Health and Sport Committee

5th Report, 2012 (Session 4)

Inquiry into integration of health and social care

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Health and Sport Committee

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CONTENTS

Remit and membership

Report  1
Introduction  1
Background  1
  Integration and Community Health Partnerships  1
  Scottish Government reform announcement  2
  Scope of inquiry  3
  Evidence  3
Key Themes  4
  Principles  5
  Structural change  7
  Implications for other social care services  10
  Leadership and culture  12
  Focus on outcomes  13
  Accountability and governance  15
  Integration of budgets  18
  Change Fund  21
  Wider engagement of the third and independent sectors  25
  Involvement of clinicians and social care professionals  26
Conclusion  28

Annexe A: Extract from minutes of the health and sport committee  29

Annexe B: Oral evidence and associated written evidence  32

Annexe C: List of other written evidence  34
Health and Sport Committee

Remit and membership

Remit:
To consider and report on health policy, the NHS in Scotland, anti poverty measures, equalities, sport and other matters falling within the responsibility of the Cabinet Secretary for Health, Wellbeing and Cities Strategy apart from those covered by the remit of the Economy, Energy and Tourism Committee.

Membership:
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Health and Sport Committee

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Inquiry into integration of health and social care

The Committee reports to the Parliament as follows—

INTRODUCTION

1. On 12 December 2011, the Cabinet Secretary for Health, Wellbeing and Cities Strategy, Nicola Sturgeon MSP (“the Cabinet Secretary”) announced the Scottish Government's plans to integrate adult health and social care.¹

2. At its meeting on 24 January 2012, the Committee agreed to undertake a short inquiry into the Government’s plans.

3. The Scottish Government has not yet consulted on its intended legislation; this report should be seen as a contribution by the Committee to that process.

BACKGROUND

Integration and Community Health Partnerships

4. Community Health Partnerships (“CHPs”) were established through the NHS Reform (Scotland) Act 2004. Under the Act, each NHS board must create at least one in their area, with the task of bridging the gap between primary and secondary healthcare, and also between health and social care.² At present there are 36 CHPs in Scotland.

Audit Scotland report

5. Audit Scotland published a report on CHPs in June 2011. The principle aim of the review was to examine whether CHPs were achieving what they were set up

to deliver, including their contribution to moving care from hospital settings to the community.³

6. In its report, Audit Scotland noted that CHPs were expected to coordinate the planning and provision of a wide range of primary and community health services in their area. This includes GP services; general dental services; all community-related health services; mental health services; and community-based integrated teams, such as rapid response and hospital at home services. NHS boards were also given flexibility to devolve any other function or service to a CHP.⁴

7. Audit Scotland found that two main types of CHP had been developed – the health-led Community Health Partnerships and Community Health and Care Partnerships (“CHCPs”) which sought to integrate social care into the partnerships.

8. Among its key recommendations, Audit Scotland concluded that the Scottish Government should work with NHS boards and councils to undertake a fundamental review of the various partnership arrangements for health and social care in Scotland to ensure that they are efficient and effective and add value.⁵

Inquiry evidence

9. As part of its evidence gathering for this inquiry, the Committee invited three Partnerships to give oral evidence: West Lothian, East Renfrewshire and Glasgow City. West Lothian and East Renfrewshire are examples of Community Health and Care Partnerships, while Glasgow is a Community Health Partnership.

10. In Glasgow, in 2006, five Community Health and Social Care Partnerships were created, covering East Glasgow, North Glasgow, South East Glasgow, South West Glasgow and West Glasgow. However, in November 2010, these CHCPs were merged into a single Glasgow City CHP which no longer had social care within its remit.

Scottish Government reform announcement

11. In her announcement, the Cabinet Secretary stated that the Scottish Government had decided not to create a new statutory organisation separate from the NHS and local authorities “which could create further barriers to integration”.⁶

12. The key elements of the Scottish Government’s plan to integrate adult health and social care are—

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Community Health Partnerships will be replaced by Health and Social Care Partnerships, which will be the joint responsibility of the NHS and local authority, and will work in partnership with the third and independent sectors

Partnerships will be accountable to Ministers, leaders of local authorities and the public for delivering new nationally agreed outcomes. These will initially focus on improving older people’s care and are set to include measures such as reducing delayed discharges, reducing unplanned admissions to hospital and increasing the number of older people who live in their own home rather than a care home or hospital.

NHS Boards and local authorities will be required to produce integrated budgets for older people’s services to bring an end to the “cost-shunting” that currently exists.

The role of clinicians and social care professionals in the planning of services for older people will be strengthened.

A smaller proportion of resources – money and staff – will be directed towards institutional care and more resources will be invested in community provision. This will mean creating new or different job opportunities in the community. This is in line with the commitment to support people to stay at home or in another homely setting, as independent as possible, for as long as possible. The Change Fund for older people’s services is already helping to deliver these improvements.

Aspects of these reforms will require legislation, and the Scottish Government is committed to holding a consultation on its proposals following the local government elections in May 2012.

Scope of inquiry

The Committee’s inquiry focused on two key questions—

What have been the challenges in better integrating health and social services in the past and are there exemplars of good practice?

What would the detail of the Scottish Government’s proposals need to address to overcome the barriers to integration?

In considering these questions, the Committee agreed to present its findings to the Scottish Government as a contribution to the consultation process, and use them to scrutinise any future legislation.

Evidence

The following organisations gave oral evidence to the Committee—

East Renfrewshire Community Health and Care Partnership

Glasgow Community Health Partnership

West Lothian Community Health and Care Partnership
• Fortuno Consulting Ltd
• NHS Ayrshire and Arran
• NHS Highland
• NHS Lothian
• NHS Tayside
• Alzheimer Scotland
• Coalition of Care and Support Providers in Scotland
• Princess Royal Trust for Carers
• Scottish Care
• Scottish Council for Voluntary Organisations
• Royal College of Nursing Scotland
• Royal College of General Practitioners Scotland
• Association of Directors of Social Work
• Chartered Society of Physiotherapy

17. The Committee thanks all the witnesses for their written and oral evidence.

KEY THEMES

18. The remainder of this report is structured around the key themes which emerged from the written and oral evidence received by the Committee during the inquiry. These were—

• Principles
• Structural change
• Implications for other social care services
• Leadership and culture
• Focus on outcomes
• Accountability and governance
• Integration of budgets
• Change Fund
• Wider involvement of the third and independent sectors
• Involvement of clinicians and social care professionals
Principles

