Draft Budget 2012-13

Further to your letter of 12 July inviting the Health and Sport Committee to report to the Equal Opportunities Committee on the ways in which equalities informed our budget consideration, I’d summarise our approach as follows.

The emphasis of the Committee’s work for this budget has been on preventative spending and, as main components of that, early years intervention and care of older people. These headline themes linked into specific projects such as family nurse partnerships and the keep well projects; funding areas such as the change fund; and wider issues such as child poverty, workforce planning, and the integration of health and social care agenda.

Equalities thinking is inherent to these themes. As the Scottish Government state in the Equality Statement that accompanied the SSRDB—

“The [Health, Wellbeing and Cities] portfolio delivers a significant and beneficial impact on equality. This is reflected in some of the priorities for spend over the Spending Review period: to protect front-line services; to continue to protect and enabling people to fully participate in Scottish society by addressing health inequalities and, through early interventions, to support our children; to improve the integration of health and social care; and to continue to fund support for carers and young carers.”

And also—

“Certain equality groups are disproportionately represented in the provision of those [healthcare] services. This is either through the level of use of the NHS or the share of its workforce that they account for.”

During its budget evidence taking, the Health and Sport Committee heard evidence from expert witnesses such as Sir Harry Burns, the Chief Medical Officer, and Professor Susan Deacon, the former Scottish Government-appointed Early Years Champion. The early years message is certainly one to which the Committee is very well attuned.

Sir Harry told us—

“Ultimately, there is a need to adopt a life-course approach. Intervention needs to occur at different points in the life cycle. Health inequalities in Scotland are widest in the 35 to 55 age group. The biggest inequalities are among people of working age,

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and the origins of much of those are in the early years. My priority would be to focus as much as possible on the early years.”

He added—

“In relation to the other end of life and the health and social care change fund, we absolutely need to focus on whether people are cared for in an appropriate setting, but I would invest some money in preventing 50 and 60-year-olds from becoming dependent elderly people.”

Professor Deacon told the Committee—

“We hear a great deal about police numbers, but we hear much less about community midwives, health visitors, speech and language therapists and other services that are fundamental to making a difference to children and families and communities more widely.”

I would also draw your attention to the following excerpts from our report to the Finance Committee, as submitted today:

- Regarding Early Years—

44. While the Committee was attuned to the consensus around prioritising care in the early years of life, that does not mean every potential intervention in early years is effective or cost-effective, nor does it mean that everything proposed in the name of “early years” should be funded. Some sifting is required and that demands evidence. The Committee was made aware that evaluations could also be time-consuming, expensive and inconclusive, but Professor John McLaren summed up the position—

“[W]e have to use what little money we have in the best way we can. That is why we need to use the evidence base and to pilot these things to an extent. It will take a bit of time.”

- Regarding ring fencing and the budget for carers—

66. The Cabinet Secretary for Health, Wellbeing and Cities Strategy suggested a “horses for courses” approach, telling the Committee—

“We ring fence only for a purpose. As I have just demonstrated with the example of the waiting times money, where we think that ring fencing is no longer the correct approach, we take a different approach. Generally speaking, there has been an attempt in the past couple of years to minimise the proportion of resource that we ring fence centrally and to put as much as possible into health boards’ baseline budgets, to allow them greater flexibility. We have also taken an approach that we call bundling, whereby the totality of three, four or five individual ring-fenced budgets remains ring fenced, but there

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is greater flexibility to move money around within these budgets. The trend has been towards greater flexibility for health boards in the management of their total resource.”

67. The Committee considers that ring fencing can be appropriate in certain circumstances. A recent example is the ring fencing for carers of 20% of the change fund for older people.

- Regarding preventative spending/intervention—

70. While budget scrutiny requires attention to the savings from preventative spending and integration, the Committee did not wish to lose sight of the outcomes for patients.

71. It therefore looked at two prevention-based projects in particular, the Family Nurse Partnerships and Keep Well. FNP is an intensive home visiting programme for vulnerable young mothers. The Scottish Government has described it as offering “intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until the child is two”. It aims to improve: pregnancy outcomes; child health and development; and, parents’ economic self-sufficiency.

