commitment and innovation. As such, their views must be voiced and their professional development and rights protected throughout all new proposed structures. We welcome the inclusion of a national outcome focused on ‘an engaged workforce’ as this is crucial to the delivery of quality care. However, the Scottish Government and CoSLA’s commitment to staff governance should also be reflected clearly in primary legislation.

We call on the Scottish Government to include a duty on all Health and Social Care Partnerships to adhere to the Staff Governance Standard within primary legislation. We also wish to see staffside representatives guaranteed on the partnership committee and any other key planning groups or sub-committees of partnership structures. We also acknowledge that the current working practices of national Partnership groups will need to be reviewed to ensure they are fit for purpose within an integrated landscape that is promoting the centrality of staff engagement across the public sector.

We note that the consultation document does not oblige partners to transfer staff between employers, but is clear that such approaches will be permitted. The RCN urges caution over the distraction from care that such significant structural changes can bring about. There are many examples of positive collaborative working in Scotland that have not required such radical re-alignments and we have yet to see how the approach taken to transfer staff in Highland will improve care and outcomes.

When we surveyed nurses on the proposal to permit staff transfer, a small majority were outright opposed to such moves. Whilst many respondents saw a potential benefit for patients in improved sharing of information if staff worked for the same organisation, key concerns were raised about access to professional supervision and clarity of professional accountability – issues we have raised elsewhere in this response. Given the justifiable concerns of nursing staff on the implications of staff transfer – particularly with regard to maintaining professional support for quality

¹⁰ Bacon, N. & Samuel, P., *Partnership in NHS Scotland 1999-2011* (2012)

service – we call on the legislation to impose a duty on partnerships to agree any staff transfer proposals with staffside and professional representatives.

However integrated teams are configured in the future, the RCN would also expect that, at a minimum, existing terms and conditions of staff will be maintained and that terms and conditions of employment are appropriately transferred if staff face a change of employer under TUPE arrangements. We would urge employers and the Scottish Government not to waste the considerable investment made in the equality-proofed and Partnership approved Agenda for Change framework operating in the NHS. Nothing in the new Bill should be included that could undermine these protections for staff.

Public and patient participation

Alongside their accountability for clinical quality, many Executive Nurse Directors are responsible for their NHS Board's patient and public involvement. We are disappointed to see so little mention of public involvement in the new structures and processes set out in the consultation. This seems at odds with wider Scottish Government policy to increase public participation in public services and does not acknowledge the important place of the public in developing services, nor the extensive positive work already in place between staff and patients/service users/public across care services.

The primary legislation must make clear the duties of HSCPs to involve the public, patients/clients and carers in decision-making and ongoing governance arrangements. Existing participation standards and guidance on involving the public in major service change within the NHS could usefully be brought into play.

In addition, we do not see how, in the current proposals, a single patient / service user on the partnership committee, without any additional mechanisms identified to support their involvement, will give that individual committee member a clear mandate to speak, nor give the HSCP the plurality of patient perspectives that are so valuable to service development and delivery. Nor are we clear how this individual would be appointed to the committee. The draft Bill must clearly set out how the governance committee (along with other planning and delivery committees or groups of the HSCP) will be obliged to engage with and involve users/carers beyond a single individual, and also clarify the appointment process for a representative to the partnership committee. This will go some way to ensure the legitimacy of the user's voice and parity of esteem among partners.

Finally, we are keen to hear how the work of the Scottish Health Council would change to support public engagement and involvement in an integrated care landscape.

Other general comments on proposed structural arrangements

In terms of the Joint Accountable Officer role, given their responsibilities under these proposals, it is important that they are a skilled, strategic leader with experience in the delivery of successful care services. The RCN would not support the post being limited to any particular profession, but believes that opportunities to fill this important new role should be open to all appropriately experienced and qualified applicants. We would expect the core skills and experience expected of the Joint Accountable Officer to be set out in regulation. Similarly we would expect the core skills and experience of other officers, such as the Clinical Director, to be set out in regulation to ensure that the scope and standards of professional input into significant areas of

health and care delivery is maintained, even if structures can be adapted to local circumstance.

