
Health and Social Care Alliance Scotland

About the ALLIANCE
The Alliance is the national third sector intermediary for a range of health and social care organisations. The Alliance has 250 members including large, national support providers as well as small, local volunteer-led groups. Many NHS Boards and Community Health and Care Partnerships are associate members.

The Alliance’s vision is for a Scotland where people with long term conditions enjoy, not endure, full and positive lives, free from discrimination and supported by access to high quality services, information and support.

Broad Comments
The Alliance welcomes the opportunity to provide its views on the Scottish Government Draft Budget 2013-14 and the Committee’s chosen approach, in relation to health spending, of focusing on the broad themes of prevention and integration, the progress of change funds, monitoring of quality, consistency and flexibility of services and savings.

Context of Information
In its role as the leading national intermediary for health and social care the ALLIANCE contributes at a strategic level to many of the elements of the Scottish Government Draft Budget that fall under the Committee’s scrutiny. As a result the ALLIANCE has insight and information that may be useful for the Committee. The ALLIANCE also delivers many programmes and projects that align closely with these elements. One such programme is the Change Fund: Enhancing the Role of the Third Sector Programme. This programme provides third sector coordination and support at a strategic level to secure the effective engagement of the sector in the Reshaping Care for Older People programme and more widely within the emerging integrated health and social care landscape. The programme team have spent the last couple of months gathering data from the sector to inform its capacity building programme. Although the full data analysis will not be completed until the end of October, given its relevance to the Committee’s considerations, some of the emergent findings are presented within this document. A copy of the final report will also be made available to the Committee as soon as it is available.

Questions 1 and 2: Are levels of health spending adequate and are we spending wisely?

Information from Our members and Our Work
In our written evidence submitted to the Health and Sport Committee on Scrutiny of the Draft Budget 2012-13 and Spending Review 2011, the ALLIANCE put forward the view that questions remain about “how the Scottish Government’s vision is realised in
decisions made by health boards and local authorities, especially as budgets continue to tighten.” We believe that this question is increasingly pressing, especially in the context of concerns about the under-resourcing of social care. Analysis compiled by the Coalition of Care and Support Providers in Scotland (CCPS) into hourly rates for non-residential care and support services for adults and older people further reinforce this view. At the same time, many local authorities are further tightening eligibility criteria for social care services, leading to the loss of vital support for many people who live with long term conditions across Scotland.

Successive governments since devolution have complimented the third sector on its effectiveness and there has been relative investment in the sector through the establishment of ad hoc funding and investment regimes.

The Third Sector in Scotland

- Employs 5% of Scotland’s workforce and includes around 1.2m adult volunteers.
- Provides over a third of all registered social care services.
- Over 3,000 organisations working in healthcare and nearly 20,000 in social care and development.
- Has an annual income of £4.36bn and expenditure of £4.24bn.
- Pre-dates the NHS with many organisations established over 100 years ago.
- Significant investor in health and social care services (including research, specialist nurses and service innovation), and strategic partner in service redesigning and improvement.

The Scottish Government has previously committed to implementing the recommendations of the Community-led Support and Developing Health Communities Task Group, which concluded that the work of the third sector “must be recognised as an integral part of the formal health system, as a planned intervention and not something that is provided on an ad hoc basis”. However at the level of service delivery the third sector continues to be viewed too often as peripheral next to statutory provision. Furthermore, given that the findings of Audit Scotland’s Commissioning Social Care report suggest a lack of transparency in where budgets for social care delivery come from, even if an integrated approach was adopted, it is unlikely that this will be resolved.

Achieving this requires a proper and sustained investment by Government in third sector capacity at local level to work with statutory partners so that a coherent and consistent programme of service redesign can be undertaken.

The transformation to self-directed support represents a key opportunity to change the way that we support people with health and social care needs. However there remains a disparity in the level of transformational costs anticipated by the Health and Sport Committee and COSLA to cover the cost of implementing such a significant agenda.
Given the scale of change required, we would question whether the three year timescale and the £2m which has been made available to third and independent sector organisations are enough to ensure that transformational change can be effectively and successfully embedded.

The draft budget refers to “£3 million for miscellaneous welfare initiatives” which “has transferred to the Infrastructure, Investment and Cities portfolio”. The ALLIANCE would welcome more detail on these initiatives, particularly how these funds will be used to ensure that people receive adequate support to prepare for proposed changes to the welfare system, e.g. advice, accessible information, advocacy.