72. Keep Well aims to increase the rate of health improvement in 40-64 year olds who are registered with participating GP practices from the most deprived areas. The aim is to identify those who are at particular risk of preventable, serious ill health, and offer health checks, screening and advice. The focus is on cardiovascular disease and its main risk factors, especially blood pressure, cholesterol, smoking and diabetes.

- Regarding early years—

77. The Committee was encouraged to hear from the Chief Medical Officer that especially for interventions in pregnancy and early years some short-term outcomes could be measured in a meaningful way—

“The single biggest avoidable cause of death in the first year of life is low birth weight, so if we see an increase in birth weight, within a year we will see a fall in infant mortality.”

78. Rachel Ormston of the Scottish Centre for Social Research said of the Family Nurse Partnerships—

“I suppose that the question is how much evidence you need, and when, in order to make decisions. There is good evidence of impacts from the US. Early

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8 Scottish Government website at: [http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/nursing/ModernisingCommunityNursing/MNCBoardMeetings/FNP](http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/nursing/ModernisingCommunityNursing/MNCBoardMeetings/FNP)
evaluation in England of the implementation of test sites suggests the potential for a lot of good impacts – for example, on mothers’ knowledge of health behaviours during pregnancy, early bonding and attachment”\textsuperscript{11}

- Regarding older people in deprived communities–

81. The Cabinet Secretary told the Committee—

“We can point to the fact that it has a proven track record in engaging people in deprived communities and to the referrals of people on to statins or smoking cessation services. We can also point to the evidence that those interventions have particular outcomes, but we would probably struggle to say that we have the evidence at this stage that keep well, in and of itself, directly delivers the benefits that we want. However, probably all of us feel strongly that implementing the programme is the right thing to do – I know that I do – and I think that the evidence on that will emerge.”\textsuperscript{12}

82. The Committee looked at the Change Fund for older people’s services and for early years intervention. More thinking has been done about the Change Fund for older people and Mr Graeme Dickson, Director of Health and Social Care Integration at SGHD, reported six outcome measures had been agreed—

“The outcomes include decreasing emergency in-patient days for older people, increasing the percentage of people who live in housing rather than care homes, reducing delayed discharge and increasing the percentage of the last part of somebody’s life that they spend at home. The outcomes are fairly clear and have been agreed with most parties—that is the approach that we want to take. The sixth bit relates to the user and carer experience.”\textsuperscript{13}

- Regarding children and young people as priority spending areas–

86. In moving from a reactive approach to a preventative emphasis, the Committee acknowledged that some form of transitional funding is required. Responding to a question about switching spending from teenagers to children, Bill Alexander of Highland Council said—

“[W]e cannot ignore and walk away from teenagers who have high-level needs. Without additional money, levering funding into preventative spend is a challenge, but I believe that that is what the various change funds that we are now looking at will involve. That is certainly what the change fund for reshaping the care of older people is about. The money cannot be used to plug the gap in existing services; it must be used as a catalyst to lever money from higher spending services, in particular acute hospital care, into preventative areas such as community-based care and intermediate services.”\textsuperscript{14}

- Regarding prevention and integration–

97. The Committee supports the concepts of prevention and integration. However, these raise a number of issues in the context of the scrutiny of the SSRDB document, and the Committee will want to return to these in future years to assess the progress that has been made.

98. The Committee will wish to revisit the progress on preventative spending – including FNP and Keep Well, the success or otherwise of other preventative measures, how the Change Fund is being deployed and its impact on quality of care and value for money – more systematically over the course of the spending review, and for the duration of this Parliamentary session.

Finally, if I may turn the tables, I wish to share an observation. The letter of invite was a generic one, flagging up broad equality areas, but it did not highlight any health-related areas that were of policy interest to the EOC Committee. I wonder therefore if specific examples or suggested lines of inquiry might usefully be factored into the invitation next year.

Health and Sport Committee
16 November 2011