ADSW
ASSOCIATION OF DIRECTORS OF SOCIAL WORK

Independent Budget Review

Response to initial call for contributions

The Association of Directors of Social Work welcomes the establishment of the Independent Budget Review and is pleased to respond to the initial call for contributions. Social Work services support the most vulnerable people in our society, alongside the unpaid care provided mainly by family members.

Social Work is the second largest local authority service, spending **£3.4 billion** (£3,409 million) in gross revenue expenditure in 2008-09. 46% of expenditure is on older people (£1,561m), 21% is on children & young people (£731m), and 18% on adults with learning disabilities (£604m). A further 12% is spent in total on services for adults with physical disabilities (£206m), adults with mental health problems (£147m) or addictions (£52m). Social Work services to the Criminal Justice system (including reports for courts, probation, community service and other supervision) account for a further 3% of total spend (£104m).

Local authority gross expenditure on social work has grown by an average of 9.3% per year in cash terms since 1997-98, equivalent to 6.8% per year in real terms using the Treasury's GDP deflator, or 4.9% per year using the Department of Health's Personal Social Services prices index which takes account of above-average inflation in the cost of care services. Some of this increase has been necessary to fund Free Personal Care for older people, implemented in July 2002. In 2008-09 councils spent £366.3 million on Free Personal Care – 11% of total spend on all client groups. The remainder of the average real increase of 4.9% per year has been needed to respond to the growth in the very elderly population, to the growth in the numbers of people with learning disabilities, to reductions in long-stay continuing care NHS beds, and to increases in child protection referrals and in the numbers of children in care or supervision.

In recent years Councils have experienced significant and growing pressures on social work budgets, and expenditure has continued to grow in real terms in response to rising demand – by 3.8% per year overall since 2005-06 (4.1% per year for Children's Social Work, 4.3% per year for Older People, and 3.1% per year for other Adult Community Care).

More than most other Local Authority services, Social Work now faces the "perfect storm" of rising demand and expenditure reductions. Demographic change continues to increase the need for services for older people and for people with disabilities, while at the same time reducing the future supply of carers (both paid and unpaid). There are rising expectations about the quality of care that should be available as a right of citizenship. Current trends in alcohol and drug misuse increase both crime and demand on health and social care, and are part of the explanation of increasing child protection referrals and family breakdown, with increasing numbers of children "looked after" by the local authority. Scotland's prison population is among the highest in Europe, relative to our population, and the need for effective community alternatives, that reduce re-offending, has never been greater.

Hard choices are inescapable. Local authorities will need to consider the priority that they place on social work services for children and young people, and adult social care for older people, people with disabilities and vulnerable groups, compared to other important council functions and services. Whilst there are no easy solutions, the overall strategy for social work services and social care must include the following objectives:

(1) increasing **support for carers** – partners and family members provide the majority of personal and other social care in Scotland, as in the rest of the UK, and it is essential on economic as well as moral grounds that they receive the support they need to continue caring;

(2) improving choice, flexibility, and quality within **more "personalised**" services and **increased self-directed care** – this will help deliver the outcomes people want, drive up quality, and may also reduce costs;

(3) investing in **preventative services**, such as rehabilitation and re-ablement, developing early intervention and preventative strategies with community planning partners and developing resources in local communities – thereby reducing the number of people entering or requiring ongoing support from social care;

(4) progressing and building on the **Integrated Resource Framework** pilots to shift resources from acute hospitals to more integrated NHS and social care community services;

(5) unlocking expenditure tied up in **high cost care packages** through improved **commissioning, procurement and service redesign/ new models of care**; shifting the balance of care to release funds tied up in residential care;

(6) **streamlining access** to services, assessment, decision making and care delivery processes; seeking economies of scale for **shared services**; continuing to deliver **efficiencies** and value for money; and

(7) planning for the medium to long term, informing the **public debate about the future funding options** for health and social work services, including the sustainability of Free Personal Care.

ADSW would be happy to provide further information on social work expenditure trends, the implications of current population projections for future demand for social care services, trends in child protection and in children looked after by Scottish local authorities, and on the policy and practical workstreams that the Association is involved in to modernise services and deliver better outcomes for people. The Association is also keen to participate in the Review Group's second phase of engagement and to provide whatever assistance it can.

RESPONSES TO THE CONSULTATION QUESTIONS

Our responses to the seven consultation questions, (a) to (g) follow. The table below shows the range of issues and initiatives mentioned in the responses.