**Evidence from Our Data Collection**

The current system which continues to be dominated by crisis driven responses and as a result will always require more investment than the available resources. The crisis driven nature of the system coupled with the tightening fiscal environment means that although the rhetoric for investing in preventative spend is evident, most investment has been driven towards initiatives that directly impact on ‘bed days’ in the short term rather than wider preventative initiatives that generate longer term outcomes, and hence fundamental changes in demand profiles. The feedback indicates that the third sector believe that unless there is a prescribed requirement for a minimum percentage of the Reshaping Care for Older People’s (RCOP) Change Fund to evidence investment in initiatives that provide outcomes in the longer term, a significant move towards this type of preventative spend will not be achieved. Furthermore, the hard procurement style processes that are in the main being used to select RCOP Change Fund funded projects, and their focus on the RCOP outcomes and targets, is not allowing the wider outcomes (often related to other marginalised groups) that potential projects deliver to be considered. This silo thinking brings into question how wise the investment decisions are in real terms when they are evaluated holistically. There were also examples of this silo thinking within Change Fund spend in relation to spend across the four pillars.

There was consensus that the current economic climate means that decisions about Change Fund spend and reinvestment of under-spend are to a certain extent driven by the need to prop up existing service provision so that it is maintained rather than driving the change agenda. Some statutory sector investment decisions are also being made with incomplete information about the full cost of the service. This lack of real cost information means that wise investment decisions will require luck as well as analysis and insight.

**Question 3: How are we ensuring that services are efficient?**

**Information from Our members and Our Work**

The ALLIANCE strongly welcomes the Scottish Government’s continued commitment to the recommendations of the Christie Commission on the Future Delivery of Public Services. We are particularly keen to see the move towards prevention and the integration of health and social care become reality.
The ALLIANCE welcomes the Health and Social Care integration agenda but recognises that if integration is to succeed then strategic commissioning – and the involvement of service users, unpaid carers and the third sector within this – must be made more effective. As identified by Audit Scotland\textsuperscript{vi}, “decisions that councils make about services… (can affect) the efficiency and effectiveness of other public services, particularly the NHS. Decisions made by NHS boards about the delivery of healthcare will also affect social care services.”

It is clear that the broad consensus towards the shift from a reactive to a preventative approach runs way ahead of investment to make it happen. Local authorities and the NHS must work together to invest in preventative services that can help to delay or avoid people needing more intensive support and monitor the impact of these services.

In partnership with a large consortium of organisations, The ALLIANCE is continuing to help shape the discussion on the future of social care in Scotland. The newly-revised Twelve Propositions for Social Care (attached) maps key issues and puts them in terms of recommendations for an integrated health and social care system that: prevents negative outcomes; reduces need for formal services; and improves health, wellbeing and quality of life.

**Evidence from Our Data Collection**

A significant focus on efficiency was reported. Although this is valuable and important, efficiency appeared to be more of a focus than effectiveness.

**Question 4: What are we doing to ensure that the quality of service regarding outcomes for patients is protected?**

**Information from Our members and Our Work**

It would be a mistake to see the prevention agenda as just about saving money. Applied with care, it should also contribute to achieving better outcomes – for example, by ensuring people receive support at the right time, when they can benefit most, in order to recover or stay well for longer. This is evidenced by the ALLIANCE’s engagement with, and investment in, the development of the national person-centred health & care programme for Scotland and our current and on-going commitment to ensuring the full and active participation of the third sector in the programme.

The self-directed support agenda is critical to improving outcomes for people who live with long term conditions. There is, however, a level of danger that the implementation of self-directed support could be used by local authorities as a driver for cuts to social care services. We believe that the starting point for the introduction of self-directed support should always be to improve the outcomes for people who use support and services rather than financial savings.
The increased emphasis on the need for commissioning and services to be driven by outcomes is to be welcomed, but in many respects it needs to progress more quickly. There is a growing body of evidence about approaches that work to improve outcomes for people, reduce levels of need and unlock the capacity of individuals and communities.

There is a growing interest in ‘asset-based approaches’ in Scotland. Asset approaches recognise that individuals and communities are part of the solution, work with people rather than viewing them as passive recipients of services, and empower people to control their future\textsuperscript{vii}.

The Self Management Fund for Scotland, for instance, is demonstrating that even a small investment in asset based approaches can produce a significant outcome in terms of quality of life for individuals, capacity building for people and communities, and reductions in the pressure on public services.

However public services are slow to adapt and remain predominantly embedded in traditional approaches where people are dependent, not empowered and the bulk of resources are spent responding to issues once they have become severe and complex.

The ALLIANCE supports the view that Scotland needs to move to a situation where preventative, asset-based approaches such as self-management, personalisation, independent living, recovery and co-production are the rule, not the exception.

