
Scottish Council for Voluntary Organisations

Summary

SCVO welcomes the opportunity to respond to the Health and Sport Committee’s scrutiny of the Draft Budget for 2013-14. We respond to some of the questions posed by the Committee and provide some general comments on the Draft Budget.

Some of the key points raised include:

- There is an opportunity to think and do things differently. We welcome some of the budget announcements e.g. that Single Outcome Agreements will have a preventative focus. However, the detail of such announcements now needs to be ironed out and consideration given to the contribution of the third sector.

- We outline some concerns around the achievements of the Change Fund and the need to shift more rapidly towards community-based approaches.

- We would ask the Committee to consider in detail what the impact of welfare reform will be for health outcomes and for public services across the board - and how – if at all – it is planned for in this Draft Budget.

More generally, we would raise the following points

- A preventative approach to public services, using community-based solutions, will save the taxpayer money in the long term and bring additional social and environmental benefits. This would seem to be a more appropriate focus for public services than maximizing economic impact.

- The Government’s National Performance Framework should be reconfigured to encompass wellbeing, social inequality and environmental impact. It should also be openly evaluated by Parliament and should build on new measures such as Oxfam’s Humankind Index.

- Government needs to think more creatively about how it integrates its budgets across portfolios and policy objectives. A focus on ‘total place’ (where public sector budgets are pooled) could offer a useful way forward here but only if combined with a community-led approach.

Spending more wisely on health

While it will always be argued we should spend more on health, the real question here is whether the levels currently committed are financially sustainable and sufficient to meet increasing demand. Secondly, we need to see a real shift from acute spending into preventative and approaches which ground support for better outcomes in the communities in which people live. The Change Fund may not be enough to drive this shift (see below).
The cumulative impact of recession, welfare reform and an ageing demographic is compelling. In this context, and with a forward view, it is very hard to say that current spending is wisely directed. There are also issues of transparency in how the health budget is spent.

*For example*, in the 2013/14 Draft Budget (p30), there is a line under allocated Health Spend:

| General Services | Miscellaneous Other Services | £ 114 million |

Is it clear what exactly this amount is for and what impact it has on achieving overall health outcomes for Scotland? At a time when the health budget, and public services as a whole, are stretched and likely to face future significant challenges, we need to review and rethink health spending – starting by gaining a better understanding of how existing spend is allocated and evaluated.

Health delivery impacts on other key policy areas. We need to look more extensively at a “cross-portfolio” outcomes approach – wider than the current focus on economic benefit/growth. A focus on the capacity of communities to ‘weather the storm’ and on families who will increasingly be relied on to provide informal support needs to feature more strongly than it does.

We need to see a significantly accelerated shift of spend away from institutions and traditional acute care, to communities. A rapid growth in support capacity will enable people to live well at home. There is nothing in the current budget structure - on the face of it - that would serve as the necessary catalyst for this change. As we outlined in our response to the [Finance Committee](#), the Government’s National Performance Framework should be reconfigured to encompass wellbeing, social inequality and environmental impact. It should also be openly evaluated by Parliament and should build on new measures such as Oxfam’s Humankind Index which looks at the outcomes that people want in their lives. This can feed down to outcomes around health, integration and other areas of policy and delivery.

**Prevention and ensuring a systemic shift in balance of care**

A preventative approach to public services using community-based solutions will save the taxpayer money in the long term and bring additional social and environmental benefits. This would seem to be a more appropriate focus for public services.

SCVO is highly supportive of the prevention agenda and wishes to see a definitive shift in public investment away from institutions and into the community. While the **Reshaping Care for Older People Change Fund** is welcome investment in ‘upstream’ support for older people to enable them to live well at home in their own communities, and to build the capacity and wellbeing of their families/informal carers, we are concerned that the Fund is not stimulating the level of systemic change that is needed and that would enable projects currently funded under the Change Fund to plan (to expand)
for the future. Taken to the extreme, having a separate fund can actually be seen as a way of ‘parking’ the need to take decisions to shift spending by health boards away from traditional acute services. We need new (carrot and stick) mechanisms, change planning and clear leadership to make this happen.