Issue	Question	Page	Issue	Question	Page
Access to work	e	11	Intermediate care	d	6
Call centres	b	5	Personalisation	d	7-8
Charges to service users	b,c	4,6	Prevention	e	10-11
Clearing house for "what works"	g	12	Private firms	c	5
Clyde Valley Review	e	8-9	Procurement	b	5
Communications	g	12	Productivity	b	5
Community resources	c	6	Re-ablement	d	6
Disinvestment in Acute Hospitals	e	9	Rehabilitation	d	6
Double running costs	e,g	10,12	Self-Directed Care	d	8
Early intervention	e	11	Service reductions	a	3
Eligibility criteria	a	3	Shared services	e	9
Externalisation	b	4-5	Sickness absence	b	5
Free Personal Care	b	4	Social capital	c	6
Health inequalities	e	10	Social enterprises	c	5
High cost packages	b	5	Spend to save investment	g	12
ICT investment	b	5	Staffing mix	b	5
Individual budgets	d	8	Telecare	d	6-7
Integrated Resource Framework	e	9-10	Volunteers	c	6

<u>Question (a):</u> Assuming a public expenditure reduction on the scale envisaged, what would be the impact upon your organisation or sector, and upon its capacity to maintain service levels and quality of outcomes for service users?

Reductions in service volumes are an inevitable consequence of expenditure reductions on the scale envisaged in the IBR consultation paper (real terms annual public expenditure decreases of: -5.2% in 2011-12, -2% in 2012-13 and -3.6% in 2013-14).

In recent years, councils have delivered significant efficiency savings – in social work, as well as in other services – and there are a large set of work-streams on the stocks to remodel services and reduce unit costs. Nevertheless, we agree with Audit Scotland's recent assessment that "efficiency savings … will not be sufficient to bridge the gap between projected future spending and future funding" and that the Scottish public sector "needs to adopt a priority-based approach to budgeting and spending, considering competing priorities and deciding where to target the limited funds available" [Audit Scotland, February 2010: *Improving public sector efficiency*].

Individual councils will decide which services should grow in response to increased demand, which services should be maintained, and which should be reduced in volume or quality and which ones should cease. While it is very likely that most councils will seek to protect social work services for children, older people and disabled or vulnerable adults, the scale of the funding reduction will mean that some social work service volumes will have to be reduced. Local authority Social Work Criminal Justice services are funded directly by the Scottish Government via Criminal Justice Authorities and the Scottish Prison Service – reductions in funding will reduce service volumes and quality, potentially reducing in community sentencing options for courts.

Social Work services face rising demand from the ageing population, increased prevalence of disability, alcohol and drug misuse, and social trends increasing demand for children's social work services: unmet need will therefore rise.

It will be very difficult to manage these reductions without tightening eligibility criteria and continuing a trend already evident in many councils whereby services are concentrated on people with the highest level of needs, excluding those whose needs are less severe *now* but at risk of *future* deterioration without support. There is growing evidence that the short-term savings achieved by tightening eligibility criteria prove to be a false economy, and that medium to long-term savings require spend-to-save investment in preventative services.

In England, the Department of Health has produced useful guidance for local authorities on the *Use of Resources in Adult Social Care* (October 2009), based on experience since 2004 in what has worked in the nationally supported Care Services Efficiency Delivery programme. The guide warns councils to "watch for short-term gains at the expense of longer-term benefits", that tightening eligibility criteria "in practice … produces minor savings" and that closing services "is not financially viable …if alternatives are not already in place for users, and ultimately savings may not be as great as first considered". The guide argues that:

> An excellent LA will …achieve efficiencies through a system focused on early intervention, prevention and re-ablement – i.e. where good information and advice, practical support, appropriate housing options, re-ablement and joint working between health and social care assist people in living fulfilled and independent lives, thereby reducing the number of people entering or requiring ongoing support from social care. (Page 6).

ADSW agrees with this advice; we return to these themes in our response to question (d).

<u>Question (b):</u> Are there constraints which would need to be addressed (and which could readily be addressed in practice) to permit you to realise savings, maximise income or increase productivity?

Most councils have increased **charges to service users** in recent years, at least in line with inflation. In 2008-09, social work service users charges produced income of some £242 million, or 7.1% of total social work gross actual expenditure. Charging policy and legislation is not entirely equitable across service user groups, with relatively more income being raised from older people (12.5% of gross expenditure) than from disabled adults (5%) or people with mental health problems (3%). Charges for residential care are prescribed in legislation while those for home-based community care services follow COSLA means-testing guidance. There is some scope for increasing income from charges for equipment and for some day services (discussed further in our response to Question (c)), although charges are not popular among service users and there is a general public presumption that care services, like the NHS, should be free at the point of consumption.

