Submission by Chest Heart & Stroke Scotland

Health & Sport Committee – Inquiry on Preventative Spend

Introduction

Chest Heart & Stroke Scotland provides advice, support and services to people affected by heart and lung disease, or living with the effects of stroke. With a decreasing mortality rate from previously life-threatening disease such as heart attack and stroke, increasing rates of lung disease, and an ageing population, more people than ever in Scotland are living with the impacts of these life changing conditions. We conservatively estimate that over half a million people are living with these conditions; and when considering the wider impact on families and carers, the impact is in reality far greater.

There is a clear causal relationship between Scotland’s public health challenges and the diseases which our service users are living with. Smoking, obesity, and physical inactivity are all significant contributory factors to the risk of heart disease, stroke, and lung disease. These conditions then directly impact on wider societal and health problems – loneliness, social isolation, and mental illness.

1. What areas of preventative spending/agenda would it be most useful for the Committee to investigate?

It is important to recognise that the preventative agenda includes ‘secondary prevention’ which enables people to maintain maximum health and wellbeing following an acute event through ongoing rehabilitation, and thus help avoid further illness where possible. Support services which are person-centred and based in communities are key to rehabilitation and secondary prevention. They also enable people living with long-term conditions to effectively self-manage their illness, the importance of which is highlighted by the National Clinical Strategy. These support services must go wider than medical services, and incorporate a holistic focus which includes social and community support for people living with long-term conditions. We would argue that secondary prevention should be incorporated within the Committee’s investigations.

Delivery of preventative activities – primary or secondary – therefore lies with a range of agencies, both statutory and third sector. Chest Heart & Stroke Scotland for example provides local peer support, exercise opportunities, medical and personal advice,
communication support following stroke, information on healthy living, practical advice on self-managing conditions, and provides befriending services.

2. How can Health Boards/IJBs overcome pressures to better maintain preventative spend?

Whilst the integration of health and social care was seen as providing opportunities to support the shift towards prevention set out by the Christie Commission etc, in reality the first year of integration has demonstrated the complexities of meeting statutory requirements whilst negotiating a budgetary landscape where Health Boards’ budgets must at times meet the differing priorities of multiple local authorities. Additionally, as the Committee recognises, there are continued pressures to prioritise the resources required to deliver acute services instead of primary care and social care.

Given the range of agencies involved in delivery of preventative services we would suggest that the better involvement of the third sector in the strategic planning and development within Integrated Joint Boards is critical to the better delivery of preventative activity – and at present this engagement is, at best, patchy. This is highlighted by many of the boards’ strategic plans which have a notable absence of discussion of service delivery by the third sector. Additionally, the Scottish Government has found that there is little evidence that data from the third sector has been included in local needs assessment.

To counteract these funding pressures, the addition of a specific measurable indicator of ‘expenditure on preventative services’ to the core suite of integration indicators and subsequent reporting by integrated boards may be effective.

3. How could preventative spend be identified/tracked more effectively?

The short-term funding cycle and at times a lack of long-term planning means that a large number of preventative programmes are delivered by the third sector, tested and evaluated, evidenced to be successful, and yet are not subsequently provided long-term funding or scaled up. Similarly, there are particular interventions delivered by the statutory sector which are evidenced to be cost-effective in prevention and yet are not universally provided. Arguably therefore it is not lack of evidence that is the problem; rather it is more systemic.

A key example are the integrated rehabilitation pathways which enable people to initially recover from an acute incident such as stroke, heart or lung disease, and then support them to transition into longer-term peer/community support and self-management. Rehabilitation is clinically-effective and makes savings in respect of reduced readmissions to
hospitals, repeat visits to GPs, and in prescribing. And yet the provision of formal rehabilitation programmes in a clinical setting, and the pathway thereafter, is patchy across Health Boards. This is perhaps indicative of the ongoing demands on funding reactive acute care which are prioritised over preventative spend.

4. **How can the shift of spending from acute to preventative services be incentivised?**

Please see the response to 2 above.

*February 2017*

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