RCN Scotland
42 South Oswald Road
Edinburgh
EH9 2HH

Theresa Fyffe
Director

Telephone: 0131 662 1010
Fax: 0131 662 1032
Email: theresa.fyffe@rcn.org.uk

Duncan McNeil MSP
Convener
Health & Sport Committee
Scottish Parliament
HealthandSport@scottish.parliament.uk

10 November 2015

Dear Mr McNeil

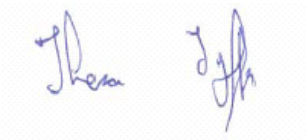
Scottish Government Draft Budget 2016-17 - health budget

The Royal College of Nursing (RCN) is the UK's largest professional association and union for nurses with around 425,000 members, of which around 39,000 are in Scotland. Nurses and health care support workers make up the majority of those working in health services and their contribution is vital to delivery of the Scottish Government's health policy objectives.

Please find attached the RCN response to the call for evidence on the Scottish Government Draft Budget 2016-17 - health budget

For further information or to discuss any of the points raised please contact Sarah Atherton on 0131 662 6172 or by email at sarah.atherton@rcn.org.uk.

Yours sincerely



Theresa Fyffe
Director

RCN Scotland response to the Health and Sport Committee call for evidence on the Scottish Government Draft Budget 2016-17

The Royal College of Nursing is the world's largest professional union of nurses, representing around 415,000 nurses, midwives, health visitors, nursing students and health care support workers, including nearly 40,000 in Scotland. Our members work across the NHS, third and independent sectors.

We are delighted to provide evidence to the committee once again as part of the annual budget cycle. Although we clearly cannot comment on actual funding decisions for 2016-17 at this stage, we hope that the comments below will support the committee in its scrutiny of future funding. The main body of our response focuses on the first question asked in the call for evidence.

Do you consider that Scottish Government spending on health reflects its stated priorities?

General comments

Over a number of years the RCN has raised concerns to the committee that the presentation of the Scottish budget has not allowed us to assess how investment decisions relate to national policy or outcome priorities. Nor does the process allow us to assess the success of spending decisions in meeting stated outcomes. Given that we expect the new funding settlement to be very tight, as a result of Chancellor's upcoming spending review, we would hope that the Scottish Government will take a new approach by making clearer the rationale for all decisions to allocate scarce resource.

We appreciate the time constraints that both the Scottish Government and Scottish Parliament have been placed under to complete the 2016-17 budget process. It is unfortunate that, just as we are likely to be faced with some of the most difficult financial decisions since the establishment of the Parliament, we will have less time than usual to consider the consequences of such difficult choices. Whilst budget discussions focus the mind, they should be considered as a part of the ongoing wider work around the local and national choices which must be made, and how best we can match available resource to stated priorities.

Allocation choices throughout the funding cycle

Although they fall outwith the formal annual budget considerations, mid-year allocation decision can have a profound impact on the prioritisation of resources, the delivery of policies and outcomes, and the ongoing sustainability of the health and care service in Scotland. They are a helpful indication of the general approach of government to investment.

For example, the Scottish Government recently announced £200m funding for six new elective treatment centres[1]. This is a major investment when boards are clearly struggling to find adequate resources to meet demand and rising costs. To put this new funding into context, it is more than the combined sum earmarked for all the following public health measures in the 2015-16 budget: health improvement and health inequalities (£55.6m); immunisations (£20.9m); pandemic flu (£8.1m); health screening (£2.6m); tobacco control (£12.2m); alcohol misuse (£40.9m); Healthy Start (£13.9m); mental health improvement and service delivery (£23.7m) and early detection of cancer (£9.3m).

[1] http://news.scotland.gov.uk/News/Major-investment-in-elective-treatment-centres-1e70.aspx

The RCN is left with a number of questions about this decision to allocate new resources.