**Question 5: How are we planning for change?**

*Information from Our members and Our Work*

The successful implementation of the proposed changes are of vital importance to the two million people who live with long term conditions in Scotland. The ALLIANCE strongly welcomes the Scottish Government’s continued endorsement of the recommendations of the Christie Commission, including the move towards prevention and the integration of health and social care.

The transformation to self-directed support represents a key opportunity to change the way that we support people with health and social care needs. Given the scale of change required, we would question whether the three year timescale and the £2m which has been made available to third and independent sector organisations – whilst welcome – are enough to ensure that transformational change can be effectively and successfully embedded. The transformation fund has been directed at local authorities, not health, but asset-based person-centred approaches need a shift in focus and service design from health as well as social care. The new National Person-Centred Health and Care Programme should help to drive this.
It has also been suggested that the review of the general medical services contract presents an opportunity to ensure GPs have a requirement to take a full part in designing services, not just delivering them.

We are also concerned that a disconnect is emerging between agendas such as health and social care integration, the review of Community Planning Partnerships, the Community Empowerment and Renewal Bill, the Social Care (Self-Directed Support) Bill and the reform of public sector procurement.

**Evidence from Our Data Collection**

A number of structural, procedural, attitudinal and behavioural issues relating to the workings of the Partnerships were raised as barriers to equal partnership and co-production. There was also very little evidence that the individual partnerships had invested resources, including time, on establishing the four-way partnership at the strategic level. Furthermore the distinct voice and perspective of older people are not represented at a strategic level on most partnerships (an area the ALLIANCE is actively looking at at present). These issues are likely to compromise the ability of the partnerships to effectively plan for the level of change required.

Our research also indicates that one of the main reasons for the level of engagement the sector has achieved to date is the requirement for the sector to sign off the Change Plan. This raises significant questions about how successfully the sector will be included in partnerships after health and social care integration, given that the current proposal is that the sector should have a role but no associated power in the new integrated structure.

Although housing and housing providers were linked into the development process in some areas this was not evident universally. Given housing’s critical role in delivering the RCOP vision this is a significant deficit in the planning process.

The hard procurement style processes that are in the main being used to select RCOP Change Fund funded projects and the move away from grants and towards more formal contracts for services creates barriers for some small community-based organisations who only require a small investment to remain sustainable. This approach may lead to more formalisation and less diversity in the market.

Much of the change investment reported appears to be focused on moving the delivery location of services from hospitals to communities. There was little evidence of the more fundamental question of whether the service delivers the right outcomes being asked or of services and systems being considered from first intentions using an outcomes perspective and then compared to existing models. The Third Sector Interfaces (TSIs) were also in the main unaware of the disinvestment strategy being driven by Change Fund investments; how the spend directed towards the statutory sector would result in disinvestment in the short, medium or long term; or how this would be monitored. This is not to say that the discussions outlined above are not
happening, it does however evidence that if these discussions are happening they are not happening in ways that enable all partners to contribute to the process. Given that the TSIs are the only partner without a significant day-to-day requirement to focus on health and, or, social care and by dint have the inherent ability to question historic custom and practice, this loss could potentially compromise the delivery of the transformational change required.

Most TSIs report that the current suite of local improvement measures relating to RCOP and the requirements of health boards to meet their HEAT targets reinforce the pervasive short-termist culture and effectively disable the change process by working against discussions focusing on long term change and the fundamental changes in approach needed to move us towards a person-centred, asset-based approach to health and wellbeing. They further argued that significant change would not be achieved unless partnerships were required to ensure that their plans evidenced links to and were embedded in other significant local strategies such as the Health Board Strategy, the local Housing Strategy, the Community Plan and through it the local outcomes in the Single Outcome Agreement.

In terms of moving forward, the Joint Strategic Commissioning plans that were in development had in the main not been started early enough for them to be properly co-produced. This deficit is likely to compromise their ability to act as a lever for change.

**Question 6: What will be the impact of this budget, in a health context, on (i) equality groups and (ii) climate change policy?**

**Information from Our Data Collection**

Although there is some evidence of partnerships seeking to actively involve ethnic minority groups, this is very patchy and in the main equalities is not on their radar at the moment.

**Health and Social Care Alliance Scotland**

17 October 2012

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1. Hourly Rates For Care and Support (2012) Coalition of Care and Support Providers In Scotland
5. “COSLA called on to justify 60m disparity in cost of Self Directed Support” (2012) Third Force News
7. An Assets Alliance Scotland, briefing (December 2010) (prepared for an event held by the Chief Medical Officer, LTCAS and Scottish Community Development Centre)