

# **THE RCN IN SCOTLAND: PRINCIPLES FOR DELIVERING THE INTEGRATION OF CARE**

# FOREWORD

Over the last year the Royal College of Nursing (RCN) in Scotland has been building its understanding of what will help make Scottish plans to integrate health and social care a success. We have reviewed the international literature, interviewed frontline nurses in collaborative teams<sup>1</sup> and discussed ideas with our members and partners. Using this initial work we have evolved a set of principles intended to support the planning and implementation of integrated service delivery.

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

As the professional organisation and trade union for nursing the RCN is, of course, specifically engaged in the experiences of nurses and health care support workers. Nursing teams hold a privileged frontline and service user focused position. As such, they will play a key role in delivering more collaborative care across Scotland and our principles draw on their knowledge and practice. Given the RCN's particular perspective, we do not pretend to speak for all professions, for all patients or for all carers. However, whilst some principles do focus explicitly on the needs of our members, we have consulted widely in developing this document in the hope it can provide an informed, inclusive and considered contribution to developments in Scotland.

It is important that anyone who cares about the delivery of health and care in Scotland has the opportunity to influence proposals. The implications of the Scottish Government's drive to integrate health and social care are wide-ranging and complex. Evolutionary changes to much-loved public services will be felt right across the country over the coming years: by the general public, by care providers and staff, and by politicians. If we are successful in offering more, including far more complex, care close to home through increased integration it is not only community-based services that will change, but institutions such as our local hospitals too.

Given the scale of change in hand, the RCN is setting out a comprehensive list of principles for delivering integrated care in the context of our understanding to date. We believe that focusing on these areas will help support success in Scotland, though we will continue to evolve our thinking in the light of experience as this agenda gains pace. We hope this document will give managers and leaders tools to plan and implement change and give the RCN a means to assess local and national integration activity.

We look forward, on behalf of our members, to working constructively with all interested parties to ensure plans to integrate health and social care will provide a safe, high quality, efficient, responsive and seamless service for all. If you have thoughts or comments on the recommendations we have made, please do share them with us. Contact details are at the back of this document.



*Theresa Fyffe, Director*

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<sup>1</sup> Robertson, Hilary, *Integration of health and social care - A review of literature and models*, RCN (2010), and Matheson, Alex, *Integration of health and social care: a snapshot of current practice in Scotland*, RCN (2011)

# OUR VISION FOR THE INTEGRATION OF CARE

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

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

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

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

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

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

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

## THE RCN IN SCOTLAND: PRINCIPLES FOR THE INTEGRATION OF CARE A SUMMARY

<b>Theme</b>	<b>Principles</b>	<b>Actions to deliver include:</b>
1. Commit to processes that sustain respectful relationships	<ul style="list-style-type: none"> <li>• Organisational processes should support collaboration that is built on respectful relationships between service users, carers and staff</li> </ul>	<ul style="list-style-type: none"> <li>▪ Sharing care planning</li> <li>▪ Designing flexible services to promote equity of outcome</li> <li>▪ Promoting service user independence and participation in shared decision-making</li> <li>▪ Involving local people in change, even if the initial steps are small</li> </ul>
	<ul style="list-style-type: none"> <li>• Organisational processes should support collaboration that is built on respectful relationships between all staff delivering care</li> </ul>	<ul style="list-style-type: none"> <li>▪ Promoting understanding between staff from different professional backgrounds</li> <li>▪ Recognising the scope and limits of practice of different professional groups</li> <li>▪ Encouraging constructive dissent</li> <li>▪ Supporting staff to make the transition</li> <li>▪ Sharing training, learning and development</li> <li>▪ Embedding fair terms and conditions for all</li> </ul>
2. Ensure local integration plans are designed, in partnership, to improve outcomes	<ul style="list-style-type: none"> <li>• Integration plans should deliver on a shared purpose, built on a clear understanding of local context</li> </ul>	<ul style="list-style-type: none"> <li>▪ Understanding both local resources and needs from the start</li> <li>▪ Committing to a shared purpose</li> </ul>
	<ul style="list-style-type: none"> <li>• All decisions to redesign services to improve outcomes should be made inclusively and transparently</li> </ul>	<ul style="list-style-type: none"> <li>▪ Assessing the options openly with all partners</li> <li>▪ Setting clear outcomes and being honest about priorities</li> <li>▪ Being clear about the risks of change and explaining how these will be mitigated</li> <li>▪ Setting out clear governance arrangements</li> <li>▪ Making transparent decisions about resource allocation</li> </ul>
	<ul style="list-style-type: none"> <li>• Improving care may require plans to be adapted in the light of experience</li> </ul>	<ul style="list-style-type: none"> <li>▪ Evaluating progress regularly to improve care</li> <li>▪ Taking the time needed to get things right</li> </ul>
3. Secure the quality and safety of integrated care	<ul style="list-style-type: none"> <li>• The public should be confident they can access the right professional care when they need it</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensuring the public's access to the right expertise</li> <li>▪ Making it easy for people to move between services</li> <li>▪ Planning the workforce for sustainable services</li> <li>▪ Ensuring fragmentation of services is not an unintended consequence of integration</li> </ul>

	<ul style="list-style-type: none"> <li>• Robust professional leadership and support is needed for staff to provide safe, and ever more complex, care in communities</li> </ul>	<ul style="list-style-type: none"> <li>▪ Respecting professional leadership and judgement</li> <li>▪ Guaranteeing appropriate professional supervision and clear lines of professional accountability</li> <li>▪ Ensuring the workforce is equipped with the right skills to deliver the health and care services needed</li> <li>▪ Maintaining a focus on safeguarding those who are at risk</li> </ul>
	<ul style="list-style-type: none"> <li>• Well-resourced IT and administrative supports are required for professionals to provide safe and efficient care</li> </ul>	<ul style="list-style-type: none"> <li>▪ Developing robust local IT systems and data policies to support integrated care</li> <li>▪ Providing adequate administrative support</li> </ul>

