The Royal College of Nursing (RCN) Scotland is the trade union and professional organisation for nursing. We have 39,000 members in Scotland, including nurses, nursing students and nursing and healthcare assistants.

We are delighted to provide written evidence to this Finance Committee’s first draft budget review and its scrutiny of the delayed CSR. Clearly some of the questions posed by the committee are aimed specifically at delivery agencies and, as such, our submission focuses on just five of the questions set.

**Question 1 – areas to prioritise in the Comprehensive Spending Review**

The RCN offered written and oral evidence to the previous committee’s Inquiry into Preventative Spending, as well as participating in the subsequent chamber event held earlier this year. We will not repeat the content of those earlier contributions here. However, during the inquiry process many of the health and care interventions that would benefit from budget prioritisation were well articulated by many participants:

- investment in universal health services from pre-conception to 3 years old, with additional targeted services where need is identified;
- improved community-based support to promote the wellbeing and independence of older people and avoid unnecessary and expensive acute admissions;
- increased access to evidence-based interventions to reduce harm from drug and alcohol misuse, smoking and obesity, and
- more early support to those with long term conditions to better self-manage their situation to avoid, where possible, accelerated deterioration of health and acute episodes of care.

The RCN would contend that, whilst the exact methods of delivering some of these interventions may differ locally according to the specific needs of geographic or interest communities, there is general consensus within Scottish civic society that these are the areas of central government spending that can best improve long-term health outcomes. In each case, prioritisation of these areas in the CSR, and improved local delivery of evidence-based interventions, could reap significant financial, personal and societal gain over the medium-to-long term, by supporting individuals, families and communities to become healthier, more resilient and more able to engage in activity.

However local agencies, including NHS boards, face an unenviable dilemma right now. With significantly straitened budgets, obligations to deliver fixed annual efficiency

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targets, rising inflation, fast increasing health costs, growing demand, and high public and political expectations, boards are being expected to re-prioritise local funding to improve long-term outcomes whilst continuing to treat those patients who have not benefited from a prioritisation of preventative spend. “Failure demand”, as the Christie Commission called it, will not be reversed overnight. As such, the key question is: in the current financial climate, and given Scotland's current health needs, where is the money for a step change in preventative spend coming from, if healthcare is to be delivered safely and equitably across the whole population?

In answering questions 2, 3, 7 and 8 of the call for evidence we offer some possible answers to this question.

Questions 2 and 3 – Scottish Government activity to support increased preventative activity

A. Efficiency savings

For 2011-12, the Scottish Government made an amendment to the wording of its NHS HEAT target on efficiency savings, adding explicitly that the board would make their 3% savings “to reinvest in frontline services”. Were this to be realised it could, in theory, provide significant upfront investment (up to around £227m this year across Scotland’s territorial boards) to shift the focus of NHS activity to more preventative work. We appreciate the Scottish Government’s intent in re-wording the target, but willing it to be so will not necessarily make it so. There are three key difficulties in releasing this funding for re-investment in preventative services:

1. As the previous Finance Committee’s inquiry report emphasised, Audit Scotland, among others, has repeatedly raised concerns that declared cash efficiencies cannot be verified.

   One of the key findings in our report is that the information really is not good enough to make it clear that efficiency savings are just that, rather than cuts, reductions in quality or money being moved around.2

   Our recent report into the financial and workforce pressures facing territorial NHS boards, Taking the Pulse3, confirmed how hard it is to monitor and track health boards’ efficiency savings and to understand the real impact that headline cash saving figures are having on patients, staff and services on the ground.

   If no-one is truly able to confirm that these declared efficiencies are ‘real’, and to track cash movements adequately, then none of us can be sure that money can be released for genuine preventative re-investment.

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3 RCN, Taking the Pulse of NHS Scotland: a report from the Royal College of Nursing on the finance and workforce pressures facing NHS Boards (Dec 2010)
2. Given the pressures on the NHS detailed earlier in this paper, many health boards are reliant on making ‘savings’ in excess of their efficient government target to ensure they meet their statutory obligation (and HEAT target) to achieve annual financial balance. In the previous Health and Sport committee’s inquiry into health board allocations, boards were asked what cash savings they would need to realise to break even as a percentage of their allocation in 2010-11. Of the boards who responded within the committee’s timescales, all indicated they would need to make more than their 2% savings target for that year, just to balance the books\(^4\). The financial situation has significantly worsened since that inquiry was undertaken and there is no reason to assume that savings made by boards this year, or in the near future, will represent surplus for genuine re-investment, however the HEAT target has been worded.