There are rapidly growing concerns in the voluntary sector that the impact of welfare reform on the most vulnerable in society will not only overstretch the sector’s own services, but will also make significant demands on mainstream services. This will have an immediate impact on resources, but also potentially distract attention away from the need for longer term shifts in spending. Increased community capacity is required to mitigate the impact as well as to meet the support and care needs of people in the long term. This is because community-based interventions are often led by the people who benefit from them. Voluntary organisations act as a vehicle for them, and as a result are better trusted, build on the human and social assets already available and act as a buffer between emerging need and the strain on acute institutional services. These approaches deliver the kinds of health and wellbeing outcomes people want for their lives and examples include:

- **Craft cafés** – Govan and Castlemilk, [run by Impact Arts](#)
- **Foodtrain** – run through volunteers and offering ‘shopping plus’ services
- **Support for family carers** – [Social and economic impact and improved health and wellbeing of carers achieved as a result of support by Carers Centres](#)

**Change Fund and change planning**

The Change Fund was understood to be designed to stimulate a shift in the balance of care, and blaze a trail for health and care integration. While it is clear that many good projects and services have been funded via this mechanism it is very unclear whether this has prompted real change in the more general approach to planning, management focus, enabling systems and the level of public spending to embed a shift from acute to community. Not all projects are truly upstream projects; of those that are, there remains little indication that they will become embedded within the mainstream budgets of public authorities, once the Change Fund resource runs out.

SCVO would like to see more emphasis in the remaining years of the Change Fund on building the capacity of communities to sustain supports and responses to people’s needs. The potential of multi-disciplinary community-based resources that can call on and deliver for specialist national health and social care voluntary organisations should be explored and developed. We need to identify and build on community solutions which give people control over how they receive support – but moreover, lets them stay connected to their communities for longer. E.g. [Community Care Assynt](#)
This amounts to a different kind of change than that already in the legislative pipeline with the integration of statutory health and social care. The outcomes of any kind of integration of public services should always be about improving the experience for people and their communities. If it is just about rearranging the public sector landscape, then integration will simply become a distraction for the third sector from its day job – another bureaucratic nightmare to deal with. We would urge the Committee to learn from what has worked and what has not worked from the recent ‘total place’ pilots in England. We believe total place which starts from the premise of pooling budgets rather than negotiating structures could bring about a better experience for people, especially if it fully takes into account the role of the third sector in planning and investment.

Welfare Reform - The elephant in the room

It is not clear how the Draft Budget for 2013 and beyond will respond to the impact of cuts to welfare in Scotland – some £2 billion with more cuts likely to emerge. Primary care practitioners including GPs are already outlining the impact of current reforms, e.g. the Work Capability Assessment, on their workloads and ability to care for all patient groups. Both the Deprivation Interest Group and the Deep End GPs lay out in their reports what welfare reform means for patients and patients’ families, including families not traditionally associated with the welfare system e.g. working families.

The combination of the recession, austerity measures, reforms to tax credits, and current benefits/conditionality are, they highlight, leading to increased alcohol abuse, and use of anti-depressants, increasing demand for public services in general, including specialist support, and also increasing demands on the third sector. A likely increase in admission/re-admission rates must be considered in the light of this. Increased investment from the NHS to tackle the impact of welfare reform must be considered e.g. funding by NHS Lothian of welfare rights workers in GP practices; links between Carers Centres and Primary Care Practitioners/hospital discharge teams.

For a range of equality groups it is self-evident that the most vulnerable in our society will be hit by welfare cuts, however it is unclear how the Draft Budget has anticipated this. The wider impact on working families of recent announcements relating to Universal Credit could well put further pressure on health services at all levels. Health inequalities in Scotland are known to be amongst the worst in Europe, with particularly stark pockets of inequality in the West of Scotland. There is a real danger that welfare cuts alongside unemployment and the decline in household budgets will simply exacerbate these inequalities. How can we reconfigure the health budget to narrow rather than widen this gap?

Health investment in the third sector

When considering the third sector in relation to the £11billion health budget, it is important to recognise that a little goes a long way. Prior to the introduction of the Change Fund it was estimated that less than 1% of health spending
reached the sector, though a baseline is hard to establish. There is evidence that organisations in the third sector which can deliver anticipatory/preventative support were significantly squeezed before current round of spending cuts. Investment now, through the Change Fund or otherwise, needs to be significant to move beyond pre-recession levels.

The potential contribution of the third sector to achieving health goals is often missed. Decision-making structures within the NHS do not consistently recognise even the medical impact of preventative support let alone the social impact e.g. an evaluation of Foodtrain in Dumfries showed that the programme fulfilled “...a critical role in supporting them in their desire to retain their independence and to remain in the comfort of their own homes and within their own communities. Its economic value in delaying the onset of higher-cost packages of care is highly significant, and is in line with current UK and Scottish Government policies on meeting the challenge of an ageing population which is living longer though with unhealthier lives.”