<b>Theme</b>	<b>Principles</b>	<b>Actions to deliver include:</b>
4. Set the national foundations for integrated care	<ul style="list-style-type: none"> <li>• The political principles underpinning integrated public services in Scotland should be clear to all</li> </ul>	<ul style="list-style-type: none"> <li>▪ Setting out the detail of the national vision for integration</li> <li>▪ Clarifying the place of choice, competition and commissioning in integrated care</li> <li>▪ Ensuring clear and transparent lines of political accountability</li> <li>▪ Preserving the founding principles of the NHS</li> </ul>
	<ul style="list-style-type: none"> <li>• Clear and coherent national expectations of local partners are essential for successful delivery of collaborative care</li> </ul>	<ul style="list-style-type: none"> <li>▪ Providing national guidance to support local decisions</li> <li>▪ Setting clear national priorities for outcomes and choices on spending</li> <li>▪ Setting clear standards for care delivery</li> <li>▪ Introducing a fully integrated performance management system</li> </ul>
	<ul style="list-style-type: none"> <li>• National oversight of the implications of local integration will help ensure equity, sustainability, safety and efficiency in the public sector</li> </ul>	<ul style="list-style-type: none"> <li>▪ Assessing how local integration plans will affect regional or national services</li> <li>▪ Holding strategic oversight of workforce planning across the health and care workforce</li> <li>▪ Leading on national oversight of workforce education needs</li> </ul>
	<ul style="list-style-type: none"> <li>• Local partners should benefit from joined-up national support for collaboration</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reviewing scrutiny and improvement regimes in the light of new service configurations</li> <li>▪ Improving central finance and data support to help collaboration</li> <li>▪ Gathering and sharing learning about what is already working on the ground</li> <li>▪ Making the most of investment in research to improve services</li> <li>▪ Completing a policy review</li> </ul>

# 1. COMMIT TO PROCESSES THAT SUSTAIN RESPECTFUL RELATIONSHIPS

Delivering good care needs everyone involved to take responsibility for their own individual part in establishing respectful relationships. RCN's Principles of Nursing Practice<sup>2</sup> (appendix 1) set out the behaviours that we, and patients, should expect of nursing staff in this regard. The RCN will continue to provide professional and employment support to our members to help them in delivering on their practice in this way. However, organisational and political leaders also have a responsibility to model an ethos of respect and, importantly, to put in place the processes that will promote and support behaviours that sustain sound, collaborative relationships within our care services.

## **Organisational processes should support collaboration that is built on respectful relationships between service users, carers and staff**

Nurses and health care support workers, who work closely with service users and their carers every day, are well-placed to play their part in modelling and promoting respect and empowerment. This will be an important support to improving the wellbeing, independence and resilience of individuals and communities. We wish to see a mutual-esteem approach embedded in all interventions where formal services are required by individuals and families. This could be supported practically by:

- **Sharing care planning**

We would expect to see care plans developed in partnership between care staff, service users, families and carers in a manner that identifies people's needs, strengths and capacities and acknowledges their differences and diversity. Shared assessment processes, with appropriate shared documentation and IT support, will be essential to ensuring that these plans are coherent and comprehensive and service users are not burdened with unnecessary repetition and bureaucracy in their dealings with staff. Individuals should be encouraged to ask questions, challenge assumptions and, wherever possible, be supported to work alongside professionals to make informed decisions about their care options.

- **Designing flexible services to promote equity of outcome**

Successful integrated care services will adapt to the different needs and circumstances of individuals and families, in order to ensure equity of outcome as far as possible. As such, organisations will need to develop policies and processes which actively support professionals to work in partnership with service users to design and deliver creative and flexible responses to individual and family needs. This may include thinking differently about how resource is allocated within localities to ensure improved outcomes for those with greatest need. It will also require professionals from various backgrounds to reflect on how different care and clinical contexts will impact on judgements regarding acceptable risk.

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<sup>2</sup> This document is informed by both the RCN's *Principles of Nursing Practice* (2011) (see: <http://www.rcn.org.uk/development/practice/principles>) and *Pillars of the Community: the RCN's UK position on the development of the registered nursing workforce in the community* (2010) ([http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0007/335473/003843.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0007/335473/003843.pdf))

- **Promoting service user independence and participation in decision-making**  
Care services should prioritise the independence of service users through shared decision-making and supported self-management, wherever possible.

In a fully integrated service, the continuum of care provision will range from daily living support such as a Meals on Wheels service, to highly complex clinical interventions. In addition, an individual's capacity for independence and decision-making, and the setting in which care is best delivered, may vary frequently and unpredictably with changes in the person's health, wellbeing or social circumstances.

Given this context, the RCN would expect to see a variety of approaches available locally to support service users' independence and participation in decision-making to ensure an appropriate and flexible person-centred response. This could range from investing in telecare resources in order to increase autonomy at home, through to supporting individuals with self-directed social care packages. It will not be sufficient to impose a one-size-fits-all approach in local plans – such as an exclusive emphasis on direct payments - as a means of personalising integrated care services.

- **Involving local people in change, even if the initial steps are small**  
Proposed reforms may not initially result in obvious changes to community services used by the public. However, it is clearly a long-term aim of government to ensure that increased integration will reduce the need for acute interventions and stays in institutional settings. Successfully implementing this shift will require a significant change in thinking on the part of the public, care staff, organisations and politicians. Therefore, it is essential that local people are engaged at the earliest opportunity in each incremental step made towards more care being delivered at home, so that they have the chance to influence each stage of reform and share their concerns, ideas and experiences.

More work may be needed in some areas to build local capacity for community engagement. Information about changes and service availability must be publicised to the local population in plain English and also in formats and languages appropriate to the wider community.

### **Organisational processes should support collaboration that is built on respectful relationships between all staff delivering care**

Respectful relationships between care staff and the public do not happen in a vacuum. The RCN is clear that the collaborative and enabling ethos we want to build and sustain in communities should be mirrored in the behaviours promoted within organisations delivering integrated services, as well as the behaviours of those accountable for them.

The RCN would want to see partners place an early emphasis on building sound relationships between staff from different backgrounds and organisations, rather than prioritising structural change. Our research suggests that investment in such relationship-building supports is crucial to success. Committing to the following approaches will help provide the basic organisational supports necessary for individual members of staff to play their part in delivering care based on respectful relationships:

- **Promoting understanding between staff from different professional backgrounds**

Different language and terminology used by staff from various professional backgrounds can become a barrier to effective collaboration and, consequently, to seamless service delivery from the service user's perspective. Basic misunderstandings can breed suspicion and confusion within teams. Our members have told us that practical measures, such as co-locating team members and work shadowing, can help overcome such issues. As such, we would expect to see practical actions, supported by Organisational Development staff, to support understanding between professional groups in integrated teams included in re-design plans, as well as ongoing protected space and time for staff in collaborative teams to meet regularly and discuss issues arising.