Free Personal Care is, of course, the biggest constraint on charging service users aged 65+, since it is illegal to charge older people for *any* personal care at home, and for the first £227 per week for residential care with nursing or £156 per week without nursing (revised rates from 1.4.10). As well as reducing income from charging, Free Personal Care has brought large numbers of older people into the local authority care system who have sufficient means to fund all their own care and would previously have done so. Free Personal Care has cross-party support in Scotland and versions of the policy have been implemented in Wales and have recently been proposed for England by the UK Government as part of the new White Paper proposing a "National Care Service". Nevertheless, the affordability of Free Personal Care in the medium to long term remains controversial.

Audit Scotland's recent report: *An overview of local government in Scotland 2009* (February 2010) states that:

> It is widely recognised that the projected growth in demand, along with increasing costs and reducing financial resources, mean that current patterns of care for older people are not sustainable. In May 2009, the Scottish Government, NHS Scotland and COSLA launched a review of care and support services for older people. Its aim is to ensure that redesigned services are both affordable and sustainable and enable older people to stay at home, with maximum independence, for as long as possible. (Page 18).

ADSW is supporting this ***Reshaping Older People's Care*** programme. Cashable savings from service re-design are not likely to be achieved in the short-term, but it is important to progress this work now to deliver savings in the medium term. The programme is linked to the *Integrated Resource Framework* workstream, discussed further below in our response to Question (e).

All councils have workstreams in place to deliver **savings** from social work services: many are **reducing services provided in-house** in favour of purchasing services from the voluntary and private sectors at lower unit costs. Social Work is delivered within a "**mixed economy of care**". In 2008-09, nearly half (49%) of local authority gross social work expenditure was spend on "third party payments" to mainly voluntary and private sector care providers. This figure was highest for Adults with Learning Disabilities (60%) and for Mental Health services (58%); followed by HIV/AIDS (54%), Older People (51%), Physical Disability (50%), Addictions (48%), and Children's services (40%), but relatively low for Criminal Justice SW services (20%).

Further social care **externalisation** remains an option, since purchased services from the voluntary and private sectors tend to be at lower unit costs, due to the lower wages, pension rights and sickness payments enjoyed by their employees. In England in 2007-08, purchased services represented 55% of total gross expenditure on personal social services; the corresponding figure for Scotland (excluding Criminal Justice SW which is not a council function in England) in 2008-09 was 50%: the gap between the two countries in this respect has narrowed over time. In Scotland,

the extent of externalisation varied between South Ayrshire (62%) and Highland (37%) among mainland councils.

Constraints on externalisation include: the state of development of the local care market; lack of political support; the belief that retaining some in-house market share has strategic value; and concerns that the quality of purchased tends to be lower than in-house services – for example private sector staff are perceived to be less trained and to have higher turnover – and is difficult to monitor. TUPE (Transfer of Undertakings, Protection of Employment) also applies to any staff who are moved from local authority to external providers.

Finally, there may be some services currently purchased at very high unit costs – for example, children's residential schools or some autism residential services – where in-house provision shared basis between neighbouring councils might prove better value for money. In children's services some progress has been made in developing a range of community supports as an alternative to sending children to expensive residential and secure placements at distance from their own homes, schools and communities: as well as better outcomes this will achieve savings.

There is significant work around **procurement**, including the development of national care contracts for expensive resources such children's secure accommodation, the development of regional procurement for residential schools, the increased use of tendering for all purchased services, including a switch from block to spot purchasing and framework agreements to support greater use of direct payments to clients and "self-directed care".

Councils are also seeking to streamline **business processes**, to maintain front-line services while delivering savings from the "back-office". Some have **streamlined access** to social care through corporate call centres, with referrals to social work assessment staff being "workflowed" electronically, allowing faster response and administrative savings. There has been significant **investment in ICT** to support information sharing across professional boundaries; to interface client information with financial budgetary, billing and collection systems; and to improve data and management focus on **high cost packages** of care, on **unit cost** variations between service and care providers meeting similar needs, and on **productivity** variations between teams. Savings have also been achieved through better management of **sickness absence** with related reductions in the use of agency staff and overtime.

Councils are also working on the **staffing mix**, to free up the time of the most qualified and experienced staff. Work is also ongoing in councils to deliver savings from **new models of care** – particularly to free up expenditure currently locked up in residential care through developing more supported housing and intensive support at home – and **shared services**, which, with **prevention**, is discussed in our response to Question (e).

Councils are therefore engaged in **large-scale service modernisation and change**, across social work as well as in all other services, in pursuit of better outcomes for citizens at lower cost. The major constraints are time, learning from others what works, and finding resources to identify, lead and support innovation and change management.

