Integration of Adult Health and Social Care: Consultation on Proposals

SCVO response

11 September 2012

1. Introduction

SCVO welcomes the opportunity to submit a response to this important consultation.

Our comments below reflect consultation with the sector through attendance at a range of events and through individual discussions with members. We have also shared this response and sought feedback from members involved through our Reshaping Care/Health Reference Group.

Our goal in this submission has been to try to take a step back from the detail in the consultation and highlight elements and suggestions to drive real and lasting change. Our primary concern with the direction of travel, in this arena and in other policy agendas e.g. welfare reform, is that the role, contribution and expertise of the third sector is not always fully recognised or acknowledged. The need to focus on building community assets, on enhancing the role of the sector in health and social care is critical to the future wellbeing of Scotland's people.

With the detail available, we have some concern that there could be further retrenchment away from the kind of community connections, family support and focus on quality of life which sits at the heart of much of what the sector does in relation to health and social care. Integration should not become a missed opportunity.

2. Summary of Key Points

- Voluntary organisations are the principal way communities organise to support themselves, and if the support needs of our rapidly ageing population are to be met over the years to come then we need to see the development of the third sector embraced by public policy, and a significant shift of investment towards it. Current initiatives such as the Reshaping Care for Older People Change Fund and the Integration agenda as outlined in the consultation document are not yet doing nearly enough to bring this about at the pace and scale required, although small gains in influence and involvement of the sector must not be lost.

- There needs to be a more intrinsic focus in the plans on embedding principles such as equality and co-production as well as stronger focus on building the assets of communities,

families and individuals into the planned legislation with a link through to service planning and delivery.

- Integration provides an opportunity to move beyond integrating budgets. It can be the start of a greater alignment of policy objectives including health and care, regeneration, procurement and community empowerment. The impact of welfare reform on these plans must be considered.

- Accountability must include the voice of service users and carers. The plans as they stand may not improve accountability as it stands in current structures. With a focus on local implementation, there is a risk of an even greater postcode lottery of support. The third sector can offer far more to the plans to integrate than being a voice for service users and carers. This is only one aspect of its contribution to reform.

- There needs to be whole system engagement of the third sector in both planning and delivering integration – from partnership committees, in strategic commissioning through to local planning and delivery. The third sector can and should play a central part in achieving wide reaching reform and with the right environment can be a key driver of change. The sector should have voting rights at committee level to help influence the totality of spend and planning. Learning from the Change Fund could help shape the contribution of the third sector in an integrated context.

- A better understanding of need is required in order to make strategic commissioning effective. Other bodies and interests have a critical role to play in developing commissioning plans such as housing, transport and planning. Commissioning also needs to take better account of informal support networks which achieve the goals envisaged for integrated health and social care.

- Our submission raises other issues –e.g. the opportunity to build up from integration to 'total' place approaches; workforce issues and the need for an effective workforce plan which fully engages the third sector; the impact of focussing on older people and adults on other groups; the crucial role of housing and the importance of culture and leadership in making integration a success. We also point out that we are bringing together two very different cultures and that we potentially risk losing a focus on the wider context in which older people live and stay well, if the 'medical model' comes to the fore. The expertise of national charities, who may find it difficult to engage with every local partnership, must be taken into account and we must identify ways in which their knowledge and experience can be brought to the table.

- We also submit some comments on the Business Regulatory Impact Assessment,

3. Principles – Not Process

The health and social care integration agenda is a significant element of public service reform. The drivers for change - increasing demand from an ageing population, declining public budgets and differential quality in outcomes and experience – provide us with a real opportunity to radically reshape services in line with Christie's vision for better services:

- Services which are focussed on people, communities and their skills, capacities and skills;
- Services which build community, family and individual resilience – building on their existing assets;

- Services which work together effectively to achieve outcomes – integrated and focussed on improving the quality of life, and the social and economic wellbeing of people and their communities;
- Services which are transparent, accountable, are cost effective but also perform effectively.
- Real priority must be placed on preventative measures and on promoting equality.