19. In its position paper on health and social care integration, the Association of Directors of Social Work ("ADSW") sought to "inform and influence thinking regarding the desire by government to pursue further integration". ADSW’s proposal was based on the following principles—

- Achieving the best outcomes for the people who use our services
- Early intervention
- Personalised care, power, choice and control for individuals
- Supporting and empowering communities and carers
- Seamless pathways of care
- Equitable access
- Local democratic control
- Evidence based decision making
- Cost neutral / cost saving, transparent and multi-sectoral reform
- Promotion of social welfare\(^7\)

20. In oral evidence, Andrew Lowe, ADSW President, welcomed the Scottish Government’s announcement of plans for integration—

"I make it very clear at the outset that we are an ally in the desire to integrate and move things forward."\(^8\)

21. In a supplementary written submission, RCN Scotland provided the Committee with a copy of a report it had published which set out its own principles for delivering the integration of care.\(^9\) They included actions required from individuals, staff, care organisations and political leaders, grouped under the following four themes—

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

22. RCN Scotland’s report reached the following conclusion—

"The range of principles and associated actions set out in this document underline the scale of change required by all involved to make better


\(^9\) RCN Scotland. Supplementary written evidence.
collaborative care the standard that service users, carers and staff should expect across all of Scotland. This is a complex task for all involved.”

23. In oral evidence, Jim Forrest, West Lothian CHCP, expressed personal enthusiasm about the proposals to integrate health and social care services, believing that this was the way forward. He stated—

“Having a partnership agreement and a proper framework with proper principles, conditions and criteria is entirely the right way to go.”

24. In a subsequent oral evidence session, Henry Simmons, Alzheimer Scotland, argued that there was a lack of “any coherent set of principles and values to govern change”. He therefore advocated the following approach—

“We should spend time considering the principles that should govern the legislation. It has been suggested that there should be a more technically orientated bill. I urge the committee to think carefully about trying to get a coherent set of principles that guide us through the change. Our experience is that every good piece of legislation that has come out of the Parliament has principles that can govern and guide practitioners as they implement it.”

25. Other witnesses, including the Coalition of Care and Support Providers in Scotland (“CCPS”), the Princess Royal Trust for Carers, Scottish Care and SCVO supported this call for a set of principles.

26. Dr John Gillies, Royal College of General Practitioners Scotland (“RCGP Scotland”), stated—

“The important thing is to get the principles of integrated care right and decide exactly what we wish to achieve from this change in legislation.”

27. Arguing in favour of the development of integration at the local level, Andrew Lowe, ADSW, concluded—

“Give us the space to create change. Give us a framework, with the principles to which you want us to adhere and the outcomes that you expect us to achieve. Then let us go away and create, as partners, which is what we do best.”

Scottish Government

28. When she gave oral evidence to the Committee, the Cabinet Secretary set out her own four key principles which underpin the Scottish Government’s policy on integration. These can be summarised as—

- Outcomes-based approach

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10 RCN Scotland. Supplementary written evidence.
Joint accountability (NHS and local government) for delivery of outcomes
Integrated budgets
Strong clinical and professional input and leadership in commissioning services

29. Responding to questions about the lessons which could be learned from the experience of integration in Scotland and elsewhere, the Cabinet Secretary referred to “challenges ahead” as change was implemented, but stated—

“There is an appetite for the changes and people are working constructively with us to ensure that we get the principles and the detail that underpins them right.”

Conclusion

30. The Committee welcomes the principles proposed by the Scottish Government as the foundation for the integration of health and social care services. It will examine in detail the principles contained in the forthcoming bill.

Structural change

31. Representatives of CHPs, CHCPs and health boards were asked whether it was feasible to provide a best-practice blueprint to make integration happen, or, alternatively, if it would be better managed if it was driven at the local level.

32. Julie Murray, East Renfrewshire CHCP, stated—

“There is a balance to be struck: we need to pay attention to local circumstances. Different areas will have different circumstances—and different scales. What works in a small or medium-sized council area might be different from what works in one of the large council areas, although there must be an element of consistency … There needs to be a framework of consistency across Scotland, but with room for local flavour.”

33. Jim Forrest, West Lothian CHCP, agreed, but emphasised that “consistency in the outcomes that we are being asked to deliver is probably much more important.”

34. Jan Baird, NHS Highland, reflected on experience of developing “the best model” for the people of Highland—

“We can focus on the principles of what we are trying to achieve and the outcomes that we want, which should be common to us all. However, how we
deliver those outcomes should be left to local decision making because the areas are so different.\textsuperscript{20}

35. Bill Nicoll, NHS Tayside, agreed that there was a need to have core characteristics in place, but there couldn’t be a “one-size-fits-all approach”. He explained—

“We are a national health service and we operate in a relatively small country, so we can effect consistency across that system, but that should not prevent local variation in delivery on the ground … The important thing is that they should all have the common characteristics that we are looking for, including single, visible accountability, an integrated resource budget and clinically led teams working on the ground.”\textsuperscript{21}

36. Dr Allan Gunning, NHS Ayrshire and Arran, argued that there could not be a “blueprint” for delivery, because, at a local level, structures within councils vary greatly—

“Therefore, a different methodology will have to be applied to arrive at best-fit solutions on the local authority side as well as on the health side.”\textsuperscript{22}

37. Anne Hawkins, Glasgow City CHP, took a different view—

“If we really want to achieve change, I would probably go for a pretty autocratic best-practice blueprint … Depending on local political views and perspectives, things can get very messy and complicated, so we need a pretty rigid approach.”\textsuperscript{23}

38. Asked whether, in a situation in which a health board and local authority could not establish a successful partnership, a structure may need to be imposed, possibly by the Scottish Government, Ms Hawkins replied—

“The challenge for the Government is in striking the balance between local political influence and will, and the targets and structures that it wants in order to achieve change.”\textsuperscript{24}

39. Dr John Gillies, RCGP Scotland, argued that it might not be possible to rely on integration simply happening at the local level. He stated—

“Some national levers from central Government will have to push things in the right direction.”\textsuperscript{25}

\textbf{Risks}

40. Several witnesses argued that structural change, in and of itself, would not bring about enhanced integration of health and social care services. In its written submission, Alzheimer Scotland stated—

“We consider there is an inherent danger in focusing attention on the structural reorganisation essential to create full integration; this would be a hugely costly process. It would also be the main focus of attention for the next couple of years, at a time when it is essential to concentrate efforts on demographic changes.”