<u>Question (c):</u> Are there new sources of finance you could develop in the short or medium term to maintain the range and scale of services offered to the public?

There is scope for promoting the involvement of **socially responsible private firms** in supporting social care initiatives. Some good examples exist where vulnerable groups are targeted for real employment opportunities, such as Barnardos' Youthbuild project in partnership with Scottish and Southern Energy. The role of **social enterprises** in terms of levering in money to public service provision will also become more important. Aberdeen City Council, for example, is examining the prospect of creating a social enterprise agency for employment/recruitment services for the oil and gas industry.

More could be done to develop **local community resources**, and to make greater use of **volunteers**, to provide activities and early intervention that would increase well-being and offset the withdrawal of many local authorities from what are perceived as lower level needs. Older people for example, including those receiving social care services, are often very concerned about their declining ability to maintain their gardens and clean their homes as they would wish – but currently these are needs that by themselves do not typically trigger a service.

Personalisation in social care is discussed more fully in our response to Question (d). This will require a radical change in emphasis from assessment of needs for sets of services that are largely pre-defined, to working with individuals to find solutions that help them realise the outcomes that are important to them. ADSW's policy paper on personalisation (2009) acknowledges that this will require ways of "**building social capital** and developing networks that help nurture informal systems of support, ensuring that solutions are informed by the people most directly affected. The return to a **community development** approach requires investment in the infrastructure that is necessary to support not-for-profit and community groups, with implications for organisational development" (emphasis added).

Income from charges too service users is not a new source of finance. There is limited scope to increase charges to older people, due to Free Personal Care; however, the fact that income from elderly service users accounted for 12.5% of gross expenditure in 2008-09, while income from disabled adults accounted for 5% (according to the local authority financial returns), suggests that there may be room for means-tested charges for some services for non-elderly adults to be increased.

<u>Question (d):</u> Are there innovative approaches to service provision or financing which you might consider using within your organisation or sector?

Yes, **re-ablement**, **telecare**, and **personalisation** are all key examples of service innovation associated with better outcomes at less cost.

There is very good evidence across the UK that **home care re-ablement**, **intermediate care** and **rehabilitation** services can have a major positive impact on both outcomes and costs, by helping people in ways that remove or reduce their need for care and support, and defer or delay their needs for longer-term care services.

In England, the Department of Health recently concluded that:

> The single biggest discovery by adult social care in the last decade is that many older people will recover from ill-health with the right treatment and support.
> *Use of Resources in Adult Social Care* (October 2009), page 26
>
> The most significant finding has been the Care Services Efficiency Delivery (CSED) programme studies on re-ablement domiciliary care services, where up to 50% of older people who were offered a short-term package of re-ablement based care did not require further social care support at the end of their treatment (medical care or intervention). The evidence indicates that this has an impact in delaying a person's need for further care by over two years. *Ibid,* page 60.