We acknowledge the focus of this consultation is to set the scene around framework legislation and that it is only one element of what is needed to achieve the kind of services which Christie envisaged. However, the consultation document overemphasises process, governance and detail set against the kind of transformational change which the previous Cabinet Secretary for Health outlined in speeches and in person. In this regard, it is disappointing, and it is not clear how integration will bring these principles to life. On the face of it, we are concerned that without having a clear vision and goals at the start, we will ultimately end up with a revised version of the systems and structures that are already in place but with a lesser place for the third sector which can offer solutions and community capacity to help people stay well and enable families to cope with caring responsibilities.

The mark of success will be whether or not the plans actually change people's experience of the current systems – and whether individuals and families are supported to build their own assets, and to achieve quality of life and independence. This is emphasised in case studies used within "Twelve Propositions for Social Care"[i] brought together with extensive input from the third sector and which argues for a rights based approach to social care. The starting point for this planned reform should be the creation of services which empower people to live, not just exist. Whether or not that is the intention, this is reality for many citizens in the current set up.

We would argue therefore that any planned legislation must have a number of core principles at its heart as well as including the changes the government would want to see. Guiding principles can 'read through' to strategic guidance, to local plans and delivery to families and communities. The Self Directed Support Bill has 'set the scene' with principles relating to involvement, collaboration and choice at its heart. For the integration Bill, the starting point is Christie, but we must also consider the following:

- The need to embed a human rights approach at the heart of the Bill, building on key aspects of the European Convention of Human Rights.[ii] As a follow through, rights based approaches such as "Care about Rights" (SHRC) need to become the norm and a core competence for the care workforce in its totality.[iii]
- In these tough economic times, responses to the needs of our aging population will come from communities and families. We need to support people and their communities to build on their existing assets - whether these are social, human or natural resources – and to help build effective connections which effect change. This could happen through investment in self-help groups, amateur sports/arts, parent support groups, community cafes/lunch clubs, grassroots campaigns, and community transport and food initiatives. We could consider the creation of "community hubs" which bring together a range of supports from the community and third sector which help to foster independence, community connections, and offer low level, preventative support.
- The intention behind these plans is to ensure more equal access to support and to ensuring positive outcomes for all who need adult health and social care – so there must be an explicit and strong commitment to promoting equality. As outlined by the Lothian Centre for Inclusive Living, the services coming together should work alongside individuals and families to tackle barriers to independent living [iv]– they should not become barriers in and of themselves which can frequently be the case.

- We need to ensure the focus on prevention and personalised approaches is rooted in community based solutions. These agendas should not be solely about addressing public sector challenges. Investment in the sector, the starting point for these planned reforms should be about supporting healthier, active and more engaged lives for people and their communities.

Finally, the voice of individuals, families and communities must underpin all of this from strategic commissioning through to local delivery. Statutory services which hold the key to accessing formal support must 'let go' and become better at working with families to combine formal and informal supports which help people to live independently and to live well. This must not mean an extra burden for families but must recognise the rights of all to have real quality of life.

4. Joining the Dots

All of this means that there are high expectations of the integration plans. Integration also presents a significant opportunity to bring key policy streams together- we need to align not just the budgets but also the policy objectives for Scotland's health, care, regeneration and procurement functions. How welfare reform fits and affects these plans is missed in the consultation document.

Introductory sentences in the consultation document highlight the plethora of different policies/legislation in place which 'guide' health and social care in Scotland. We need to see a better articulated read-across between these plans, the Social Care (Self Directed Support) Bill and plans around Community Empowerment and Procurement legislation/guidance. Together, these potentially could give people real control over their lives, to stay fully connected to work, to leisure and to their communities. If we do not 'join the dots' now, we will have missed the opportunity to shape real reform in our public services – so that they are actually directed and planned by the people they are there to empower and support.