41. Martin Sime, SCVO, relayed concern from some in the third sector that the time and energy spent on dealing with structural matters would detract from the need to make change on the ground where it has an impact on individuals—

“The current focus—certainly in some quarters—on structural change is misdirected; such change must have a point, must be seen in a wider context and must be part of a narrative that is about compelling change on the ground.”

42. He concluded—

“We might need a certain amount of structural change, but any such change should not take the focus away from the front line.”

43. Ranald Mair, Scottish Care, also supported this position—

“I add to the unanimity behind the view that we should not pursue structural change. Any proposed change should relate to the clarity of the outcomes that have to be delivered.”

Scottish Government

44. The Cabinet Secretary indicated that she had sympathy with the concerns raised by some witnesses and stated that her approach to the issue had been “informed by a desire to avoid something driven by structures and structural change”. Reflecting on the principles which formed the basis of the Scottish Government’s plans, she added—

“Any structural change … will be structural only to the extent that that is required to deliver on the principles. Our approach does not start with structure and instead sees structure as the servant rather than the master of the changes. As long as we continue with that firmly in our minds, we will avoid what people legitimately say is a concern—getting tied up for years in structural changes that direct people’s energies away from front-line care.”

45. That said, the Cabinet Secretary also indicated that there would be flexibility for areas that wanted to go further in terms of service integration, but there would be a legislative framework that described the minimum expected from partnerships—

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26 Alzheimer Scotland. Written submission.
“That minimum will be a lot more than is statutorily expected of partnerships now. However, we do not intend to hold back partnerships that want to go further or are already further down the road than others are.”

46. Asked whether, as part of the integration process, it would be necessary to try to integrate the terms and conditions of the staff involved, the Cabinet Secretary replied—

“Our legislation is not going to require organisations to transfer staff, nor is it going to prohibit that.

If we start by saying that we are going to transfer all local authority social care staff to the health service—or vice versa—everybody’s energies would be consumed by that instead of being spent on the outcomes-driven approach. That is not to say that it is wrong for partnerships such as Highland to decide that they want to do that kind of transfer. As I said, I am supportive of what Highland is doing, and if other partnerships feel that that approach is right for them, they have the freedom to follow it. However, we are not going to say that it is an essential requirement.”

Conclusion

47. On the basis of the evidence it has received, the Committee agrees that the Scottish Government’s plans for integration should avoid being driven by structures and structural change. Furthermore, the Committee believes that any necessary change should have at its core, a clear focus on outcomes.

48. The Committee welcomes the intention of the Scottish Government to provide flexibility within a legislative framework which will prescribe minimum standards.

49. The Committee also welcomes the assurance received from the Cabinet Secretary that there will be no requirement for wholesale transfer of staff between employers.

Implications for other social care services

50. Some witnesses raised with the Committee the potential consequences for other social care services from the present concentration on integration of adult care and support.

51. Julie Murray, East Renfrewshire CHCP, told the Committee—

“The initial focus on older people is understandable, but the danger is that, if that is the minimum, it might fracture existing services and management systems. Personally, I cannot see any reason why we cannot put all social care services in with NHS services from the off; to do otherwise could create
different structures and arrangements and there might be duplication. The services should all be in together.\textsuperscript{34}

52. Bill Nicoll echoed these comments—

“If we limit our aspirations to older people’s services, we will miss an awful lot of opportunities, given the work of CHPs and the significantly devolved services that are operating close to their local communities and local authorities. The work has to embrace all that … If we are to make big steps forward, we must incorporate all the activity that is already devolved to local areas and build on that work.”\textsuperscript{35}

53. Elaine Mead, NHS Highland, pointed out that in the partnership model they had adopted, Highland Council would become the lead agency for children’s services. She stated—

“If the objectives and outcomes that we aspire to for older people’s services are valid, they are also valid for children’s services, so we encourage people to consider the issue.”\textsuperscript{36}

54. Annie Gunner Logan, CCPS, stated—

“We understand the priorities for older people’s care—I know that the committee does as well, because it held an inquiry into the matter—but an awful lot of other services might be trailed along in the wake of the proposals, which are not based on the priorities for other groups. I want to put that on the table, because it will become more of an issue as we proceed with the proposals.”\textsuperscript{37}

55. Andrew Lowe, ADSW, explained that local authorities often have to move money around in order to meet the demands on children’s services and learning disability services—

“Once we lock in the resource for older people, local partnerships will face challenges in how to meet demand in other areas, but we will resolve that if we follow this course.”\textsuperscript{38}

Scottish Government

56. Asked about the focus of the proposals on adult services and particularly on older adults, the Cabinet Secretary replied—

“I am clear that the early priorities are around the care of older people. When you see the suite of outcomes and indicators on which we will consult, you will see an emphasis on improvements to the care of older people. That is the scope that we are dealing with.”\textsuperscript{39}

57. Looking to the longer term, the Cabinet Secretary commented—

“It is clear to me that the principles of integration will apply generally. I say quite openly that if we can demonstrate the benefits of integration of adult services, as I hope and expect that will we do, the direction of travel over the longer term will be towards ever-greater integration of provision. For a variety of reasons, however, it is right that we focus on adult services at this stage, as we set the legislative framework.”

58. Referring specifically to the lead agency approach being adopted in the NHS Highland area, the Cabinet Secretary said—

“Our setting a legislative framework for adult services will not stop any partnership deciding to apply the same principles to children’s services; what it means is that the legislation will focus on adult services.”

Conclusion

59. The Committee notes the intention of the Scottish Government to establish a legislative framework which will allow local partnerships to extend the principles of integration beyond adult services.

60. The Committee encourages all interested parties to highlight any issues arising from this approach when responding to the forthcoming Scottish Government consultation.

Leadership and culture

61. The Committee explored with witnesses the importance of leadership as part of the integration process.

62. Henry Simmons, Alzheimer Scotland, linked leadership with vision—

“You absolutely need leadership, and you need it right from the top, but anyone who is engaged in managing teams and organisations will tell you that you also need vision. You need a collective vision of what you are trying to achieve, which takes us back to the argument about principles.”

63. In its written submission, RCN Scotland had called for “decisive and transparent national leadership”. In oral evidence, Theresa Fyffe told the Committee—

“We want national leadership to set a direction of travel and be clear about what will be done. However, leadership works at all levels … Talking about leadership and drivers across the piece would involve the third sector, but it particularly involves the drivers from patients and the public.”