- **Recognising the scope and limits of practice of different professional groups**

Differences and similarities between the specific expertise, codes of practice and legislative responsibilities of professional groups should be articulated and explored early on in the process of integration. This shared understanding of the scope and limits of practice will support clear decision making, appropriate delegation and safe working practices in teams providing integrated care. Local policies and procedures, which take into account these professional differences, must be in place before changes are implemented.

- **Encouraging constructive dissent<sup>3</sup>**

Staff should be enabled to voice their concerns, challenge decisions and engage in constructive dissent - and for this to result in positive change and improvement, where appropriate. Such debate should be viewed constructively at all levels of organisations involved in care delivery. The RCN would expect to see open, challenging and respectful discussion reflected in minutes and reports, and be evidenced in feedback from local and national Partnership working.

As accountable registered professionals, nurses are obliged to raise concerns about care standards to their employers under their regulatory body's code of conduct. When they can raise concerns easily and be heard respectfully, whistleblowing should become an action of last resort. However, the RCN continues to call for the revised NHS PiN policy, *Dealing with Employee Concern* to be implemented consistently and for compliance to be reported on through local governance structures. The Scottish Government should advise how this policy can be used across collaborative teams.

- **Supporting staff to make the transition**

The pressure to continue to deliver safe and effective services whilst undergoing significant change should not be underestimated. The RCN would expect partners to set out a clear transition plan to make arrangements for safe service delivery during change and communicate plainly with staff and their trade union representatives throughout the transition process. Without such a clear framework, professionals will be anxious about the possibility of unacceptable risk to service users and staff during change. This will not help to promote the creativity and flexibility needed to deliver successful collaboration.

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<sup>3</sup> For a brief overview of Prof. Keith Grint's thinking on constructive dissent see: <http://www.lums.lancs.ac.uk/news/5150/timesgrintopinion/>

- **Sharing training, learning and development**

Joint training, learning and development opportunities need to be in place to enable delivery of an integrated model of working, which supports respectful relationships in pressured environments. Shared learning is central to building a common ethos, encouraging respect and acknowledging different professions' contributions to an integrated team. To complement profession-specific development opportunities, the RCN would expect to see joint training and development arrangements built into local plans for integrating care and into ongoing activity.

Undergraduate and vocational courses designed to deliver the future workforce will have to adapt to reflect the behaviours needed to deliver successful collaborative working. This should include opportunities for all aspiring professionals to spend time in education together and to benefit from placements in integrated service teams.

- **Embedding fair terms and conditions for all**

Recognition of skills, experience and commitment is a basic mark of respect for those engaged in public service. Every member of staff delivering integrated care, whatever their level of skill and experience and whoever they are employed by, must be assured of fair terms and conditions of employment.

However integrated teams are configured in the future, the RCN would expect that, at a minimum, existing terms and conditions of staff will be maintained and that terms and conditions of employment are appropriately transferred if staff face a change of employer under TUPE arrangements. We would urge employers and the Scottish Government not to waste the considerable investment made in the equality-proofed and Partnership approved Agenda for Change framework operating in the NHS.

NHS Scotland's Partnership arrangements have been celebrated as a positive model of industrial relations<sup>4</sup>. Whatever service changes are made, the RCN is clear that the Scottish Government should embed the learning from this statutory model in all future staff / employer / government relationships.

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<sup>4</sup> See: [http://www.nottingham.ac.uk/business/37522\\_UoN\\_NHS\\_Scot\\_Research\\_WEB1.pdf](http://www.nottingham.ac.uk/business/37522_UoN_NHS_Scot_Research_WEB1.pdf)

## 2. ENSURE LOCAL INTEGRATION PLANS ARE DESIGNED, IN PARTNERSHIP, TO IMPROVE OUTCOMES

Much of the activity and responsibility for integrating services will be seen at a local level. The RCN is not advocating a single model of integrated delivery: clearly a large city and an island community may require quite different solutions. However, we do think there are some core national principles that should inform the process of developing all plans for the future within the context of building and sustaining respectful relationships in care services. The following principles set out the actions we believe integrating organisations should undertake to make the transition to new collaborative services successful.

### **Integration plans should deliver on a shared purpose, built on a clear understanding of local context**

Local partners should begin service redesign by understanding the local issues they need to address and the aspirations of the local community, using a change process that models collaboration and ownership. This would include:

- **Understanding both local resources and needs from the start**

An integrated strategic needs assessment should form part of any plans for service re-design and delivery. Local people will need to be involved in the process of drawing up any such assessment, and the RCN would expect nursing staff to be fully engaged in this profiling, as well as in the subsequent decisions around the provision of services and the development of professional roles.

However, building on the call of Scotland's Chief Medical Officer<sup>5</sup>, we also think there is real merit in the Scottish Government helping partners and communities to map the full spectrum of support resources available in their locality. Formal public, third and independent sector services are only a part of the network of contributions available to improve health, independence and resilience. In reality, it is often the work of unpaid carers, self-help groups or local social clubs, for example, which provides this support for many local people.

Bringing partners and communities together to understand an area's total resource base will help to highlight what types of service or activity local people really value. It will also ensure that planning for formal integrated services is focused on complementing existing activity and supporting new capacity building where there are gaps or where informal supports are over-stretched. Finally, it would help local funders recognise those local activities which are preventing isolation and ill health and are, therefore, lessening the need for people to engage with the formal care system at all.

- **Committing to a shared purpose**

Generating a shared, clear vision or purpose for the integration of health and social care, based on an understanding of local need, is crucial to success. Our research shows<sup>6</sup> that successful integration requires staff to be motivated specifically by a focus on improving the health and wellbeing of their communities, not a drive to reduce budgets.

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<sup>5</sup> See: <http://www.scotland.gov.uk/Publications/2011/12/14120931/10>

<sup>6</sup> Roberston, Hilary, *ibid.*

The RCN expects local plans for integration to include evidence of a clearly articulated purpose, rooted in an understanding of what really matters locally, and which has been developed through engagement with staff across services and with local people. This shared vision must become the key measure against which the success of integrated care is assessed.

### **All decisions to redesign services to improve outcomes should be made inclusively and transparently**

As the options for change begin to take shape, and choices are made and delivered, it is important that decisions are made in the spirit of respect expected of the services being planned. This could be underlined by:

- **Assessing the options openly with all partners**

To ensure the shared purpose is realised through the best possible service model, partners should engage in a process of appraising the options for integration. This would include consideration of needs, priorities, risks, costs, benefits, barriers, equality impacts and potential outcomes of all options, including the status quo. Leaders must be clear which services are being included in any re-design proposal. An account of the options process and the final decision should be made public.