How will the new partnerships respond to the Self Directed Support (SDS) Bill (once it becomes law)? Where will principles underpinning self-directed support – of having real choice and control - sit? The SDS Bill in its current form does not cover health services, so what does that mean when aspects of the two different services – and cultures – are brought together? Charging and eligibility criteria are applied extensively to social care services whilst health remains largely free at the point of use. There is scope for confusion about what constitutes a health service and what constitutes a social care service; having evolved in very different operating cultures these will suddenly be brought together. The Scottish Association for Mental Health (SAMH) response highlights the practical impact of this in its response to this consultation:

"Elsewhere in the UK, where health and social care services have been well integrated within pooled budgets, there have been resultant difficulties in providing direct payments to people experiencing mental health problems. This is largely due to difficulties disentangling pooled NHS or social care funds into separate personal social care budgets and funding for health services."[v]

SCVO members have highlighted concerns that in focussing on integrating the two systems we risk losing sight of pressing challenges relation to charging and discrepancies in quality of care and in eligibility criteria. The existing support system is not being reviewed, nor are we looking at fairer charging (or charging caps) - or how we actually fund social care in Scotland. Indeed, there is no real review of these thorny issues, and the scale of 'shift' from acute to community is left to local partnerships to work out. The fact that the document mentions that "some acute

spend" will be transferred leaves a lot to chance, and creates a risk that there will be no real shift in the balance of care.

With localities being left to work out how to 'do' integration themselves, we will most likely continue with the same postcode lottery which exists at the moment. Here is a comment from Foodtrain, an SCVO member with extensive experience of working with older people:

"..health and social care (integration) indicates that all local authorities will still set their own eligibility criteria and priority frameworks. This existing approach has led to the current postcode lottery facing Scotland's older population. They are already seriously disadvantaged by choice, range and cost of services depending on the criteria set by each Local Authority. The integration of health and social care is an opportunity to truly align community care based services with the National Care Standards and the principles of Reshaping Care… across the country."

There is a risk that integration may make no substantive difference if we leave these key elements untouched.

5. Accountability

SCVO welcomes moves to improve accountability within the planned HSCPs. The proposed approaches do still look relatively complex; time will tell if joint accountability to Ministers and Local Authority leaders will make a difference.

There is already a lack of clarity and accountability for spending and service delivery decisions as highlighted by third sector organisations such as Foodtrain:

"The third sector plays a significant role with the field of health and social care offering dynamic, responsive and cost effective solutions but until there is clarity in how councils and NHS make decisions on how and what to provide, procure, commission or fund by way of community care based services, then it remains very difficult to see how the sector can play a bigger role."

Any improvement in accountability to be gained by the proposed changes is challenged by the fact that there are, potentially, 32 different ways of doing things, no clear parameters or guidance about how spend will shift, and sometimes ineffective approaches for public scrutiny. E.g. Many Health Board AGMs allow public attendance but not public input.

There is a missing element in the consultation - accountability and transparency to service users, their families and communities whose lives will be affected by the proposed changes. The role in the planned partnership committees for users' and carers' voices is vital, but that voice needs to have *real influence* and provide a conduit for all partners to understand local needs and how to respond to these.

Public involvement and 'voice' is linked closely with a 'place at the table' for the third sector in the new partnership structures. Whilst the sector *can* amplify the voices of users and carers in this context, clear and effective public engagement strategies need to be developed. This is something which the sector can help support. However, it has a separate and wider role to play - with its' connection to people, to communities and its role in providing the kinds of supports which help people to remain independent, the sector can bring a wealth of intelligence that could help planning and commissioning of services strategically and operationally and in the delivery of better outcomes for families and individuals.

6. Equal Partners – The Role of the Third Sector

The drive for service reform at the heart of integration should not be just about public sector health and social care. The interface between the NHS, local authority social work departments and other services is critical. From our perspective, the role that the third sector can play is central– and largely missed. We see mixed messages about the role of the sector in this document – referred to as both a stakeholder and a partner. The lack of voting rights including for the third sector in Health and Social Care Partnerships is a missed opportunity.

The interface with Community Planning is vital, given this is the context in which local strategic priorities and outcomes are set. The link between Community Planning Partnerships and the new Health and Social Care Partnerships will be important.