64. Andrew Lowe, ADSW, commented—

“The greatest trick in all this is to get the appropriate alignment between local energy and determination, and national leadership and guidance. A draft set of outcomes is being developed for this work, and guidance is being developed by the various professional organisations. We need to bring that together and bring it to bear on local partnerships without stifling local initiative.”

65. Commenting on the challenges associated with engaging GPs in the new local partnerships, Dr John Gillies, RCGP Scotland, said—

“I make a plea for leadership. It sometimes seems that, whatever the problem, leadership is the answer, but we need cultural leadership that engages in the new world, which we need to engage in, and which forms relationships across clinical and professional communities and with voluntary organisations.”

66. Dr Gillies also told the Committee that “the tone at the top” was really important—

“We probably need national voices saying that integrated care is an important policy for the Scottish people. However, we need the sort of leadership that allows the innovation and creativity of professionals working at the front line to come through to deliver the service. That needs a kind of subsidiarity approach. We need leadership at all levels.”

Scottish Government
67. In response to questions about how change would be driven at a national and a local level, the Cabinet Secretary replied—

“Central leadership for the system will be very strong ... The system will be very strongly driven by local partnerships taking ownership. That is what will happen in most cases when we get the legislative underpinning right. As a minister, my interest will be in ensuring that those partnerships deliver the outcomes that have been set. If that is not happening in any area, it will not be allowed to go by the board.”

Conclusion
68. The Committee welcomes the Cabinet Secretary’s commitment to ensure that there will be strong national leadership for the integration process as a whole. The Committee considers that this must be allied to the development of strong and collaborative leadership from representatives of all sectors in commissioning services at a local level.

Focus on outcomes
69. The Committee received evidence from a number of witnesses which emphasised the importance of an outcome focussed approach to integration. For

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example, both ADSW and RCN Scotland emphasised this in their written submissions.

70. In oral evidence, Annie Gunner Logan, CCPS, commented—

“Our message to the committee is that this project is about better outcomes, not about integration; integration should be seen as a means to an end rather than the end in itself.”

71. Jan Baird, NHS Highland, argued that rather than measuring inputs, the focus should be on the achievement of outcomes—

“We have become tied to measuring inputs as a measure of success, but that is not a measure of success. The measure of success is what makes a difference to the patient, the client, the family and the carer. We need to get smarter at assessing that.”

72. Jim Forrest, West Lothian CHCP, suggested that consistency in the outcomes that local partnerships were asked to deliver was more important than flexibility.

73. Allan Gunning, NHS Ayrshire and Arran, expressed the view that it was important to understand and agree jointly, at a local partnership level, not only the outcomes that were to be achieved, but also, the resource available and mechanisms for delivery.

74. Dr John Gillies, RCGP Scotland, argued that the important thing was to get the principles of integrated care right and decide exactly what the change in legislation was intended to achieve—

“We need to have clear outcomes for those principles, against which people can be measured. If we are to achieve integrated care, some of the outcomes could be related to integration.”

75. Dr Gillies also argued that with an integrated budget, there should be “clear, measurable, appropriate outcomes”. He continued—

“The outcomes of integration should be simple things that we all want to see, such as a reduction in delayed discharges and the availability of services for frail people who could be managed in the community with a little extra service that will prevent them from having to go into hospital.”

Scottish Government

76. The Cabinet Secretary explained the Scottish Government’s position regarding outcomes—

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“One of the very deliberate decisions that we have made is to approach this not from the starting point of structural change but from the other end—in other words, the outcomes we want to achieve for people, the improvements we want to make and the standards of care we want for older people, regardless of where they live in the country. Outcomes form our starting point and the legislation that will help to implement these changes will very much have an outcomes-based approach.”

77. She also explained how partnerships would be held to account for their performance—

“In a sense, along with local authorities, my part in the process is to set the outcomes that the partnerships must deliver and to intervene to take appropriate corrective action if a partnership is not delivering those outcomes.”

Conclusion

78. The Committee welcomes the Scottish Government’s focus on outcomes as the starting point for its legislative proposals for the integration of health and social care.

Accountability and governance

79. As part of its proposals announced in December 2011, the Scottish Government stated that health and social care partnerships, would be the joint responsibility of the NHS and local authority, and would work in partnership with the third and independent sectors.

80. In its report on Community Health Partnerships, Audit Scotland had commented that CHPs’ governance and accountability arrangements were complex and not always clear, particularly for integrated CHPs. They noted that few CHPs and councils had comprehensive partnership agreements in place for delegated or joint services.

81. The Committee explored with witnesses how governance arrangements operated at present and how accountability could be enhanced.

82. Julie Murray explained the existing governance arrangements for East Renfrewshire CHCP—

“I am accountable for the budget for the whole social work department and for community primary care. We make an integrated financial report to a committee every two months. We also have joint performance accountability...”

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meetings with the chief executives of the health board and the local authority, at which we look at financial reports.”

83. Later in the same session, Ms Murray concluded—

“Single accountability is crucial. There can be no undermining of that, because it is important that a single person is responsible.”

84. Anne Hawkins, Glasgow CHP, supported the creation of a single accountable director role as it would “ensure clarity about who is accountable and responsible for what”. She also supported keeping the governance arrangements “as straightforward as they can be”.

85. Theresa Fyffe, RCN Scotland, commented on the need to avoid a repeat of past problems with partnership working—

“I can see why there might be concerns that we will get bogged down in accountability, but we must have some form of accountability and performance management to ensure that what happened seven years ago cannot happen again.”

Democratic accountability
86. The Committee explored the degree of democratic accountability which currently exists within CHPs.

87. Julie Murray set out the membership of the East Renfrewshire CHCP committee—

“Our CHCP committee includes five elected members and two non-executive health board members. As I said, there are also public partnership forum representatives, one of whom is also the voluntary sector representative. We have staff-side representatives from the NHS and local authority trade unions. There are also various professional representatives, such as GPs, a clinical director, the chief social work officer and, I think, a pharmacist. The committee is diverse, but it is a good debating committee.”

88. However, she explained that, legally, only the five elected members constituted the Council’s CHCP committee—

“Therefore, although it feels like a whole committee, if it came down to the wire, the five elected members would make the decisions on local authority funding.”