Investment in support for the capacity of families (unpaid carers) e.g. pre discharge is vital to individuals going home from hospital and staying home. Voluntary organisations can also play an important role to "fill the void" whilst statutory services are put in place as people move from institutional settings back into their communities.

A "medical model" very often misses the social context in which people live each day. In line with this, it is important for the Committee to consider the quality of support people receive to remain well, alongside the quality of care and treatment they receive when they are ‘patients’. Third Sector organisations see the full context and can help people stay connected to their communities.

Unfortunately a level of risk aversion in decision-making in statutory services is evident – there is a reluctance to ‘let go’ of resources. This is compounded in some cases by an undeserved disrespect for the professionalism of the third sector and/or misplaced fear of job displacement, which is likely to harden as budgets get tighter. This is particularly pertinent within the Scottish Government’s recommitment in its draft Budget to no-compulsory redundancies for directly employed public sector staff.

In the context of the proposed reforms of Health and Social Care, SCVO has argued for an explicit role for the voluntary sector in planning and strategic commissioning which should, over time, bring the necessary broader perspective to bear on investment decisions. However given the scale and urgency of the challenge, additional mechanisms such as a direct funding for the sector should be explored.

Specific questions
We would ask the Committee to consider the following questions as part of its wider scrutiny of the Draft Budget. These may also help in shaping the scope of the Committee’s scrutiny work:
How much investment within the Change Fund is truly being focussed on preventative spend, and indeed how can we dig down deep enough to see what exactly is being spent on existing statutory services as opposed to being shifted into community settings for anticipatory support?

We spend some £11 billion on health services, yet how much of this goes to community and family support which helps people to stay at home and helps families to provide informal care? The commitment in the Change Fund to some £40 million for carer support was welcomed by the third sector but again how much is actually directly benefitting carers and their families?

Could the Committee seek evidence from families/ carers who are in the health system? What is their experience of the current systems and what works well for them?

Anecdotally, SCVO and other third sector organisations are picking up on an increased tightening of access to support within health and social care e.g. rehabilitation, access to Allied Health Professionals, respite, carer support and access to social care. This increasingly leaves a gap in provision at local level and in due course could actually lead to increased demand for statutory interventions. Can this be further investigated? How does the Draft Budget seek to remedy/tackle this?

Conclusion

Firstly, the elephant in the room is welfare reform and its impact – already being felt now across the statutory and third sectors. This requires a fundamental re-think of existing spend and planning for additional demand, impact on health, local services, transport and other areas. This is a major area where UK policy will affect Scottish Government planning and delivery.

Secondly, the role of the third sector in health delivery – in achieving health focussed outcomes, needs to be better recognised and supported. A planned meeting with the Cabinet Secretary for Health and Wellbeing will help in this regard. The drive to achieve systemic change in health delivery and a move towards community based support needs to be more urgent.

We once again have an opportunity in scrutinising the Draft Budget to do and think differently. We would urge the Health and Sport Committee to consider this as they carry out their scrutiny.

About us

The Scottish Council for Voluntary Organisations (SCVO) is the national body representing the third sector. There are over 45,000 voluntary organisations in Scotland involving around 137,000 paid staff and approximately 1.2 million volunteers. The sector manages an income of £4.4 billion.

SCVO works in partnership with the third sector in Scotland to advance our shared values and interests. We have over 1300 members who range from
individuals and grassroots groups, to Scotland-wide organisations and intermediary bodies.

As the only inclusive representative umbrella organisation for the sector SCVO:

- has the largest Scotland-wide membership from the sector – our 1300 members include charities, community groups, social enterprises and voluntary organisations of all shapes and sizes
- our governance and membership structures are democratic and accountable - with an elected board and policy committee from the sector, we are managed by the sector, for the sector
- brings together organisations and networks connecting across the whole of Scotland

SCVO works to support people to take voluntary action to help themselves and others, and to bring about social change. Our policy is determined by a policy committee elected by our members.¹

Further details about SCVO can be found at www.scvo.org.uk.

Scottish Council for Voluntary Organisations
17 October 2012

References

Scottish Voluntary Sector Statistics 2010, SCVO


² Co-production in Health and Social Care: What it is and how to do it? Governance International/JIT, 2012

¹ SCVO’s Policy Committee has 24 members elected by SCVO’s member organisations who then co-opt up to eight more members primarily to reflect fields of interest which are not otherwise represented. It also includes two ex officio members, the SCVO Convener and Vice Convener.