At present, the third sector is expressing increasing frustration around engagement with Community Planning Partnerships (CPPs) and similarly with Community Health Partnerships (CHPs). Decisions on substantial spend do not always involve those organisations or people likely to be affected, highlighted in the Audit Scotland review of CHPs which says that decisions can be taken "without consulting with partners". [vi] And whilst progress has been made in Reshaping Care/Change Fund work, the sector still feels in some cases that it is being marginalised from planning and activity in which it could play an important role. Real influence is important – and people, communities and the organisations which serve them feel increasingly isolated from the planning and choices made in their localities. Integration potentially offers us an avenue to change that to a positive.

There is currently a range of views across the sector as to the nature and extent of its involvement in the new structures and in relation to its exclusion from having voting rights on the proposed partnership committees.

SCVO believes the third sector can and should play a central and **equal** part in achieving wide reaching reform in public services and that includes the plans to bring health and social care together for adults. It delivers a substantial proportion of the services which will be considered as integration is implemented. It delivers interventions which keep people out of formal structures. With the right environment, the third sector can be a key driver of change, improved wellbeing and community resilience. There therefore needs to be whole system engagement of the third sector in these committees, in strategic commissioning through to locality planning and delivery.

We acknowledge the Deputy First Minister's commitment at a meeting in June to see the third sector being truly involved. However, the full role and contribution of the sector is missed in this consultation. There is also a lack of understanding and acknowledgement of the totality of this contribution and the professionalism and expertise that the sector can bring to the table. In relation to this last point, third sector teams/organisations are subject to the same professional scrutiny and inspection as statutory sector colleagues.

There is a range of options which can help achieve an equal role for the sector in this context:

- Full voting rights for the sector at partnership committee level: SCVO, along with other third sector bodies, support this, as outlined in the recently published "Shared Statement" on Integration.[vii] It is up to the sector to decide on the infrastructure needed to achieve this goal, and to ensure that local organisations are fully involved in supporting the representative sitting alongside statutory partners. As the joint statement says, having voting rights gives the sector a level of equality and recognition it does not always receive,

despite its contribution and potential input to this agenda. The consultation does not chime with comments made by the previous Cabinet Secretary for Health at a Health and Sport Committee evidence session in March where she said "it was the intention that the voluntary sector is there not just to speak for its resource but to influence the spend of the totality of the resource in a much stronger way than perhaps it does just now." As The Coalition of Care and Support Providers in Scotland (CCPS) point out[viii], it is hard to see how we can achieve this without the sector having the right to vote.

- Influencing opportunities particularly around strategic commissioning. Third sector organisations bring a range of resources, experience and intelligence to the table. Any potential conflict of interest can be dealt with in the normal way – again with an infrastructure of support behind the representative voice;

- Direct involvement in locality planning – and we believe that resources should be devolved where possible to local communities to develop local solutions and preventative approaches. We believe the idea of community hubs, outlined above on page 2/3 is worth exploring further.

There has been engagement of the sector at strategic/national level through the Ministerial Strategic Group, the Delivery Group, Strategic Commissioning group and in national workstreams involved in planning integration and the legislation. That involvement is welcome and can help put in place some of the requirements which open the door at local level for the third sector to be deeply involved in shaping and planning integrated services. However, we still retain real concerns that the sector will be excluded or its role 'downgraded', and that it won't be able to do all it can to achieve the kinds of outcomes and services that people want for their lives – that the plans for integration are meant to achieve.

Integration will impact on the third sector in a range of ways – see section 7 below. Therefore, it must be an equal partner in shaping local plans given the impact these will have on local organisations already delivering on health and wellbeing outcomes and in providing commissioned services. Change Fund processes (whilst often frustrating) have in some cases enabled third sector involvement in decision making on spend to shift the balance of care. Yet it remains the fact that the sector is still not fully embedded in the structures that will make integration and strategic commissioning/locality planning a reality. Learning from the Change Fund process must be taken into account.