Given the complexity of governance arrangements proposed – which may vary between services for different age groups and will not include all of the acute sector or all relevant council services – the RCN suggests that minimum standards for partnership agreements, set out in regulation, should include clear schemes of delegation to ensure both those with governance and with delivery responsibilities are supported by a clear understanding of the scope of their roles.

Scope of HSCPs beyond individual council boundaries

Given the lack of co-terminosity between many councils and NHS boards, we are not convinced there is a perfect solution to how to manage the boundary issues that will arise in the current landscape. The JIT paper, *Barriers to Partnership Working* states that “different geographical boundaries (lack of co-terminosity) will hamper accountability, decision making and budgeting”. This may indeed be a significant difficulty for some NHS partners, like NHS Greater Glasgow & Clyde or NHS Lothian. We note that when the Scottish Government chose to pilot elected Health Boards, it selected two NHS boards with co-terminus councils to trial the approach, presumably because of the ease of managing governance changes in these circumstances. We are unclear how longer-term partnership agreements involving more than one council area may be affected by changes in political leadership at council elections.

We also note that the current JIT guidance on preparing Joint Strategic Commissioning Strategy for Older People states: “Where the NHS Board area and Council boundaries are not co-terminus [the strategy] should sit above individual partnership plans and provide a pan-NHS Board area perspective”. We presume this guidance is anticipated to be the basis for future strategic commissioning for HSCPs, but are not clear how this directive to develop strategies at NHS board level sits alongside the proposed permissive but not directive approach to multi-council partnerships.

Integrated budgets and resourcing

Quality and safety safeguards in delegated financial decisions

The RCN’s recent survey of nurses on the Scottish Government’s integration proposals showed very mixed views from staff on the ground regarding the proposals for fully integrated budgets. Particular concerns were highlighted around:

- Significant cuts to social care budgets resulting in health monies being spread too thinly to cover the shortfall
- Pressures from increased paperwork
- Fears that the founding principle of an NHS which is free at the point of need would be threatened by wholesale financial integration with council services which do not share this approach.

Discussions with nurse leaders in Scotland showed more consistent strategic support for full integration of budgets, but only if certain safeguards are guaranteed to ensure that safe, high quality patient care and public protection are reflected in financial decisions made. The RCN is willing to support moves to integrate budgets as proposed, with a clear focus on channelling expenditure to improve outcomes for

local people, as long as there are such robust safeguards in place, which include, but are not limited to:

- Clear outcomes for all patient groups and accompanying indicators
- A defined role for nursing expertise, alongside that of other professional colleagues, in the governance and the commissioning of services
- Established lines of professional accountability and delegation, with a defined leadership structure
- Clarity of clinical and social care governance arrangements, which includes an emphasis on improvement support as well as assurance and scrutiny
- Robust performance management and risk management processes
- Clarity on arrangements for local and national scrutiny of budgets
- Support from the Scottish Government to standardise financial systems and expectations in order to reduce bureaucracy and improve transparency
- Clarity at national policy level on the role of private sector procurement within Scottish healthcare

These safeguards are, however, not yet all clearly articulated in the proposals for legislation and this must be addressed as the Bill is drafted. Our concerns, and potential solutions, in relation to these safeguards are detailed through this response.

Understanding the scope of budgets 'without identity'

In terms of the proposal that health and social care monies will 'lose their identity' in the integrated budget, we would appreciate further clarification on how this principle will take account of the substantial, ring-fenced money channelled to GP practices through current contractual arrangements. If, as we assume, the current funding mechanism for GP services will remain with just minor amendments (for example to financially support GP engagement in new integrated planning models), we would also welcome a better understanding of how GPs will be freed to innovate to deliver services within the Joint Strategic Commissioning Plan and how, if at all, specific QOF arrangements might be adjusted to leverage required change identified through an HSCP's Strategic Commissioning Plan.