89. Anne Hawkins explained the arrangements in Glasgow—
“For Glasgow, we have a large committee that includes three councillors—one from each of the sectors—and the councillor who is the NHS board local authority member for Glasgow. There are also four non-executive members plus the chair, who is an NHS non-executive member of the board. We then have six PPF [public partnership forum] representatives—two from each of the sectors … We then have the representatives from each of the professions—pharmacy, general practice and so on. It is a big committee. That is the committee that is required under the scheme of establishment.”\(^{64}\)

90. For West Lothian CHCP, Jim Forrest stated—

“In West Lothian, our community health and care partnership board has four elected members and four NHS Lothian appointees … Under the guidance, we have a CHCP sub-committee, which has a minimum representation of 18. There are one or two additions to that. The vice-chair of the CHCP board, who is a councillor, attends the sub-committee as the elected member representative, and the chair of the board also chairs the sub-committee. The sub-committee involves GPs and various others such as pharmacists and it has voluntary sector and PPF input. We must have that sub-committee, which is seen as the stakeholder group that produces reports and proposals for the board of governance—the CHCP board—to approve.”\(^{65}\)

Scottish Government

91. Reflecting on previous Government initiatives designed to integrate health and social care, the Cabinet Secretary argued that the lack of success was in part a result of “too much local choice about the degree and extent to which integration happened”. She continued—

“We had no genuine joint accountability; we still had separate silos of accountability. I do not blame health or local government for that because, in truth, on different occasions one or the other will have been more responsible, but the separate lines of accountability have meant that it is too easy to pass the buck.”\(^{66}\)

92. The Cabinet Secretary confirmed that in the current Scottish Government plan the concept of single accountability was particularly important—

“One of the key features of the system that we are designing is the single accountable officer, which will help to give form and meaning to the integrated budget. That person’s accountability to me or to whoever sits in my seat comes through the health board accountability structure—and health boards are accountable to me and to local authorities already. Of course, the key point about accountability for delivery of the outcomes that will be set is that there will be accountability to the partnership board.”\(^{67}\)

“We are not saying that one person has to deliver everything, as they will be supported by a substantial infrastructure. However, just as the chief

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executive of a health board is the accountable officer for that health board, or the chief executive of a council is the accountable officer for that council, it is perfectly reasonable for accountability to rest with one person. Not only is that reasonable—it is right, because it ensures that there is an organisational focus across everybody who works in the organisation on meeting the objectives for which that person is accountable.”

Conclusion

93. The Committee acknowledges the findings of Audit Scotland that governance and accountability arrangements for CHPs have been “complex” and “not always clear”. The Committee therefore welcomes the Scottish Government’s proposal for a clear line of accountability to rest with a single individual for each health and social care partnership.

94. The Committee also considers it essential that the governance arrangements for each local partnership should retain strong links with local government through representation of councillors on partnership boards.

Integration of budgets

95. The Committee explored with witnesses whether having integrated budgets would assist successful partnership working. Representatives of current CHPs were asked about the system operating presently within their partnerships.

96. Anne Hawkins quoted, as an example, an integrated addiction service in Glasgow which had an “aligned budget”.69 However, later in the same evidence session, Ms Hawkins confirmed that this was the only aligned budget as Glasgow City did not operate as a Community Health and Care Partnership.70

97. Julie Murray explained that East Renfrewshire CHCP had an aligned budget—

“For an integrated management team it makes enormous sense to have that system—although I would go further and have a pooled budget—because we can avoid any of the cost shunting that sometimes goes on. We know that if we make a saving in one area, it might impact on another area, and we need to keep an eye on that. That is particularly the case with older people’s services.”71

98. Dr David Farquharson, NHS Lothian, was, however, more cautious—

“I am not sure that a pooled budget will necessarily be a panacea. We require a change in culture to implement integration successfully. I would not want to concentrate on pooled budgets as the main vehicle; we must ensure that we have a very different culture that puts the patient at the centre. Jim

Forrest’s work in West Lothian provides examples of different models that work very effectively.”

99. Jim Forrest commented—

“In West Lothian, we also have aligned budgets … I am the accountable officer for both, and we have fairly rigorous discussions around how the money and resources are being used.”

100. Dr Allan Gunning, NHS Ayrshire and Arran, argued that understanding and pooling resources was “fundamental to moving integration forward”. He added—

“Certainly, starting with older people’s services, we have agreed to a pooled budget approach. I think that our work in the IRF and mental health services will take us down the same line.”

101. Asked whether he was confident that that would achieve a shift in resources from the acute sector, Dr Gunning responded positively—

“If you understand the totality of the resource that is available, you understand the outcomes that you are trying to achieve and the delivery chain for those outcomes. As a natural consequence of that process, you will shift the resources accordingly.”

102. Annie Gunner Logan, CCPS, expressed interest in integrated budgets—

“From the third sector point of view, I think that that is how resources will be released to invest in community action and take demand out of the system, in a way that would not happen if there was no integrated budget. It might be decided that an integrated budget was a requirement of any particular model, if for no other reason than to ensure that halfway through the process people could not pick up their ball and go home with it, which is what has happened on a number of occasions.”

103. Phil Gray, Chartered Society of Physiotherapists, advocated integration of budgets as an alternative to structural changes—

“Where there is the possibility of allied health professionals, including physiotherapists, intervening by a change system that can save substantial amounts of money, it is vital that people do not spend from one budget and make savings in another budget with none of that money ever going near them. If people need to invest to save, there must be joined-up budgets that recognise the collective benefits of doing that and which can work towards a new and better system.”

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104. Andrew Lowe, ADSW, commented on some challenges associated with integrating budgets—

“At the moment, the budgetary cycles of local authorities and NHS boards are not aligned, and their budget-building processes happen in different temporal spaces. It strikes me that one of the first things that Government can helpfully do is in different ways to encourage an alignment of budget processes.”

Scottish Government

105. In oral evidence, the Cabinet Secretary explained the Scottish Government’s expectation regarding the integration of NHS board and local authority social care budgets—

“We are suggesting not that they need to align their budgets—that is what they are expected to do now—but that they need to genuinely integrate their budgets. In effect, aligned budgets are two budgets sitting together but, often, money cannot be transferred between them. With genuinely integrated budgets, once the money goes into the pot, whether it is from the health service or the local authority, it loses its identity and can flow in different directions. That means that we will not get the situation that sometimes arises in which, for example, a local authority says that its part will be overspent, so it has to rein back; instead, the budget is genuinely integrated.”