7. Commissioning and Understanding Need

Our members and submissions from representative bodies such as CCPS have highlighted the importance of getting strategic commissioning right both for the totality of spend and for locality planning. What can be missed when commissioning takes place is a strong understanding of need in local areas, a challenge brought to the fore by the recent Audit Scotland review[ix]. The lack of housing representatives on the partnership committee suggest a missing link given that local housing stock, availability and its general 'accessibility' will impact on what is being commissioned. How will local health and social care partnerships take account of local transport, influence local planning regulations and their impact on the type of community/housing in which people live?

Strategic commissioning, as pointed out by Jim McCormick in the "Twelve Propositions" paper, needs to take account of informal support e.g. the contribution of unpaid carers, community transport, peer support etc. It will not be an effective strategy unless partners consider how key informal networks, family capacity and the wider needs of older people – and all other adults –

are addressed or indeed how the wider context in which people live can impact on social care or health needs.

We are waiting for feedback from one local authority where key staff responsible for strategic commissioning may be seeking to involve some grassroots organisations in shaping the Strategic Commissioning Strategy – this may be an example of good practice where people who are affected by decisions on commissioning are consulted at the early stages of developing strategic approaches.

8. Other Issues

Total place:

The idea of 'total place' approaches could sit well in a context in which budgets are integrated and services start to come together. Looking at the health and wellbeing of people in a wider way and the approaches which bring planning, housing, transport and other interests together in communities could follow through from a more integrated approach to health and social care.

Workforce issues:

The consultation suggests that integration could provide new job opportunities in the community, where the focus is on independent living, helping to maintain wellbeing and enabling people to remain part of their communities. It is important to point out these types of job already exist and many are within the third sector – providing peer support, supporting financial wellbeing, befriending, carer support, care and repair etc. There is an opportunity to invest in and expand in the kinds of interventions recognised as being crucial to helping people to remain well, and at home.

Integration plans need to include a coherent workforce strategy which embraces the third sector as a key employer and connects it fully to opportunities for secondment, skills development and exchange with public sector partners.

Transition:

There is some concern that a focus on older people and in turn all adults may drive attention away from some of the very real challenges which other groups face e.g. children who are making the transition to adult services. It will be interesting to see how the Highland model develops, as adult services are now under the auspices of the health board and 'separate' from children's services which remain with the local authority.

There is some concern that the drive to integrate adult services means will weaken the focus on this important transition.

Housing:

The importance of housing to health and wellbeing and in connecting older people to their communities is largely missing from this document. Access to aids and adaptations remains a challenge and is one of the reasons why people remain in institutional care or in hospital. We welcome involvement with Audit Scotland's planned overview of housing in Scotland and look forward to bringing representatives from across the sector in housing, care and repair, carer support and other areas to help shape this review and its consideration of the overall impact of housing on people's lives. We should also consider whether, in designing housing stock we

could 'require' that developers build more communal facilities which can help those who require social as well as medical support to remain in their communities.

Clash of the Cultures?:

Other responses such as that submitted by CCPS highlight the fact that we are bringing a 'medical model' and a 'social model' together with the integration of health and social care – a potential clash of cultures. CCPS suggest that there may even be an "imbalance of power" between health and social care and one in which health is effectively the 'senior partner'. There is concern that integration will place community support and the focus on independent living within a medical context where professionals focus on getting people well enough to go home but do not look at what is needed in total to help that individual stay well and retain quality of life. This is a speculative point, but one worth making.

Business Regulatory Impact Assessment:

See the attached appendix which includes specific points about the potential impact of integration plans for the third sector. This has also been provided separately to the Scottish Government team leading this work.

Local engagement and planning – practicalities

It is very difficult for national charities e.g. Stroke Association to engage with 32 local authorities and every CHP/new HSCP. Yet they can bring a wealth of resources and information to strategic commissioning and service planning, including the voice of service users and carers. How we bring that expertise to the table needs to be considered.

9. Conclusion

Responses to the significant challenges being faced in Scotland - including our aging population - need a tri-partite partnership, with the third sector playing an equal role in shaping and delivering service responses.