The RCN appreciates the intention to include some acute budgets within the financial control of the HSCP to leverage change, but the proposals as they stand are simply too vague to have the desired effect or convince NHS staff of the genuine commitment to direct a shift in resource from acute to community provision. The scope of the Scottish Government's intent with regard to acute budgets must be clearly and meaningfully articulated within both the wider narrative required on integration and, where appropriate, in legislation.

Finally, it would be helpful if the Scottish Government could detail the impact of these integrated budget proposals on current funding approaches to the NHS which include significant non-recurring funds, earmarked for specific projects linked to Scottish Government policy priorities. We presume that the Scottish Government would lose significant levels of current directive power over community health in these new partnership arrangements.

Transparency and external scrutiny

The RCN has been closely monitoring national investment and local expenditure in NHS Scotland for the past four years. This has supported us to better understand the pressures boards are facing, and assess the possible impact of those pressures

on workforce and care quality, in order to engage meaningfully in discussions as both a trade union and professional body. To do this work we have been reliant on the comparative data provided in NHS monthly monitoring returns and ISD data, as well as the parallel work conducted by Audit Scotland and the Scottish Parliament's Health and Sport Committee on both the annual budget and health board expenditure and savings. The RCN, Audit Scotland and MSPs on the current health-focused subject committee have all raised concerns about the quality of data available, even in the current single system, to understand the true impact of financial decisions made. With demand increasing, finances tightening and decisions being made to invest resources differently this level of external scrutiny and assessment will become ever more important.

The RCN calls on the Scottish Government to clearly set out how national audit and parliamentary scrutiny of public sector spending and investment will be delivered when budgets are fully integrated. In addition we seek clarity on how comparative and meaningful national data sets on performance will be delivered. We also ask the Government to consider whether there are any specific duties that should be placed on the statutory partners to comply in these regards.

Professionally led locality planning and commissioning of services

The commissioning and planning arrangements anticipated for HSCPs lack clarity within the consultation paper, making it difficult at this stage to make definitive statements about our support, or otherwise, for the proposals.

Regulation on the minimum content of partnership agreements

In terms of the scope of a partnership's work, the RCN urges the Government to agree to set out in future regulation the minimum content of partnership agreements, in addition to providing guidance and model agreements to support partnerships in the complex task of contractual agreements. We agree that it is important that the financial contributions of partners are clarified in these agreements, as suggested in the consultation document, but the scope of essential issues to be addressed is much wider. In other parts of this response we have set out some of the areas that we think should be covered in a national directive on partnership agreement content. Partnerships should also be under an obligation to publish their formal agreement online with one month of it being signed.

Clarity on procurement

In terms of the scope of commissioning itself, the RCN continues to hold concerns about the tensions between current Government policy on a 'publicly funded and publicly-delivered'¹¹ NHS and a commissioning definition that includes procurement in a scenario where health and social care monies are expected to lose their separate identities. As the Government itself acknowledges, health and social care services have taken quite different philosophical approaches to the purchasing of services in Scotland. As health money is no longer to be ring-fenced, but will be merged with social care funding, we call on the Scottish Government to clarify how they envisage that local planners and purchasers of integrated care services can confidently assure politicians and the public that they are implementing national policy on a publicly delivered NHS. We also ask the Government to make public any risk management plans drawn up in relation to the increase in private sector delivery

¹¹ Scottish National Party, *Re-elect a Scottish Government working for Scotland: manifesto 2011* (2011)

of healthcare in Scotland.

We note that the parallel consultation on a Procurement Reform Bill further opens up the possibility of obligations to include the private sector in all public sector procurement decisions.

The merging of budgets as proposed also, we believe, has implications for the limited social care focus of the Self-Directed Support Bill currently before Parliament, which is why we have written to the Minister for Public Health to request he consider postponing the legislation until we are clear it can be future-proofed adequately against these integrated budget proposals.