106. She also commented—

“What has been lost sight of is the fact that it does not really matter whether the money belongs to the NHS or local government; what matters is how the money is spent on delivering the outcomes that we set for care.”

107. Discussing the ways in which such integration could take place, the Cabinet Secretary stated that this would be subject to consultation, but there were two main ways—

“One is for one body to host the integrated budget on behalf of both bodies; the second is for the money to continue to sit in both organisations legally and in terms of accountability, but for it to be genuinely integrated in the sense that the partnership has free use of it.”

108. Asked about the need to bring about a shift of resources from the acute sector to the community, the Cabinet Secretary replied—

“In terms of integrated budgets, it is vital that a portion of acute spend is included so that we can effect that shift in a planned and managed way and

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enable services in the community to build up in a way that supports our efforts to ensure that fewer older people have to go into hospital.”\textsuperscript{82}

\textit{Conclusion}

109. The Committee considers that an inability to establish genuinely integrated budgets has, in the past, acted as a barrier to efforts to integrate health and social care. The Committee notes the legal obstacles which require to be overcome in order to change this position, but hopes that this can be achieved by legislative means.

110. The Committee also shares the Cabinet Secretary’s desire to see a shift in the balance of care for older people away from the acute sector and into the community. The Committee does not underestimate the challenge that this represents. It expects to examine this issue again as part of its scrutiny of the forthcoming Scottish Government bill.

\textit{Change Fund}

\textit{Background}

111. The Reshaping Care for Older People Change Fund (“the Change Fund”) is a Scottish Government initiative that is aiming to improve services for older people by shifting care towards anticipatory care and preventative spend.

112. Local partnerships were asked to submit Change Plans in order to access the £70m available in the 2011/12 financial year. Plans were received from 32 partnerships, one for each local authority area. Following the 2012 Spending review, a further £80m Health and Social Care Change Fund will be available for partnerships in 2012/13, with £80m committed for 2013/14 and £70m for 2014/15.

113. According to the Scottish Government, the Change Fund will enable health and social care partners to implement local plans for making better use of their combined resources for older people’s services. The Change Fund will provide bridging finance to facilitate shifts in the balance of care from institutional to primary and community settings, and should also influence decisions taken with respect to the totality of partnership spend on older people’s care.\textsuperscript{83}

\textit{Evidence received}

114. The Committee asked witnesses whether the Change Fund could provide a form of bridging finance to enable a shift of resources.

115. Bill Nicoll, NHS Tayside, commented—

“We must guard against simply using the change fund to build extra capacity without having the ability to transform services … We must use the change fund genuinely to lever change: to create a different profile of services that


\textsuperscript{83} Scottish Government. (2012) \textit{Change Fund}. Available at: \url{http://www.scotland.gov.uk/Topics/Health/care/reshaping/changefund}
people actually use; and to reduce demand and pressure, and reliance, on expensive and unnecessary admissions to hospital."^84

116. Dr David Farquharson, NHS Lothian, told the Committee—

“It is also important to ensure that some good outcome matrices are associated with the change fund so that success can be clearly demonstrated.”^85

117. Roddy Ferguson, Fortuno Consulting, reported the findings of the interim evaluation of the Integrated Resources Framework (IRF), developed jointly by the Scottish Government, NHS Scotland and COSLA to enable partners in NHS Scotland and local authorities to be clearer about the cost and quality implications of local decision-making about health and social care. The evaluation had highlighted differences between the attitude of partners towards the IRF and the Change Fund—

“One of the difficulties with the IRF was that it was pilot funding and it was seen as short term. Introducing large-scale structural change based on short-term funding is a big ask. The change fund was reported to have more significant longevity, and funding on that model is seen to be more likely to shift resources.”^86

Involvement of the third and independent sectors

118. The Committee also sought evidence from witnesses about the role which representatives of the third and independent sectors had played in determining local Change Fund plans.

119. Ranald Mair, Scottish Care, argued in favour of measuring progress through the Change Fund on joint commissioning by each partnership—

“Tight scrutiny around commissioning practice is a fairly central plank of how we ensure and satisfy ourselves that things are happening, so it is one possible vehicle for addressing the issue.”^87

120. He also reflected on the process of signing off Change Fund plans—

“The change fund plans were seen as involving important empowerment: there was some guarantee that the third and independent sectors would have a say … A person cannot sign something off unless they have been involved throughout the engagement and development process, but the sense of having at least a point at which a person would have a clear say has not been unimportant, and it has led to quite significant negotiations and shifts as the plans for the coming year have gone through the process.”^88

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121. However, Mr Mair expressed disappointment at the low level of Change Fund expenditure which had found its way to the third and independent sectors—

“There is no significant shift in year one from in-house to external spend. The bulk of the spend by the change fund partnerships—the £70 million—is in-house spend. The figure is over 90 per cent. The percentage of money that has been spent through the change fund on either the voluntary sector or the private sector to develop new capacity has been minimal. We need a long-term approach that values the diversity of provision and involves looking at areas’ needs in an integrated way.”

122. Martin Sime, SCVO, commented on the degree of engagement with the third sector where representatives are sometimes required simply to sign off plans—

“Sometimes that is easy for the organisations involved; sometimes it is difficult. We are beginning to organise our infrastructure more effectively to ensure that all the different people who represent the third sector in the system are talking to one another. However, on occasion, we are not seen as an equal partner, and we need to move on such situations. For example, on the local joint strategic commissioning that Ranald Mair mentioned, the third sector has not yet been guaranteed a seat at that table, despite the fact that such commissioning plays a critical role and is supposed to cover priorities for not only investment but disinvestment.”

123. Later in the same session, Mr Sime commented—

“... in general we get patronised, patted on the head and offered 10 per cent of the change fund. That is what has happened. We have been seen as a necessary but rather inconvenient adjunct to the delivery of health and care services and the major budgets.”

124. Annie Gunner Logan, CCPS, told the Committee—

“Most of the change fund plans that I have seen give significant recognition to the third sector, but whether resources follow that is a different question.”

Carers

125. Martin Sime also raised the issue of the commitment to spend 20 per cent of the Change Fund on carers—

“That was watered down in guidance—which the SCVO resisted and opposed—that states that, rather than the 20 per cent going to carers and carers organisations, any intervention that makes life easier for carers, including medical interventions, will qualify. That is the kind of thing that goes on in diverting the fund away from its purposes.”