In its current format, the plans outlined in the consultation document may not permit this to happen. The benchmark of success for Integration will be whether or not we have a system which moves away from the current approaches which "*'default' to emergency admissions rather than looking at the capacity of individuals, their families and wider communities to ensure people stay at home… and have good quality of life*." [x].

Our view is that there needs to be much greater scrutiny of where the Change Fund is contributing to this change, if at all. The RCOP Change Fund is the 'precursor' to moving towards more integrated services. Integration must also change the fact that people spend more time navigating systems which serve themselves rather than the individuals, families and communities who use them.

These potentially significant plans are being taking forward whilst Scotland is facing unprecedented welfare cuts which are likely to have a critical impact on communities and families across Scotland. This is all taking place in a period of extreme financial constraint. As well as the impact on pub2011ic spending and services, the recession crucially affects the resilience of individuals and families, and their ability to find solutions as they or their relatives get older/experience poorer health.

The third sector's role here is vital at all levels of the Government's plans and has something very positive and concrete to contribute. It is well suited to being the primary vehicle through which older people and communities can support themselves and each other. The sector can unlock and build on the assets in families and communities. Already a key player in health and social care , there is much more that the sector can do in response to aging in Scotland[xi] and in shaping more effective services. It needs to be an equal partner here.

The focus on outcomes in the consultation is welcome but it seems to be that the starting point is that people will need care rather than a stronger focus on preventing/delaying of people needing care/putting in place things which reduce level of care needed. Reforming services which have prevention, a focus on assets and fostering independence at their heart should be what integration is all about.

Lastly, we cannot overemphasise the importance of the need to tackle culture, the need for strong leadership in achieving the kinds changes we have heard the former Cabinet Secretary for Health articulate. This is wider than 'workforce training' – and whilst a focus on outcomes can help drive new behaviours, support for staff to work differently and to think differently will be critical. This points apply to all partners and organisations involved in integrated services, including the third sector.

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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.

[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.

Appendix

Integration of Health and Social Care – Business Regulatory Impact Assessment

Background

The impact of health and social care integration plans on third sector organisations of all sizes is largely missed from the BRIA Appendix in the consultation document on legislation.

It is important to point out that the third sector has a significant role in health and social care already in a number of different ways:

- as providers of care (at least one third of providers registered with Care Commission are third sector);
- as providers of information and advice;
- as providers of practical support to older people and their families/carers;
- as providers of opportunities/services which help keep older people in their communities/keep them well/ eating normally/help transport them

The document **"Working with the third sector in Health and Social Care"** is designed to help people working in any of the statutory partner organisations involved in the reform of adult health and social care to enhance understanding of the role and potential of the third sector in their area. This document outlines why the third sector is currently – and could be more involved – in reshaping care, the reform of public services – of which integration of health and social care is a key aspect:

"The third sector - made up of voluntary organisations, social enterprises and community groups – has two broad roles to play in relation to public service reform and health and care in particular. Its representatives are well placed to make informed and creative ***input to strategic planning and commissioning****, and third sector organisations, either separately or working in collaboration, can play a major role in* ***prevention, the delivery of services, and responding to need****. Indeed in relation specifically to care 38% of all services registered with the Care Inspectorate are in the third sector. In thinking about engaging with the third sector it is helpful to distinguish between these two dimensions. In the context of an ageing population and cuts to public spending the potential of the third sector is increasingly being highlighted in public policy"*

Role of the third sector in providing Intermediate Care – ICF recently published by Scottish Government. Intermediate care is critical to helping people to remain independent and have quality of life. Sector could play a significantly greater role in this area. This point is clearly in the ministerial foreword to this document.

Taking all of this into account, it is very likely therefore that the plans for integrating health and social care, the development of integrated budgets, shifting responsibilities across statutory services, joint commissioning could impact in a range of ways.

BRIA – Third Sector Perspective

Any shift of resources from acute settings into local partnerships/communities as part of integrated budgets ***could*** **provide new opportunities for the third sector** to develop existing and new approaches which work to help older people to stay connected to their communities, remain at home for longer, cope with basic day to day tasks.