- Given that the Scottish Government's 2020 policy vision remains focused on community-based care, why is this investment more than three times the new funding of £60m over three years to reform the primary care sector[2]?
- What is the evidence base on which this investment decision was taken and which national performance measure(s) is it intended to address?
- How will this national decision impact on the allocation of resources to existing local services or other plans for re-design underway locally? How have clinicians, managers and the public been engaged in shaping this major national service re-design?
- How does this decision align with the as-yet unpublished clinical strategy, which we would expect to support evidenced decisions on radical redesign that underpin sustainability and quality?
- What will this £200m investment cover and how will the ongoing operation of these new centres be financed to ensure sustainability?
- Given that this is the third announcement on additional investment in elective procedures[3] in less than a year, how is the government ensuring that each new investment decision is delivering against clear performance measures before further funding is committed?

This is just one example which we have chosen to highlight. This investment decision may well be designed to support key government priorities, but the rationale and the consequences attached to this major decision on committing funds in the current climate are not yet clear to us.

We suggest it would be helpful, given the national focus on securing best value against the national performance framework, that all major allocation decisions, made either within the budget process or in- year, should be expected to address a clear, consistent and transparent set of criteria for investment, which are then used rigorously to test decisions. This could also support committee scrutiny of major investment, and indeed disinvestment decisions, year-round.

Are current priorities the right ones?

In June 2015, the RCN and the Academy of Medical Royal Colleges issued a joint statement on the future of the NHS in Scotland. This was spurred by a shared sense, across health professions, of the urgency required to take concerted action to put the health service on a more sustainable footing. Following on from detailed discussions with partners across all the health professions we concluded:

> *The current approach to setting and reporting on national targets and measures, while having initially delivered some real improvements, is now creating an unsustainable culture that pervades the NHS. It is often skewing clinical priorities, wasting resources and focusing energy on too many of the wrong things. As a matter of urgency, there needs to be a more mature approach to how the NHS uses targets, standards and other performance measures to ensure better and sustainable outcomes across the health service[4].*

---

[2] http://news.scotland.gov.uk/News/Primary-care-investment-1a90.aspx

[3] http://news.scotland.gov.uk/News/Support-for-health-boards-1639.aspx and http://news.scotland.gov.uk/News/Golden-Jubilee-Expansion-1918.aspx

[4] http://www.rcn.org.uk/__data/assets/pdf_file/0011/626528/Externally-designed-final-statement-no-embargo-3-June-2015.pdf

Targets continue to set the line of sight of boards, of government, of parliament and of the media. However, we do not believe they are driving the fundamental changes to healthcare we will need to see. Nor are they helping politicians, managers, staff and the public to embrace a new set of priorities for public spending that may require disinvestment to develop new areas of service that better meet demand and reduce the need for urgent care.

Despite broad support for shifting the balance of care to the community, the most high-profile targets remain those which focus on the hospital sector. Some may argue that targets focussed on hospital beds or waiting times should be used as a proxy for improving community services: for example, in theory A&E use would fall if we invested in better community-based anticipatory care, reducing pressure on emergency departments and speeding patient throughput at the hospital door. However, we are not seeing a step change in investment in community-based services. We note the Auditor General's recent comments that the government has not made sufficient progress in implementing the 2020 vision to shift care to the community[5].

Boards are spending significant resource and maintaining focus on solving the conundrum of meeting targets in the face of small budget rises but exponential increases in demand and costs. In our analysis of financial risk in the 2015-16 Local Delivery Plans of the 14 territorial health boards, three areas linked to the HEAT performance system stood out:

Financial targets

Eleven of the 14 boards noted that meeting their savings target was a key risk. At the start this financial year 30% of savings across Scotland had not been identified and of those that were, many were still classed as high or medium financial risks. Comments included:

> *Continual challenge to meet real cash savings each year with major service change / impact…whilst 2015/16 position is likely to be achievable, 2016/17 onwards remains a real risk*
>
> *Risk that sectors will not be able to make efficiency savings without impacting on patient care and reducing staffing levels.*

In our recent evidence to the Finance Committee on the draft 2016-17 Budget - Prevention we again called for boards to be given the flexibility in their financial targets to invest to save and move to the new models of service required to meet health needs in the 21st century. This is key, given that the period of full double funding that would support a genuine shift in care provision is highly unlikely to be forthcoming in the current financial climate.