126. Lynn Williams, Princess Royal Trust for Carers, commented that with the Change Fund and the change plans as they stand now, some partnerships would struggle to decide how to spend the 20 per cent of the fund that is supposed to support carers—

“It is easy to sit in an acute setting and say, "We will invest in an additional consultant so that we can get people out of hospital more quickly." That is fine, but who will pick up the pieces at home? How are we supporting family members through the discharge process so that people can get home much more quickly, stay at home and be happy there?"\(^{94}\)

Scottish Government
127. In relation to the Change Fund, the Cabinet Secretary said that she was open to hearing views from the third sector—

“The change fund is still relatively new and it is a transitional fund, not something that will exist in perpetuity. It is designed to kick-start and be a catalyst for the shift in the balance of care that we all know needs to happen, and I have made it clear that the third sector must be very involved in that.”\(^{95}\)

128. She explained that the Scottish Government had “ring fenced 20 per cent of the change fund in 2012-13 for carers’ organisations” and would be scrutinising the plans very carefully to ensure that that commitment was met.\(^{96}\)

129. The Cabinet Secretary also highlighted issues surrounding the Change Fund including—

“... ensuring that the money is not just spent on new services in the community but that resources are transferred from institutional acute care to the community, to allow the spend to be sustainable in the longer term.”\(^{97}\)

Conclusion
130. The Committee acknowledges that the purpose of the Change Fund is to stimulate and support a shift in the balance of care for patients at a local level. Several witnesses were able to provide specific examples of such changes. However, the Committee was concerned by the evidence from representatives of the third and independent sectors which suggested that, in some areas, their input to planning and decision making had not been embraced wholeheartedly by statutory partners.

131. The Committee therefore recommends that as part of its preparations for the primary legislation which will establish health and social care partnerships, the Scottish Government should conduct a review of third and independent sector partner involvement in Change Fund planning in order to ensure their full involvement in the future design and commissioning of new services and wider partnership arrangements.


Wider engagement of the third and independent sectors

132. The Committee also received more general evidence about the need to engender closer working relationships between health boards, local authorities and the third and independent sectors.

133. In written evidence, Scottish Care argued that for integration to work, it had to be “as much about integration between the statutory sector and the Third and Independent Sectors, as about integration within the statutory sector between councils and the NHS”. Scottish Care expressed concern that there was a “serious danger” of councils and health boards being so preoccupied with their own integration that they would become even less focussed on the third and independent sector partners who were delivering the bulk of social care.98

134. In its written submission, SCVO noted the findings of the Christie Commission99 which had recognised that the third sector was central to the success of public service reform, “both in terms of the public services it can deliver and its ability to provide interventions which keep people out of the formal health and social care system by tackling developing needs before they become crises”.100

135. In oral evidence, Martin Sime, reflected on the current state of relations between the third sector and public sector partners—

“We have a long way to go to improve relationships with health boards, but the Scottish Government has recognised the demand and has been doing a lot of work and thinking on getting health boards more attuned to working with the third sector successfully. There is a long history of third sector engagement with local government; although it is still patchy in some parts of the country, in others the partnership is very strong with all sorts of different relationships.”101

136. In an earlier session, Elaine Mead, NHS Highland, had commented—

“In addition to the engagement of clinical colleagues, the development and support of the voluntary sector and independent organisations will be crucial as we develop services that are much closer to home and which provide support and independence for older people.”102

Scottish Government
137. Asked whether as a legislative minimum, the third and independent sectors would be given the right to be on health and social care partnership boards, the Cabinet Secretary replied—

98 Scottish Care. Written submission.
100 SCVO. Written submission.
“There will be a legal right for councillors, non-executives on NHS boards and representatives of the third sector to be on the partnership boards.”\(^{103}\)

138. In relation to the role these representatives would play on boards, the Cabinet Secretary said—

“My view is that, in the context of the new arrangements, the voluntary sector is there not just to speak for its resource but to influence the spend of the totality of the resource in a much stronger way than perhaps it does just now.”\(^{104}\)

**Conclusion**

139. The Committee considers that the third and independent sectors have a crucial role to play in local partnerships if the plans for more effective integration of health and social care are to be realised in practice.

**Involvement of clinicians and social care professionals**

140. In its written submission, BMA Scotland suggested that there was a need to refocus CHPs and reinvigorate them by “re-engaging doctors from primary and secondary care to provide professional input into service development and delivery, outwith or alongside, current medical management structures”\(^{105}\).

141. Dr John Gillies, RCGP Scotland, reflected on the experience of general practitioners engagement with CHPs—

“While there has been an astonishing degree of variation in the way in which community health partnerships have delivered services, there have been many instances in which there has been little engagement between CHPs and general practices and the clinical community. There have been notable exceptions to that, but it is important that we do not repeat that in this iteration of legislation.”\(^{106}\)

142. Dr Gillies highlighted a suggestion from RCGP Scotland which could inform the design of health and social care partnerships—

“We have suggested that a useful way forward would be the establishment of general practitioner clusters to advise, suggest and interface with new organisations so that our voice—which, we feel, can reflect what patients and carers want and need—is reflected in the new organisations.”\(^{107}\)

143. However, Dr Gillies also highlighted that the capacity available to a general practice to perform this role was an issue—

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\(^{105}\) BMA Scotland. Written submission.


“Most GPs want to see patients and do not always want to contribute elsewhere. That is a support issue that will need to be addressed. There is no doubt, however, that service redesign is essential.”\textsuperscript{108}

144. Community Health Partnership managers were also keen to ensure that clinicians and social care professionals were engaged with the work of partnerships. Julie Murray, East Renfrewshire CHCP, stated—

“It is important that we strengthen GP and other clinical involvement and professional social work involvement, but we must recognise that that will need to be thought through and resourced properly.”\textsuperscript{109}

145. Bill Nicoll, NHS Tayside, argued that in order to make decisions about the system of care that are based on local knowledge and information, it was important to “bring in the influence of general practice much more at a local level”.\textsuperscript{110} He argued—

“We need to re-engage general practitioners and pool the activity and resources back into the local population, in order to make more use of local community care infrastructure, make it more resilient and build confidence that it is a viable, strong alternative to admissions to hospital; otherwise, I do not think that it is too strong a view to say that we will end up with a busted flush.”\textsuperscript{111}

146. Dr Allan Gunning, NHS Ayrshire and Arran, stated—

“... if we do not achieve closer clinical practitioner engagement through these changes, we will have wasted our time, as that is the single most important ingredient, rather than the structural issues.”\textsuperscript{112}