Service users, the public and staff need to be engaged proportionately throughout, to shape and influence the aims and configuration of integrated services in their area. Partner organisations must be able to demonstrate that feedback and queries have been encouraged and acted upon to support local ownership of the plans.

Given the role and position of nursing teams, they will have valuable perspectives to contribute to the development of new service models and we would expect to see evidence of their full engagement in plans.

- **Setting clear outcomes and being honest about priorities**

The RCN has supported a focus on outcomes to improve health and wellbeing in Scotland, though there is still some way to go before outcomes-delivery is fully embedded as an approach across the health and care system. Within the current economic climate it is unlikely that partners will have the resources to do everything they would like to improve quality of life. As such, energy and assets should be focused on delivering against those outcomes that will be most likely to help achieve the shared purpose. Priorities should be set openly.

Within the context of shared ambitions to deliver on significant long-term outcomes, we would expect to see local plans setting out and evaluating incremental, practical targets that staff can focus on delivering together as steps toward the larger goal.

- **Being clear about the risks of change and explaining how these will be mitigated**

Understanding the potential risks and unintended consequences of change is an essential part of planning for integration. Partners will need systems in place to identify and manage risk, which should include the production of robust risk assessments. These should include, but not be limited to: clinical / client safety, financial and workforce risks, risks to equitable access and risks associated with

failing to achieve the planned outcomes in implementing a new model of provision. This activity should be focused on promoting a realistic risk-aware, not risk-averse, culture.

- **Setting out clear governance arrangements**

Health and social care partnerships must have clear governance structures and associated management arrangements in place to be fully accountable for the use of public money, the management of staff and the quality of care delivered through collaborative services, however those services are configured. These must be demonstrated in their local plans for integration and be based on the national model for the governance of integrated care. We would expect to see evidence of clear processes for effective communication between frontline staff and governance bodies. Governance meetings should be held and reported openly.

- **Making transparent decisions about resource allocation**

Increased sharing of funding and of financial responsibility will be highly likely to support better collaborative care if this can be achieved with transparency, and with clear accountability and scrutiny processes in place. Robust financial management arrangements, which set out each partner's respective contributions and liabilities, will need to be in place from the start of any change process and reviewed as circumstances change. The cost of transition should be made clear within the options appraisal and the source and amount of any additional funds needed to support change made public.

Integrated planning for resource allocation should include the acute healthcare sector alongside the contributions of other partners to ensure decisions take into account all options for re-balancing allocations effectively and meeting need. Executive nurse directors will be accountable for the quality and safety of significant elements of local care provision. As such, we expect that they, or their delegated leads, will be represented in all commissioning or planning structures.

Ongoing allocation and spending decisions, and information on how budgets reflect the priorities and outcomes the partners have set, should be transparent so that politicians and the general public can be assured that public funds are being spent efficiently and appropriately. RCN will continue to monitor local and national spending on care services.

### **Improving care may require plans to be adapted in the light of experience**

In integrating care, all partners will be learning by experience and mistakes may well be made along the way. A commitment to ongoing evaluation and incremental development will support a culture of improvement and success, rather than one of blame and failure. This could be supported by:

- **Evaluating progress regularly to improve care**

Focusing on the shared purpose, agreed outcomes and interim targets, partner organisations should set up robust, ongoing evaluation processes from the start of the change process. Given the importance of getting the right processes in place to underpin relationship-based care, this should also be a focus of evaluation. The evaluation should involve staff and service users in design and delivery with results reported publicly and findings used to adjust approaches in a spirit of continuous improvement.

- **Taking the time needed to get things right**

There are clear pressures – demographic, financial and political – to drive forward with this step change in care provision. Not every part of Scotland will share the same starting point; some areas are already further down the path towards integrated care than others. Learning will be incremental as plans progress. As such, the time needed and path taken to establish the right foundations for successful integration will not be the same for all partners. However, reforms will be set up to fail if partners respond to pressures by rushing through the design and early implementation stages without clarity of purpose, the time to build the right relationships, transparency of decision making, recognition of risk, and the understanding of staff and the public.

The RCN would expect local partners to demonstrably address the principles set out in this document within the timescales needed in their context to deliver successful change.

### **3. SECURE THE QUALITY AND SAFETY OF INTEGRATED CARE**

It is imperative that the public, service users, care staff, organisations and accountable politicians can have confidence in integrated care services. Such assurance will require advance planning and ongoing investment in, and review of, activities to support good care. It will also require both the experience of service users and carers and the expertise of professional groups to be positioned at the centre of developments to improve the seamless route through different care services which share an ethos of respectful relationship.

#### **The public should be confident they can access the right professional care when they need it.**

When they need to access any sort of formal care, service users and their families should be assured that the right staff will be on hand to work with them when they most need it. Better continuity of care should be the result of improved collaborative working, but this will require some different ways of thinking about journeys through the care system. The following actions will help to deliver on this principle:

- **Ensuring the public's access to the right expertise**

Everyone should know that they can draw easily on the expertise of appropriate, professionally-qualified staff when they need them. As a professional nursing body, for example, we would expect this to include the public having access to the full range of physical and mental health nursing staff within teams delivering integrated care. As such, local partners must demonstrate that their plans will offer seamless access to a full range of health and care supports. In collaborative teams, one care professional should be identified to lead ongoing care co-ordination, providing continuity and a clear point of contact for both the service user and colleagues.

Where specialised services are shared across neighbouring areas, or at a national level, it must be clear in local plans that provision has been made to ensure that all service users, however limited their mobility or wealth, can access these facilities equitably.

- **Making it easy for people to move between services**

Partners will need to ensure people can access services through clear referral processes that provide them with timely and relevant interaction with the right staff. If service users are to experience smooth and appropriate transition between staff groups and different services in this new landscape, traditional assumptions about professional control of access to services should be reviewed and referral pathways clarified. Eligibility criteria, where they must exist, should be transparent, consistent and equitable on paper and in practice.

The RCN would expect to see pathways developed which take account of integrated care delivery. These could usefully build on the success of existing clinical/care pathways such as the mental health integrated care pathways. These pathways must take into account the full spectrum of care needs, including the most complex care. Current clinical pathways in use within the NHS must be reviewed to ensure they are fit for purpose within an integrated landscape.