Links between locality planning and commissioning strategies

Although it is proposed to place a duty on HSCPs to 'consult' with local professionals with regard to planning arrangements and then implement and maintain those arrangements, we understand that: it is the Joint Accountable Officer who will hold responsibility for commissioning and managing services; the partnership committee which will have responsibility for 'the efficient, effective and accountable governance of the Partnerships', and the NHS Board Chair and Council Leader will form a 'community of governance' overseeing 'the effectiveness of the Partnership'. In this context we have not been able to be wholly clear how the Scottish Government is envisioning the commissioning plan being produced, how distinctions are being clearly drawn between operational and governance functions and how the Joint Accountable Officer or Partnership Committee will manage the apparent policy drive to integrate a top-down and bottom-up approach to professionally-led planning and commissioning.

The RCN would like to see clearer parameters for the development of commissioning plans across all HSCPs set out in legislation to ensure basic standards in the balance of expertise required to develop strategic commissioning plans. If the Partnership Committee is to take an active role in the writing of the full strategic plan, as well as the governance of it, then this further underlines our call for professional, staffside and user/carer representatives to take voting roles on this group. If operational development of the full strategic plan is to be delegated to a separate group, the minimum membership of any such commissioning group of the partnership should be set in statute and certainly include the expertise of a nurse lead among other professional representation.

We are involved in ongoing Government work to define the role of locality planning at a sub-partnership level and we have seen a draft of the principles set out from the group leading this work. We agree that Partnerships should be under a duty to *involve* groups of practitioners (including nurses), users/carers and staffside representatives in defining local needs and designing interventions and supports to meet these needs in a manner that will contribute clearly to the overall partnership commissioning plan. If locality planning groups are to hold delegated financial, performance and quality responsibility for delivery of their local activity and outcomes within the partnerships strategic commissioning plan then, there should be an obligation for HSCPs to produce clear schemes of delegation to ensure that all parties understand the responsibilities they are discharging. Again, to ensure consistency of available expertise to influence quality across Scotland, we would like to see the minimum membership of locality planning groups set out in statute.

We know that, in terms of clinicians, the balance of those engaged in planning groups has changed over time, as, for example, LHCCs developed into CHPs.

Having learnt from experience that the actual or perceived exclusion of any professional group does not support the best in integrated services, we call on the Scottish Government and, in the future, HSCPs to ensure that all efforts to engage staff in local activity – legislative or otherwise - are rooted in an ethos of parity.

We wholeheartedly agree with the statements in the draft paper on locality planning that to make locality planning a success, employers must be adequately resourced to free up professionals' time, including that of frontline nursing staff, to engage meaningfully and equitably. Partners should be expected to demonstrate this as part of their performance management arrangements.

As the Community Empowerment and Renewal Bill proposals are also taken forward, we trust that the Scottish Government will ensure that any decisions regarding delegated control of public sector planning and budgets to local communities will be coherent with locality planning arrangements set out within integrated care proposals.

Finally, all partnerships should be under a duty to publish their Joint Strategic Commissioning Plans online within one month of their agreement.

Defining a locality

When we asked our membership their opinion of using GP practice boundaries to define a locality through our survey, responses were mixed and there was no majority opinion on this proposal. Until we are clearer what exactly the function of a locality planning group will be, defining its form appropriately is not entirely possible. On a practical note, if partnerships are to be defined by local council boundaries, imposing GP boundaries on locality planning groups may well result in some localities crossing over local authority borders.