Waiting time and access targets

Nine of the 14 boards raise these set, time-bound targets as a financial risk. Most of the risks raised involve concerns of insufficient funding, capacity and/or workforce to meet demand. The ongoing pressure from unscheduled care is raised and one island boards notes the risk of shared care models between boards potentially coming under pressure as individual boards struggle to meet their own targets.

[5] http://www.audit-scotland.gov.uk/docs/health/2015/nr_151022_nhs_overview.pdf

Delayed discharge

Five of the 14 boards raise this as particular risk and note the links between meeting this target and finding the hospital capacity required to meet other waiting time /access targets. One board noted that contingency beds, usually opened just for winter, have had to stay open all year to cope. We do not believe this is an isolated case.

The RCN has begun a project to work with partners from across the health and care sector to develop a set of principles to drive a sea-change in how performance is measured and then used to hold delivery organisations, and the government, to account for over a third of the Scottish budget.

We hope that this will be a helpful contribution to a debate that will help the committee make a robust assessment of how budgets are invested to successfully improve the health of the people of Scotland. We would be delighted to continue to work with this, and future committees, in finding a consensus for the future.

Monitoring performance and determining priorities within Integrated Joint Boards (IJBs)

It is early days for the IJBs and we do not underestimate the scale of reforms that local partners are required to deliver. We will be interested to see the first set of performance reports that IJBs will publish, though we do note that the health and wellbeing outcomes will not be delivered in the short term. IJBs must have time to drive the step change in health this radical change is intended to bring about.

In the context of Scottish budget scrutiny, the RCN has raised in previous years the inability to engage in cross-portfolio discussions that would allow a fuller debate on the consequences of separate investment decisions. However, in terms of the scrutiny of IJB decisions on health and social care funding we assume that the national budget process will not look very different. We understand that general allocations to health boards and councils will be apportioned and delegated to IJBs through local agreements. That said, a live question remains on how the Scottish Parliament will scrutinise the outcomes of those investment decisions across committees and portfolios. We note the work of the health committee in recent years to scrutinise how individual health boards have spent their allocations and hope that, in future, this work might be extended.

The strategic planning process within boards will be an evolving process as all partners learn to work in new ways. Significant effort is being made, particularly within NHS NSS, to provide IJBs with robust public health, workforce, cost and service data to help them make decisions that are fit for the local population. This will inevitably result, over time, in quite different services developing in different localities. We hope that future committees will spend some time scrutinising how well this data is being analysed to inform decisions on priorities and to meet outcomes.

Is the current level of spending in health appropriate?

Too often funding debates bounce between claims of real terms or not real terms rises in health spending. Not only does this not take into account the impact of decisions on other budgets on the health services (for example in social care, criminal justice or third sector support), but it also only considers half the balance sheet that NHS boards have to work with. If demand and costs rise faster than any increase in funding is able to meet – and if services are under pressure as a result – the exact amount of marginal increase in investment is not what matters for patients.

It's only when we can answer what "appropriate" means that this question can be answered. This takes us back to the committee's opening question around spend and priorities.

We understand that there is not going to be scope to match funding to demand / costs by simply continuing with current ways of delivering care. We appreciate the need to do things very differently to ensure both quality of care and sustainability into the future. This will require honesty about the current pressures; it will need a fundamental review of what success looks like to support politicians, health boards and IJBs to prioritise clearly, and it will require us all to work in partnership and to grapple with truly difficult choices.

> *To bring about genuine and substantial change, we need to be bold and visionary. We need to work together across the health professions, with the public, the Scottish Government, NHS Boards and Integration Authorities to agree how to secure better sustainability in the health service for our own families, as well as for future generations…. As professional leaders, we share a collective aim to see our health service put on a more sustainable footing in the future through tangible actions, taken now. We are committed to playing our part in leading the professions in designing and delivering the changes that are required to achieve this aim.*[6]

RCN Scotland
November 2016

[6] http://www.rcn.org.uk/__data/assets/pdf_file/0011/626528/Externally-designed-final-statement-no-embargo-3-June-2015.pdf