Scottish Government

147. Confirming the importance she attached to engagement with GPs, the Cabinet Secretary stated—

“... vital to the success of integration is ensuring that we have good locality planning, with clinical involvement. GPs will have a critical role to play, as will other professionals.”\textsuperscript{113}

148. Commenting on whether this meant a return to the local healthcare cooperative model,\textsuperscript{114} she said—

\textsuperscript{114} Local Health Care Cooperatives (LHCCs) – created through “Designed to Care” (Scottish Office, 1997), and coming into being in 1999, these were part of Primary Care Trusts (PCTs) and organised round groups of GP practices in distinct geographical areas. They were not statutory bodies, but were intended to bring health and social care providers together to deliver services.
“I would say that it did, to a point; the key difference is that although GPs will play a critical role we have to take a much wider approach and involve all sorts of clinical and professional interests. However, one of the prerequisites of success will be having clinical drivers at a locality level.”

Conclusion
149. The Committee considers that in order to be effective, the new health and social care partnerships must re-engage general practitioners and other health and social care professionals in locality planning. The Committee welcomes the commitment from the Cabinet Secretary to include this as part of a locality planning approach.

CONCLUSION

150. The Committee submits this report for the consideration of the Parliament and the Scottish Government as an initial contribution to the scrutiny of proposals for closer integration of health and social care services in Scotland.

ANNEXE A: EXTRACT FROM MINUTES OF THE HEALTH AND SPORT COMMITTEE

6th Meeting, 2012 (Session 4)

Tuesday 7 February 2012

1. **Decision on taking business in private:** The Committee agreed to take items 3 and 4 in private.

3. **Work programme:** The Committee agreed its approach to a short inquiry into the Scottish Government's plan to integrate adult health and social care.

9th Meeting, 2012 (Session 4)

Tuesday 6 March 2012

**Inquiry into integration of health and social care:** The Committee took evidence from—

Anne Hawkins, Director, Glasgow City CHP, NHS Greater Glasgow and Clyde;

Julie Murray, Director, East Renfrewshire CHCP;

Jim Forrest, Deputy Chief Executive & Director, West Lothian CHCP;

Elaine Mead, Chief Executive, and Jan Baird, Transitions Director, NHS Highland;

Bill Nicoll, General Manager, Perth & Kinross CHP, NHS Tayside;

Dr David Farquharson, Medical Director, NHS Lothian;

Dr Allan Gunning, Executive Director, Policy Planning and Performance, NHS Ayrshire and Arran;

Roddy Ferguson, Director, Fortuno Consulting Limited.
10th Meeting, 2012 (Session 4)

Tuesday 13 March 2012

Inquiry into integration of health and social care: The Committee took evidence from—

Lynn Williams, Policy Officer (Scotland), The Princess Royal Trust for Carers;
Martin Sime, Chief Executive, Scottish Council for Voluntary Organisations;
Ranald Mair, Chief Executive, Scottish Care;
Annie Gunner Logan, Director, Coalition of Care and Support Providers in Scotland;
Henry Simmons, Chief Executive, Alzheimer Scotland;
Andrew Lowe, President, Association of Directors of Social Work;
Theresa Fyffe, Director, Royal College of Nursing Scotland;
Dr John Gillies, Chair, Royal College of General Practitioners Scotland;
Phil Gray, Chief Executive Officer, Chartered Society of Physiotherapy.

11th Meeting, 2012 (Session 4)

Tuesday 20 March 2012

1. Decision on taking business in private: The Committee agreed to take item 7 in public but agreed that its consideration of a draft report on its inquiry into integration of health and social care should be taken in private at future meetings.

6. Inquiry into integration of health and social care: The Committee took evidence from—

Nicola Sturgeon, Cabinet Secretary for Health, Wellbeing and Cities Strategy;
Kathleen Bessos, Deputy Director, Health and Social Care Integration;
Alison Taylor, Team Leader, Integration and Service Development, Scottish Government.

7. Inquiry into integration of health and social care: The Committee considered the main themes arising from evidence received during the inquiry and agreed to publish a report of its key findings.

13th Meeting, 2012 (Session 4)
Tuesday 17 April 2012

Inquiry into integration of health and social care (in private): The Committee considered a draft report. Various changes were agreed to, and the Committee agreed to consider a further draft, in private, at a future meeting.

14th Meeting, 2012 (Session 4)
Tuesday 1 May 2012

Inquiry into integration of health and social care (in private): The Committee considered a draft report. Various changes were agreed to, and the report was agreed for publication.
ANNEXE B: ORAL EVIDENCE AND ASSOCIATED WRITTEN EVIDENCE

9th Meeting, 2012 (Session 4), 6 March 2012
Written Evidence
Glasgow City CHP
East Renfrewshire CHCP
West Lothian CHCP
NHS Highland
NHS Tayside
NHS Lothian
NHS Ayrshire and Arran
Fortuno Consulting Limited

Oral Evidence
NHS Greater Glasgow and Clyde
East Renfrewshire CHCP
West Lothian CHCP
NHS Highland
NHS Tayside
NHS Lothian
NHS Ayrshire and Arran
Fortuno Consulting Limited

10th Meeting, 2012 (Session 4), 13 March 2012
Written Evidence
The Princess Royal Trust for Carers
Scottish Council for Voluntary Organisations
Scottish Care
Coalition of Care and Support Providers in Scotland
Alzheimer Scotland
Association of Directors of Social Work
Royal College of Nursing Scotland
Royal College of General Practitioners Scotland
Chartered Society of Physiotherapy

Oral Evidence
The Princess Royal Trust for Carers
Scottish Council for Voluntary Organisations
Scottish Care
Coalition of Care and Support Providers in Scotland
Alzheimer Scotland
Association of Directors of Social Work
Royal College of Nursing Scotland
Royal College of General Practitioners Scotland
Chartered Society of Physiotherapy

Supplementary Evidence
Royal College of Nursing Scotland
11th Meeting, 2012 (Session 4), 20 March 2012

Oral Evidence
Scottish Government
ANNEXE C: LIST OF OTHER WRITTEN EVIDENCE

Evidence received on the inquiry into integration of health and social care

- Age Scotland
- BMA Scotland
- Independent Living in Scotland Project, Strategic Advisory Group
- Royal College of Speech and Language Therapists
- Scottish Association of Social Work
- UNISON Scotland
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