The Scottish Government could helpfully clarify how clinically led collaborations that have proven successful in bringing together professionals, such as Managed Clinical Networks, will develop within an integrated care model.

Finally, we urge the Scottish Government and local partners not to ignore ongoing tensions in transfers between primary and acute health services in their focus on improving integrated health and social care in the community. As one aim of integration is to reduce unnecessary hospital admissions, all parts of the healthcare sector should be included in the reshaping of care. At present, routes in and out of acute-based services, including access to acute outreach and diagnostics, are largely managed at the interface between general practitioners and hospital consultants. Therefore changes to patient journeys and the location of complex care delivery will only succeed if the medical profession is engaged in reforms alongside all other partners.

- **Planning the workforce for sustainable services**

The RCN maintains that robust workforce planning processes are required at both local and national levels to ensure the ongoing sustainability of the health and social care workforce to deliver high-quality care in integrated services. Workforce changes need to be accompanied by detailed clinical risk management plans to demonstrate that risks to the quality and safety of service user care have been identified and mitigated.

We would wish to see the Scottish Government continue to realise the considerable investment made in developing nursing workforce and workload planning tools by directing local partnerships to use these, as designed, to plan and review nursing requirements. This will help assure staff and the public that nursing staffing levels and skill mix are not being diluted to the detriment of care.

Those nurses and health care support workers who have developed careers in the acute sector will require support, through education and mentorship, to transfer to integrated community teams should they wish, or be required, to do so. These development pathways should be clear in all plans.

Any changes required to workforce roles, which emerge from these reforms, should be agreed with the professional and trade union representatives of the professions involved.

- **Ensuring fragmentation of services is not an unintended consequence of integration**

There have been occasions in the past where political and professional interests have resulted in services become more, not less, fragmented. Equally, there are risks in the unintended consequences of future integration. For example, if the range of professional groups to be included in collaborative teams is defined too narrowly, it risks excluding others who are vital to the delivery of joined-up, service user-focused care services. The sorts of improved relationships we are advocating in these principles should help reinforce future partnerships. But, in addition, we would expect partners to map pathways through services from the early planning stages for integration. This will ensure that it is clear which staff groups need to come together to provide seamless care and how professional relationships and service user transitions will be managed to help militate against unintended service fragmentation.

## **Robust professional leadership and support is needed for staff to provide safe, and ever more complex, care in communities**

Key to the change in care anticipated through this reshaping process is the delivery of far more complex healthcare at home to reduce hospital stays. Staff will not simply be providing more of the same types of care packages that they do now; in many circumstances, they will be offering something more akin to a hospital at home, or 'virtual ward' services. An example of this in operation already would be the intensive at-home palliative care services offered to patients at the end of life. Partner organisations will have to plan now to ensure that all the leadership and support mechanisms are in place for staff to deliver safe, dignified and ever more complex integrated care. This could be done by:

- **Respecting professional leadership and judgement**

Robust, visible and influential professional leadership is needed to plan and manage change and to ensure the safe and effective practice of frontline practitioners. Clear structures for professional leadership, from community teams and acute wards to governing boards, must be articulated in change plans and delivered in new service configurations. Respect for the professional judgement of professional leaders, including nurses, should be visible in records of discussions and decisions made.

Similarly nurses, like other key care professionals, hold a wealth of knowledge and experience in delivering successful community care and in meeting the needs of their local population. They should therefore be engaged in all integrated structures with responsibility for designing or commissioning services. We would also expect that opportunities will be created for nurses to take a clinical, managerial and contractual lead in the development of services.

- **Guaranteeing appropriate professional supervision and clear lines of professional accountability**

Professional accountability is not the same as line management. Accountability and supervision for care staff should be provided by appropriate practitioners in their own field, regardless of whether ultimate management of the service is undertaken by a member of staff from a different professional background. For nurses, we expect clinical supervision to be delivered by nurses working as Advanced Practitioners (Level 7), at a minimum. To ensure the safety and ongoing development of care services, professional staff will need easy access to such professional guidance and supervision, however collaborative teams are configured.

Registered nurses retain ongoing accountability for all nursing tasks they delegate to other staff, such as health care support workers. As such, to ensure the safety of both service users and staff, it is crucial that the frameworks for integrated care delivery set out by partner organisations clearly enable nurses to continue to oversee and supervise the support workers carrying out these tasks

The accountability structures of any new bodies created to facilitate integrated working should demonstrably embed clinical governance into their operation.

- **Ensuring the workforce is equipped with the right skills to deliver the health and care services needed**

Partners will want to ensure that in both the planning and delivery of services, staff such as nurses and health care support workers have access to fully funded and high quality education and development opportunities. These will need to fulfil mandatory training requirements, as well as the continuous professional development opportunities required to build the core competencies needed to deliver integrated care. Resource allocations in these circumstances will clearly need to include funding for adequate backfill to allow staff to attend training.

- **Maintaining a focus on safeguarding those who are at risk**

Local integration plans need to clearly set out how the safeguarding of people who are at risk will be managed across staff within local teams. This should include particular provisions for the period of transition to new service configurations.

Moves to increase integration between health and social care, which will be accompanied by ever-more complex practice for staff working alone in the community, also further emphasise the need to regulate health care support workers, as consistently called for by the RCN.

### **Well-resourced IT and administrative supports are required for professionals to provide safe and efficient care**

Many of the proposals already detailed will help professionals deliver more efficient care when their intervention is needed. However, to deliver safe, high quality and collaborative care, frontline staff are reliant on supports which are often invisible to those outside of services. Plans should, therefore, include:

- **Developing robust local IT systems and data policies to support integrated care**

Integrated care will require joined-up IT provision to ensure smooth organisational administration, the accurate management of service user records and support for service users to enjoy greater independence through the provision of telehealth and telecare. Our members and partners have told us that IT incompatibility is a significant barrier to integration. We appreciate the Scottish Government is working on a joint health and social care IT strategy, due for delivery in 2014, and we hope that this will support moves to integrate care.

All local re-design plans will have to address how data access, security and issues of confidentiality will be handled to enable frontline practitioners to do their job efficiently and safely and protect service users. In addition, the provision and upgrading of IT hardware and software, as well as IT training needs for staff and service users, need to be clear in all local re-design plans.