Organisations such a Food train – grounded in their communities and delivered through volunteers– have a key role in preventing older people from becoming vulnerable, isolated and more likely to need intensive home care. They can also help in delaying admission to institutional care. There are economic benefits arising from such community focussed approaches and social return on investment evaluations show the value to statutory partners (local and national) of investment in building carers/family capacity – a key source of informal care (some £10.3 billion each year in Scotland alone).

Experience and learning within the Change Fund is critical here, as the third sector has not found it easy to get to the table. Impacts and challenges experienced here will apply in local discussions to move towards integrated services/budgets.

For the third sector to benefit, it would need to be viewed as an equal partner in planning and design and delivery of services. It is equally professional, and can innovate/respond flexibly and often quickly e.g. to help a family prepare for discharge of an older relative from hospital. It could potentially do far more to help statutory services achieve goals around delayed discharge/emergency admissions.

Integration could lead to a shifting operating environment for third sector organisations if e.g. funding and responsibility for delivery shifts from social care shifts to the NHS or vice versa. Operating within a different business culture could mean:

- The need for new reporting systems (IT/software changes)
- Data sharing – needs to be recognition of third sector providers as being bound by similar confidentiality concerns. Impact on IT systems again?
- Need for workforce development
- Different language used, terminology, more of a medical focus which can crowd out wider wellbeing, wellness and connectivity outcomes.
- Different funding regimes/financial systems/accounting.
- Possible need to review governance; expertise of trustees?

This presents a risk in terms of having to operate within a medical context where potentially only medical rather than social benefits may be recognised. The role of the sector in providing or supporting acute care is still not widely recognised.

Some third sector organisations receive finances from more than one source e.g. council funding, NHS funding and funding from trusts, lottery etc. So they have to manage different reporting systems, reporting on a range of outcomes which can put pressure on staff within organisations. **Integration could lead to a rationalisation which might benefit third sector organisations – e.g. less reporting.**

However, there is a potential risk for many. It seems likely that statutory partners bringing together "integrated budgets" would review existing spend and seek to make savings. There is

a risk that voluntary organisations might see further rationalisation of local spend and further cuts rather than increased investment.

Such a review would almost certainly seek to reduce duplication of effort in the sector, and encourage third sector organisations to collaborate – a positive move. In reality however, there is more of a risk that this could lead to further local cuts and hamper third sector organisations and their ability to plan and contribute positively to integration and local planning of services.

Focus on costs in tendering rather than on outcomes achieved/quality of provision – impacts already on the third sector when organisations sit within/provide social care. See CCPS FOI report on this area – would this apply in new "integrated" contexts?

Moving adult social care provision – in all its guises- into a health care setting (Highland model) means that third sector organisations affected need to be taken into account in the development of patient pathways/care frameworks.

References

Scottish Voluntary Sector Statistics 2010, SCVO
www.scvo.org.uk/evidencelibrary/Home/ReadResearchItem.aspx?f=asc&rid=1078

[i] Twelve propositions for social care – Revised Discussion Paper, September 2012, Dr Jim McCormick

[ii] As above – page 10

[iii] As above and Chetty, Dalrymple and Simmons (2012) Personalisation and Human Rights – A Discussion Paper

[iv] Personalisation and Independent Living – are they connected" – Lothian Centre for Inclusive Living

[v] SAMH Response: Integration of Adult Health and Social Care in Scotland (August 2012)

[vi] Review of Community Health Partnerships, Audit Scotland, June 2011.

[vii] Integration of Adult Health and Social Care in Scotland: Consultation. A Shared Statement from Third Sector Organisations

[viii] Scottish Government Consultation on the Integration of Adult Health and Social Care, CCPS response, Sept 2012

[ix] Commissioning Social Care, Audit Scotland, March 2012

[xi] "Why Involve the Third Sector in Health and Social Care Delivery?" – Evidence Paper, Scottish Government/Scottish Third Sector Research Forum, 2011