Finally, whilst we welcome the genuine engagement of local practitioners and local people in the planning and accountability process, we are mindful of the need to ensure that artificial lines drawn across geographic or interest groups do not result in the unintended fragmentation of services within communities or the disconnect to services provided on a whole-partnership, regional or indeed national level. For this reason it is imperative that the Scottish Government is clear in its expectations of how local, partnership, regional and national health and social care priorities and service re-design plans should be co-ordinated in the future. For example, a locality might have to significantly adjust its planned community service provision if the Scottish Government decided to centralise a specialist acute service into a single hospital base, on the assumption that increased community healthcare services are available on discharge. In current proposals, the links between the different levels of planning needed to make integration work seamlessly are simply not clear enough.

Conclusion

We do not underestimate the scope or complexity of reforms suggested by these early proposals and by wider discussions with the Scottish Government. Clearly those with political and performance accountability for public services are facing important questions about the scope and limits of their influence and responsibilities in this new landscape - questions that will be familiar to frontline practitioners responsible for negotiating the boundaries of integrated care services on the ground. We hope that this point of mutual recognition will increase awareness of the

challenges, anxieties and real opportunities these changes will bring, whatever part an individual is playing in Scotland's care services.

Our key message, throughout the detail of our response, is that if the legislation is to support the delivery of person-centred and relationship-focused care to improve outcomes, then the Bill cannot ignore the opportunity to legislate for quality, protect safety and ensure the engagement of staff and the public. On this basis, there is more work to do to ensure a Health and Social Care Integration Bill truly does provide the levers we have been missing to date.

We look forward to continuing to work with our members, the Scottish Government and other partners to develop these proposals over the coming months.

Yours,

A handwritten signature in blue ink, appearing to read 'Theresa Fyffe', is shown next to a circular official stamp. The stamp is partially obscured and contains illegible text.

Theresa Fyffe
Director

OUR VISION FOR THE INTEGRATION OF CARE¹²

People in Scotland using health and care services should expect to experience seamless and timely access to the dignified and compassionate care they need to improve their quality of life. This care should be delivered by appropriately trained staff in the home or the local community wherever possible. Staff working in health and care services should be able to do the best job possible for their client group, without being hindered by needless organisational, professional, financial or political obstacles. Although this is not always how care is delivered in Scotland right now, better collaboration could allow it to be the norm in the future.

The integration of care is not ultimately about where organisational lines are drawn and re-drawn. Care involves people working with and for people. As such, the focus of our vision of integration is on teams of people, with different expertise and experience, collaborating to meet health and care needs and improve outcomes for individuals, families and communities.

For example, if a frail older person with dementia and a long term respiratory condition wants to stay at home, they may need: a community nurse to check they are responding positively to treatment and to keep their GP and hospital consultant up-to-date; a social worker ensuring respite is on hand for the family and day-to-day living support is in place; a welfare rights worker helping them get the most of their benefit entitlements; and a befriender supporting them to find the confidence to engage with community activities. Integration should be about service users, carers, staff and volunteers working together in a co-ordinated way to enhance quality of life wherever possible.

Good integrated care will involve recognising and nurturing the distinct knowledge, expertise and contributions of everyone involved: patients and carers, frontline health and care staff, managers and leaders. This culture of mutual respect should permeate all aspects of the planning, design and delivery of care in Scotland: from the boardroom to the frontline, from the Scottish Parliament to the family home.

None of this will be possible without organisational and political leaders putting in place the right conditions to underpin these behaviours and relationships. The Scottish Government, and its partners, will need to ensure that they set out the policies, processes, governance systems, accountability structures, resources, difficult choices and realistic outcomes needed to support those at the frontline to deliver such respectful, collaborative and high-quality care.

Building on this vision, our principles for delivering integrated care are intended to apply to whatever model, or models, of integrated care are promoted in Scotland and whether plans focus on adults, children or both. Grouped under four themes, they set out actions required from individuals, staff, care organisations and political leaders:

1. Commit to processes that sustain respectful relationships
2. Ensure local integration plans are designed, in partnership, to improve outcomes
3. Secure the quality and safety of integrated care
4. Set the national foundations for integrated care

¹² From: RCN, *Principles for delivering the integration of care* (2012)