All key professional groups must be involved in the development of the structure and content of electronic records/assessments within any newly integrated service. Nursing input, for example, will help to ensure processes capture clinical information appropriately.

In addition, the RCN would encourage the Scottish Government to support partnerships to increase investment in telehealth and telecare. This will help

them take advantage of the long term benefits it can deliver for service users in an integrated care system intended to promote independence and self-care.

- **Providing adequate administrative support**

Within the NHS we are beginning to see how administrative support is being eroded to make savings in the current financial climate. Such pressures will not be isolated to the health service. However, we short change both service users and the taxpayer if professional staff, such as nurses, are routinely expected to carry out core administrative tasks like stock ordering and appointment booking. All integrated teams must be equipped with adequate administrative support to let professional health and care staff do the skilled frontline jobs they are paid for. Administrative support needs must be reviewed regularly.

## 4. SET THE NATIONAL FOUNDATIONS FOR INTEGRATED CARE

Although the integration of care will be delivered locally, it cannot work without decisive and transparent national leadership. Achieving seamless care delivery, built on respectful relationships at the frontline, requires those in leadership roles to set out the right conditions for such a culture to flourish. Politicians must lay the foundations for success, embedding in their policies and in their own relationships with partners the same ethos of mutual respect expected elsewhere. In addition, national oversight will also be required, for example, to: ensure consistency in service eligibility or availability; ensure the prioritisation of regional and national resources; provide coherent policy and legislation to support collaboration; and to allocate and scrutinise the use of taxpayers' money.

### **The political principles underpinning integrated public services in Scotland should be clear to all**

Over the years, health and social care services have evolved on the basis of different political principles. The variation in universal and means tested entitlements or local and national democratic accountability are just two examples of this. Politicians cannot expect frontline staff to collaborate successfully without being clear about how the political decisions behind public service delivery can support integration. To deliver on this principle, the RCN suggests the Scottish Government should focus on:

- **Setting out the detail of the national vision for integration**  
To set the direction of travel across the whole of Scotland, the Scottish Government should publish a detailed national vision for integration to shape change. All technical legislative changes should be developed to deliver against this vision.
- **Clarifying the place of choice, competition and commissioning in integrated care**  
This is one of the most significant differences in approach between health and social care currently. The Government has openly acknowledged that there are considerably different 'commissioning' and 'planning' cultures between the NHS in Scotland and Scottish local authorities<sup>7</sup>.

We understand that social care procurement in many areas is driven by delivering individual client choice through a competitive provider model. A heavy emphasis on price in the current climate is resulting in significant pressure on some providers. This is not the model currently at play in the Scottish NHS, which has evolved since devolution by removing the internal market and creating unified health boards which both plan and deliver services. Indeed, the current Scottish Government is committed to providing a "wholly publicly-funded and publicly-delivered NHS"<sup>8</sup> – a policy which could come under significant strain if purchasing healthcare services through competitive procurement policies became part of a fully-integrated commissioning landscape. It is not yet clear whether the Scottish Government's promotion of "joint commissioning" is one solely of supporting better local decisions on investment through shared planning

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<sup>7</sup> Scottish Government, *Integration across Health and Social Care Services in Scotland – Progress, Evidence and Options* (Mar 2010)

<sup>8</sup> Scottish National Party, *Re-elect a Scottish Government working for Scotland* (2011)

processes, or one which also includes a shared ethos of procurement, drawing in the full spectrum of possible providers. To make matters more complex, the NHS and social care often work with quite different assumptions about universal and criteria-based entitlement to services.

The RCN is concerned that in the drive to integrate care services, and given discussions to date, competitive social care procurement approaches may be expected to translate into the Scottish NHS through joint commissioning, without open consideration of the potential consequences to the future of healthcare delivery. For this reason, we believe the Scottish Government should lead an open civic debate on the parameters of competition and individual choice within an integrated health and social care service, and then set out clearly its policy position. This will ensure local partners and the public are fully aware of the significance of the choices being made, and are clear on the limits and possibilities of future commissioning approaches.

- **Ensuring clear and transparent lines of political accountability**

Where accountability rests for the delivery of public services is a wholly political decision which requires the support and understanding of the electorate. However, we expect to see national plans for integration to clarify who holds ultimate responsibility for the oversight, scrutiny and strategic direction of publicly funded and delivered services in Scotland. Whatever accountability model is chosen, it should apply to all parts of Scotland to avoid public confusion and retain national coherence.

- **Preserving the founding principles of the NHS**

The RCN has been clear across the UK that whatever reforms are implemented in the NHS, healthcare must remain free at the point of need. The Scottish Government should make its position on this clear in the detail of its integration proposals. We will carefully examine all proposals for integration to ensure this basic principle is not undermined.

### **Clear and coherent national expectations of local partners are essential for successful delivery of collaborative care**

Local partners face a significant challenge in re-designing health and care services and delivering new types of collaborative, complex care services within the context of ever-increasing demographic, financial and political pressure. In the spirit of modelling respectful relationships, and so that local energy invested in change is not wasted, the Scottish Government should support local partners by:

- **Providing national guidance to support local decisions**

The Scottish Government has published guidance for NHS Scotland on delivering major service change<sup>9</sup>. Given the scale of service re-design we expect to result from the integration of health and social care, we call on the Government, with its local government partners where appropriate, to make clear its expectations by either:

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<sup>9</sup> The Scottish Government, *CEL 4 (2010) Informing, engaging and consulting people in developing health and community care services* (February 2010). See also, Scottish Health Council, *Identifying Major Service Change* (February 2010) and *Involving Patients, Carers and the Public in Option Appraisal for Major Health Service Changes* (February 2010)

- Clarifying how the existing NHS guidance should be applied across partnerships to local integration planning processes, or
- Providing new guidance to support local partners on delivering change appropriately

This will do much to avoid wasted resource and effort at a local level in planning service changes that are not consequently acceptable to accountable politicians.

- **Setting clear national priorities for outcomes and choices on spending**

The decision to reform health and social care services comes during the toughest financial climate in the public sector for a generation. When resources are this tight, and the need to provide safe services is paramount, difficult political decisions will have to be taken on where to prioritise spending public money to best effect.

The Scottish Government will need to take the lead in making increasingly difficult choices on which parts of the public sector should continue to receive the same or more resources, and which should receive less, or indeed, no further funding. Such leadership would support local partners by clearly setting out realistic priorities for their health and social care spending. Only then can local services and budgets be reconfigured appropriately to reflect these priorities for the long term and ensure safe and high quality care services that are fit for the future.