3. Fixed one-year targets for individual public sector bodies to release cash efficiencies risk skewing the prioritisation of savings schemes away from medium-to long-term efficiency (such as many preventative spend initiatives) or from sharing financial benefits across those organisations funded by the public purse - despite both approaches being central to current political discourse. When NHS chief executives and finance directors are being actively performance managed by the Scottish Government to realise annual efficiencies as currently configured, there is no real incentive, or indeed sufficient room, for health boards to increase investment in activity that will deliver on priorities for prevention. Incremental cuts to meet annual targets may well distort, not support, attempts to re-configure services towards early intervention.

In overseeing the acceleration in nursing posts being lost from the NHS, for example, neither the Scottish Government nor health boards have demonstrated how cash savings declared through reducing clinical staff will facilitate re-investment plans to increase preventative services\(^5\).

Clearly, more must be done to ensure NHS boards and the Scottish Government are obliged to demonstrate how changes to staffing will support the prioritisation of preventative activities.

Scotland’s NHS performance management system was conceived in a time of plenty and has yet to adapt to offer NHS boards – and their partners - the flexibility they require to meet the new challenges they face. The current approach to cash saving targets, realised by individual public bodies in-year, emphasises the importance of accounting balance, but not the importance of economic benefit to communities and the wider public purse. The RCN could not support a CSR which simply squeezes individual


\(^5\) Figures released by ISD on 30 August 2011 show that: there has been a decrease of 485.7 nursing and midwifery whole time equivalent (WTE) posts in the first quarter of this financial year between 31 March 2011 and 30 June 2011. The decrease over the last quarter shows an acceleration in loss of posts, following a decrease of 711.3 WTE over the previous six months from 30 September 2010 to 31 March 2011, and a decrease of 550.2 WTE between September 2009 and September 2010. Nursing and midwifery WTE is now at the lowest level since 2006 (56,783.9 WTE in Sept 2006 compared with 56,681.2 WTE in June 2011). See: http://www.isdscotland.org/Health-Topics/Workforce/Publications/index.asp#836
public bodies to balance the budget and release funds for re-prioritised spending through continuing with the current configuration of fixed, local efficiency targets.

The Scottish Parliament, among others including the RCN, has raised these issues repeatedly over a number of years. We appreciate the need to ensure financial stability in the public sector; however, to deliver a shift to the prioritisation of preventative spend by local bodies in the current climate these structural barriers must be addressed, practically, by central Government now, however hard the targets may be to redesign. The Scottish Government must, as a matter of urgency, support health boards to prioritise preventative spending by developing a creative new approach to verifiable savings realisation which better capture economic and societal benefit and incentivise joined-up, longer term planning for improved outcomes from wider public sector investment.

B. Focusing on budgetary priorities to facilitate the necessary step-change

Local public bodies cannot be expected to deliver a step change towards preventative spend without a clear direction from central government over what to value, and therefore what to prioritise financially.

An accounting focus on efficiencies is not the same as a budgetary focus on priorities. There is certainly still scope for the NHS to deliver more efficient services by, for example, reducing unnecessary variation in prescribing or surgical approaches. However, over-emphasising the place of local bodies in releasing re-investment funding from limited budgets, when much of the low-hanging fruit has already been picked, risks perverse and disjointed decisions being made over where to focus limited funds. In addition, it is unlikely to release the scale of funding required to make the shift in resourcing, whilst also managing current “failure demand”.

National prioritisation of ever-more limited public funds, when public expectations and demands of services are running high, is never going to be an easy or comfortable activity for any chief executive, politician or, indeed, trade union. However, if the political will is for increased preventative investment in the current climate, the Scottish Government and the Scottish Parliament will need to be as clear in their support for disinvesting from those areas no longer prioritised, as they are in their support for investing in prevention.

As one step, the Scottish budget process could underpin this shift by more clearly linking national allocation decisions to stated priorities for the public sector. As another, a clear framework for regional and national disinvestment decisions should be set out. This would address some very real concerns noted in the recent Ministerial Strategic Group report on the first wave of Change Fund applications:

...the area that is generally weakest across the Plans is with respect to how the Change Fund will enable shifts in core budgets over the next 5 years. In most cases it is not clear to what extent partnerships have associated planned
activities with tangible targeted reductions in institutional care, and associated budgets (hospital and long-term residential care) in favour of community based services…. The Group also notes partnerships’ anxiety over political support for disinvesting in institutional provision…  

Linked to this point, we are generally supportive of the proposal put forward by the Christie Commission for a set of criteria to be agreed for the reform of public services. Their initial ideas could usefully be further developed, through consultation led by the Scottish Government, to support the process of prioritisation at both local and national levels and ensure a supportive, shared approach to the sorts of re-configuration of services that would be needed to underpin improved outcomes through preventative approaches.