Once these priorities are set, the Scottish Government must ensure that all of its own national policies and budget proposals are consistently focused on delivering them.

- **Setting clear standards for care delivery**

Whilst some variations in care options may be an inevitable consequence of local planning, the Scottish Government and its partners have an important role in setting clear standards for the delivery of care, including setting agreed national entitlement criteria for non-universal services. This will assure communities of the quality and accessibility of care available to them and ensure local partners are clear of their responsibilities in care delivery.

- **Introducing a fully integrated performance management system**

To support the integration of health and social care, the Scottish Government should provide clear leadership to frontline staff by introducing a coherent, joined-up performance management system for the whole of the public sector and simplify the current confusing landscape of outcomes, targets and indicators which hinder collaboration on the ground.

### **National oversight of the implications of local integration will help ensure equity, sustainability, safety and efficiency in the public sector**

In a small country like Scotland, change in one area can have a significant impact on the availability or sustainability of services for another. National oversight to plan for the consequences of change on services, workforce and outcomes, and to ensure access to the most specialist care services required by a minority of people at the times of greatest need, the Scottish Government should focus on:

- **Assessing how local integration plans will affect regional or national services**

We anticipate that more integrated community-based health and social care provision will reduce emergency hospital admissions and delayed discharges over time, even given the increased demand expected from an ageing population. As such, the pattern of hospital use should gradually change every bit as much as that of community service use. To ensure the quality, sustainability and efficiency of specialist clinical inpatient care, the Scottish Government should plan to model and report on whether changes in integrated services could, and should, impact on the provision of local, regional or national acute-based services. This should be made public to support debate on change.

- **Holding strategic oversight of workforce planning across the health and care workforce**

It is essential that the Scottish Government take an ongoing strategic and future-proofed national view of workforce need and changes to ensure sustainability of all health and care services within Scotland. This may well require a review of current national workforce groups to ensure they are fit for purpose. More work is required to ensure that the interface between different professional groups within an integrated system is reflected in decisions made for individual professions. For example, a decision to reduce the number of trained doctors could not be made in isolation if it required planning for an increase in the number of advanced nurse practitioners.

The Scottish Government should also continue to invest in developing workforce and workload planning tools relevant to the new configuration of services and including all partners.

- **Leading on national oversight of workforce education needs**

From SVQ provision to pre- and post-registration professional courses, education and professional development opportunities in Scotland will need to be fit for purpose in a newly integrated landscape. We know there is already work ongoing in this area. For example, the Chief Nursing Officer is currently reviewing nursing and midwifery education and NES/SSSC have completed extensive work on an education framework for health and care support workers. The implications of these separate streams of activity must be drawn together by Scottish Government at the earliest opportunity to ensure that Scotland's further and higher education institutions can make coherent and timely plans to meet the needs of an integrated landscape, and so that all staff can develop the right skills and competencies to deliver services in a new way.

### **Local partners should benefit from joined-up national support for collaboration**

Given their responsibility in setting the direction of travel and retaining a share of political oversight of public services, the Scottish Government and its national partners have a responsibility to ensure their own processes, supports and approaches are integrated to enable local partners deliver collaborative care services.

- **Reviewing scrutiny and improvement regimes in the light of new service configurations**

As health and social care services are further integrated, the RCN believes it makes sense to move towards the creation of one body to oversee the scrutiny and improvement of health and social care as recommended in the Crerar

review<sup>10</sup>. This will ensure that both quality assurance and development support are well co-ordinated on behalf of service users and staff in the context of collaborative care.

- **Improving central finance and data support to help collaboration**

The RCN believes the Scottish Government should provide clear financial guidance and support throughout this process and ensure that its own expectations, such as those regarding the delivery of public sector efficiencies, are framed in such a way to support collaboration between public sector organisations. All local partners will want to be clear, before the start of each financial year, of the total annual budgets allocated to them by the Scottish Government and the expectations on when, how and to whom they should report on financial activity. More work is required to address ongoing concerns raised by Audit Scotland and others about the quality of data available to measure success.

- **Gathering and sharing learning about what is already working on the ground**

There are many examples of mature and successful collaborative working in Scotland and there is much to be learnt from approaches developed elsewhere. There are also significant lessons to be learnt from those integration projects that have not worked well in the past. Not all successful innovations are necessarily scale-able or transferable, but understanding the experience of practitioners and service users elsewhere will be invaluable to those implementing local change. The Scottish Government should play a key role in gathering and disseminating learning and good practice to integration partners.

- **Making the most of investment in research to improve services**

To complement ongoing local service evaluation, the RCN would like to see the Scottish Government invest in new research, and make the best use of existing research, to ensure lessons from past and current activity can be understood and shared. New activity could usefully include, for example, studies into: the impact of integration on service user experience and health outcomes; the impact of service changes on clinical quality and safety; changes in the patterns in the use of services (especially in the acute sector); the impact on health and social care costs; and whether non-co-terminus boundaries for NHS boards and councils hinder the success of integration.

- **Completing a policy review**

The aspiration to integrate care delivery could easily be hampered by existing national strategies and policies which have not incorporated collaborative approaches. Given the particular focus of current integration proposals, it would be helpful for the Scottish Government to begin with a review of existing public health, inequalities and care workforce strategies to examine how they might be best adapted to support practitioners deliver integrated care services in communities. Any policy review should also assess the synergy between major public sector strategies, such as the National Performance Framework, the NHS Quality Strategy and the associated 20:20 vision<sup>11</sup>.

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<sup>10</sup> See: <http://www.scotland.gov.uk/Publications/2007/09/25120506/19>

<sup>11</sup> See: <http://www.scotland.gov.uk/About/scotPerforms>, <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/NHSQuality>, and <http://www.knowledge.scot.nhs.uk/scln/resources-library/resource-detail.aspx?id=4002697>

## CONCLUSIONS

The range of principles and associated actions set out in this document underline the scale of change required by all involved to make better collaborative care the standard that service users, carers and staff should expect across all of Scotland. This is a complex task for all involved.

Some of the questions we raise, like the role of market-based choice in healthcare, are difficult to answer – for us, and for the political and organisational leaders responsible for setting the direction of travel. However, it is important that these issues are debated openly now with the people of Scotland to ensure we all understand the possible consequences of proposals to integrate care. Other issues are clearer: the need for respectful, dignified relationships to underpin care and the priority of ensuring public safety, for example, have to be embedded in whatever approach is taken.