Finally, this should dovetail with a fully integrated performance management system for the public sector in Scotland that sets a clear purpose and outcomes that reflect any agreed prioritisation of preventative spend. The RCN recently responded to a limited Scottish Government consultation on NHS HEAT targets, which remain largely orientated to process-targets like reduced waiting times, arguing for a single system of integrated measurement for the public sector. This would support NHS boards and their partners to collaborate more easily in delivering on preventative measures, aid in benchmarking and ensure consistent reporting across agencies.

We understand that the National Performance Framework is also under review. As this is an accountability system intended to apply to the whole of the Scottish public sector, commenting on HEAT proposals outwith this wider context seems to us to be an artificial and unhelpful split in practice… We believe that central government could far better support practitioners’ delivery of national policy on collaborative, outcome-focused service delivery by instituting an integrated performance management system. Whilst some individual clinical targets may still be relevant to the NHS alone, broad outcomes and many specific indicators should be clearly shared across public bodies.  

C. Ensuring equity

Scotland’s health inequalities are shocking and persistent. Scotland has one of the lowest life expectancies in Western Europe with a four year difference in life expectancy between men living in the borders Borders (77.1 years) and their counterparts in Greater Glasgow & Clyde (73.1 years). In 2007/08, healthy life expectancy at birth was just 57.5 years for males and 61.9 years for females in the most deprived areas of Scotland. Realistically, much preventative spending is likely to be required to be targeted at those populations presenting with high levels of health need to ensure equity of outcome and reduce the personal and financial costs of ill health in Scotland.

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6 Ministerial Strategic Group on Health and Community Care, Reshaping Care for Older People Change Plans – national overview report (Mar 2011)
7 RCN response to: Developing proposals for new HEAT targets 2012/13 (Aug 2011)
8 General Register Office for Scotland, Life Expectancy for Administrative Areas within Scotland, 2007-09 (Sept 2010)
9 See: http://www.scotland.gov.uk/Topics/Statistics/Browse/HealthTrendLifeExpectancy
Clearly some areas of concern in overall preventative spending that impact on equity, such as welfare payments, are outwith the scope of this scrutiny process. However, we note that the Scottish Government had clearly intended to extend the socio-economic duty contained within the UK Equalities Act to Scotland. Imperfect though the detail of this legislation might have been, it would have placed a statutory duty on public bodies to take account of the socio-economic impact of their decisions, including their financial decisions. However, the decision by the UK coalition to refuse to commence this part of the Act has removed the direct route for Scotland to set this standard for public bodies. The RCN would be keen to hear, as part of the CSR process, what alternative approaches the Scottish Government may now be considering.

Questions 7 & 8 – improved collaboration to support a preventative approach to spending

We have already noted how a new approach to efficiency savings and performance management frameworks could support better collaboration to deliver preventative work across the public sector.

Ways to remove local barriers, such as increasing the flexibility of shared budgets, is the focus of much political discussion at this time and we look forward to engaging with the Scottish Government in detail on its plans to increase collaboration in the delivery of adult health and social care over the autumn. However, we have noticed that much political store is being placed in the Integrated Resource Framework as the means to deliver improved pooling of budgets. We would highlight to the committee that the IRF is still in a pilot stage, with just 4 partnerships taking forward the second stage of the pilot. These are at different stages of development and one area, Highland, has made a decision to go far beyond the scope of its original proposal. The evaluation of this approach is not due to be completed until the end of this year and we caution against deciding that this is the answer in advance of that report. Audit Scotland provided a very helpful summary of shared budget arrangements in its recent, critical report, of Community Health Partnerships:

There are two types of joint funding approaches that NHS boards and councils in Scotland use: aligned or pooled budgeting. Each approach has advantages and disadvantages. In Scotland, the most common joint funding approach is aligned budgeting.

Whichever approach to the funding of services is chosen it is important that NHS boards, CHPs and councils focus first on what they are trying to achieve through joining up their services. Clarity about this should help in choosing the most appropriate approach to the joint funding of services.

We found only one example of a genuine pooled budget in Scotland … Pooling budgets requires significant trust between organisations and a jointly agreed vision for services. Pooled budgets can allow more flexibility and a faster
response to individual user needs, but setting them up can be more complicated and resource intensive than aligning budgets in the short term.\textsuperscript{10}

Finally, given the highly cluttered landscape described in this recent Audit Scotland report on CHPs, RCN advocates a national review of these local partnerships to ensure sound and transparent governance of integrated services.

\textsuperscript{10} Audit Scotland, \textit{Review of Community Health Partnerships} (June 2011), pp.26-28