We, like everyone involved, will continue to learn from experience over the coming years. However, as this particular integration journey begins in earnest, we hope our principles will be a support to a successful start.

# APPENDIX 1

## THE RCN PRINCIPLES OF NURSING PRACTICE

### Principle A

Nurses and nursing staff treat everyone in their care with dignity and humanity – they understand their individual needs, show compassion and sensitivity, and provide care in a way that respects all people equally.

### Principle B

Nurses and nursing staff take responsibility for the care they provide and answer for their own judgments and actions – they carry out these actions in a way that is agreed with their patients, and the families and carers of their patients, and in a way that meets the requirements of their professional bodies and the law.

### Principle C

Nurses and nursing staff manage risk, are vigilant about risk, and help to keep everyone safe in the places they receive health care.

### Principle D

Nurses and nursing staff provide and promote care that puts people at the centre, involves patients, service users, their families and their carers in decisions and helps them make informed choices about their treatment and care.

### Principle E

Nurses and nursing staff are at the heart of the communication process: they assess, record and report on treatment and care, handle information sensitively and confidentially, deal with complaints effectively, and are conscientious in reporting the things they are concerned about.

### Principle F

Nurses and nursing staff have up-to-date knowledge and skills, and use these with intelligence, insight and understanding in line with the needs of each individual in their care.

### Principle G

Nurses and nursing staff work closely with their own team and with other professionals, making sure patients' care and treatment is co-ordinated, is of a high standard and has the best possible outcome.

### Principle H

Nurses and nursing staff lead by example, develop themselves and other staff, and influence the way care is given in a manner that is open and responds to individual needs.

## APPENDIX 2

### Glossary of terms

We have said that language can be a barrier to improved collaboration – and nursing teams are not immune to using jargon. We have provided a short glossary of some of the terms used in this document to help make the detail of our principles clearer.

**Acute care:** Covers emergency care for accidents and trauma or specialist services, including surgery, that deal with short term but severe episodes of an illness or health condition. Acute care is usually delivered in hospital or clinic settings, although services can also be delivered in the community through **acute outreach** teams.

**Advanced Practitioners (level 7):** An experienced registered nurse who has a high level of skill and competence that allows them to make high-level decisions about clinical care. “Level 7” refers to the specific skills and competency level of the Skills for Health careers framework.

**Agenda for Change:** A UK-wide, standardised terms and conditions package that applies right across the NHS.

**Care pathways / Clinical pathways / integrated care pathways:** A way of mapping the process of how a patient or service user with a particular need or condition might journey through the whole care system. Pathways will show when certain actions might be necessary and which member(s) of a multi-disciplinary team should be involved to deliver them.

**Clinical Governance:** The system of accountability within the NHS for monitoring and improving the quality of the care provided and ensuring the highest possible standards.

**Codes of practice:** The rules set by professional bodies that registered professionals such as nurses and social workers must follow in their everyday practice.

**Constructive dissent:** Encouraging different, and sometimes opposing, perspectives to be shared openly to help resolve particularly difficult problems.

**Delayed Discharge:** When someone who is ready to leave hospital cannot be discharged because the conditions for them to be safe outside of hospital are not in place. For example, there may be no suitable nursing home place available or a care package at home has not been agreed.

**Direct payments:** See “self-directed support”

**Eligibility Criteria:** A list of measurements used to decide whether or not someone is entitled to a particular service. For example, some public services may not be available to people who have a certain amount of savings.

**Managed Clinical Networks:** Groups of health professionals from across different parts of the NHS coming together around a particular issue or clinical condition to ensure high quality care is delivered in a co-ordinated way.

**NES (NHS Education for Scotland):** The health board responsible for NHS workforce education and training in Scotland.

**Nursing workforce and workload planning tools:** Detailed tools developed by the Scottish Government to ensure nursing numbers and the mix of nursing skills and experience can be planned accurately to ensure patient safety. The tools currently in use or in development do not yet cover all areas of healthcare.

**Outcome:** The end result of a change that has come about for an individual, a family or a wider community as a result of planned actions.

**partners:** in the context of this paper, we mean the full spectrum of public sector, third sector, independent sector and patient/service user organisations and groups coming together, as appropriate, to plan and deliver integrated care.

**Partnership:** With a capital “P”, in this paper, Partnership refers specifically to the arrangements in place in Scotland between The Scottish Government, Trades Unions and NHS employers to build positive employment relations and engage staff in service improvement.

**Performance management systems:** Formal systems designed nationally or locally to assess the success of activities undertaken by individual organisations or by partners.

**PiN policy / guidelines (Partnership Information Network):** Scottish-specific NHS guidelines, which define minimum standards in relation to good employment practice.

**Primary care:** Health care provided in community settings or at home. This could be delivered by community nurses or GPs, for example.

**Professional supervision:** The support and oversight offered to one professional by another more experienced professional. The focus of supervision may include issues of professional development, safe practice, quality of care, and support in decision making.

**Registered professionals:** A professional included on the register of the relevant regulatory body, such as the Nursing and Midwifery Council.

**Shared assessment / Single shared assessment:** A tool used to assess the care needs of a service user on behalf of a number of different organisations and/or professionals at the same time.

**Self-directed support:** A variety of ways to support individuals and families to take greater control over deciding which care services will help them. It can include giving a service user a **Direct Payment** to buy their own services.

**SSSC (Scottish Social Services Council):** The Scottish body responsible for registering people working in social services and regulating their education and training.

**SVQ (Scottish Vocational Qualification):** A vocational qualification based on a set of national standards.

**Telecare:** Uses a combination of alarms, sensors and other equipment, usually in the home environment, to help people live more independently by monitoring for changes and warning the people themselves or raising an alert at a control centre.

**Telehealth:** The remote monitoring of an individual's health data (such as blood pressure) that can be used to diagnose or help manage a condition. It can also refer to using information and communication technology for clinical consultations or for capturing and sending images needed for diagnosis.

**TUPE (Transfer of Undertakings (Protection of Employment)):** The legal regulations that protect an employee's terms and conditions if their job transfers to a new employer.

**Unified health boards:** NHS boards in Scotland which have a responsibility for both acute and primary care, and which are also responsible for both planning and providing services within their area.

**Universal services:** Services provided to all members of society. In Scotland, free prescriptions and the universal health visiting service offered to new parents are examples of this.

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