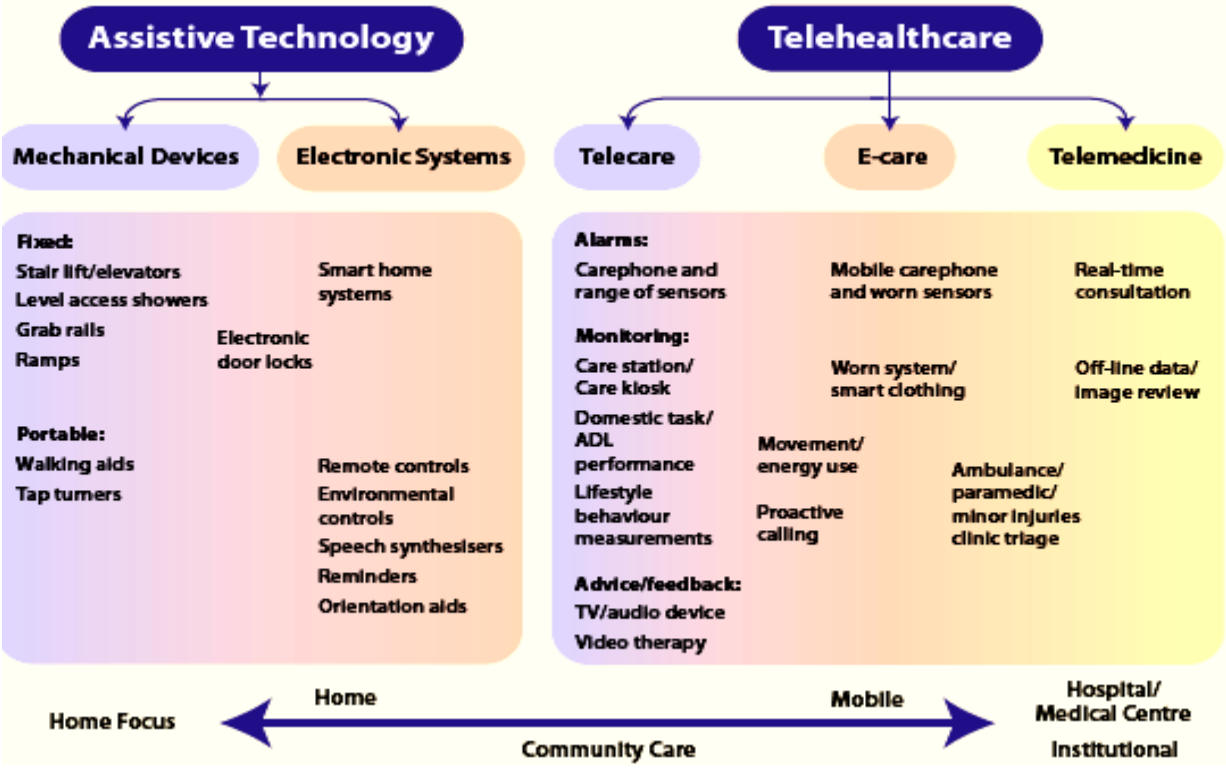
There is growing interest in Home Care Re-ablement in Scotland, following work in Edinburgh that was evaluated by Scottish Government funded research published in 2009. In Edinburgh, all adults referred for domiciliary care receive around six weeks of re-ablement to help restore confidence, activity and self-care ability, and hence increase independence. The net reduction in service hours required at the end of the re-ablement period is currently around 35%. Reablement has the potential to release significant savings, as well as delivering better outcomes for older people and younger adults.

Telecare has considerable potential to help support more people in their own homes, reducing both hospital and care home admission. "Telecare" refers to a range of technological interventions

that support and enable people to be independent in their own homes, through use of systems of sensors and alerts, and is part the continuum of technology that enables individuals to manage risks and health and social conditions within a home or community based environment, encouraging and facilitating a higher level of self care. The Joint Improvement Team (2010) report from which this definition has been adapted includes the chart overleaf showing the range of assistive technology, telecare and teleheath.

The Scottish Government has invested £16m in the Scottish Telecare Development Programme over the two years 2007-09, with a further £4m announced for 2010-11. Independent evaluation and monitoring over the first two years found that 16,482 new telecare users were being funded from the programme, of whom 13,000 were able to maintain themselves at home with care [packages including telecare. Most users are older people but partnerships are extending telecare to people with learning disabilities, physical disabilities and mental health problems. Outcomes attributed by the Joint Improvement Team to the Telecare Programme over the two years included: a reduction in delayed discharge of 894 patients, unplanned hospital admissions reduced by 3,800, and care home admissions reduced by 1,465.

The Telehealth Umbrella for Technology (Doughty et al)



From: *Summary of Telecare Services in Scotland*. Joint Improvement Team, Scottish Government, March 2010

Gross financial benefits are estimated to exceed investments costs. Indicative estimates were that that investment spending of £7.3m over the two years generated benefits of some £23m over this period: £10.6m in reduced hospital bed-days, £9.9m in reduced care home admission and reduced sleepover/waking nights cover, and £2.7m in reduced home care visits and other efficiencies. (Newhaven Research, May 2009). In addition, detailed qualitative research commissioned by Carers Scotland, and conducted by the University of Leeds, indicates a wide range of positive effects of telecare on caring roles and circumstances.

ADSW is firmly committed to the **personalisation** of social care as the best means to focus on the outcomes that people wish to achieve, and to transfer power and control from professionals to citizens. The Association's policy statement is available at:
http://www.adsw.org.uk/doc_get.aspx?DocID=102

Self-directed care is an essential element within the wider policy of personalisation, and the Scottish Government is currently consulting on its vision and draft strategy:

> The lives of people who require support are enriched through greater independence, control, and choice that leads to improved health and well being, and the best outcomes possible. Self-directed support should become the mainstream mechanism for the delivery of social care support. Building on the success of direct payments, every person eligible for statutory services should be able to make a genuinely informed choice and have a clear and transparent allocation of resources allowing them to decide how best to meet their needs. The choice should be available to all but imposed on no-one.
> Scottish Government consultation paper (2010): *A Strategy for Self Directed Support*, page 14

The allocation of resources to individuals would be determined by a "Resource Allocation System" that scores different elements of need; this in turn gives "an approximate indication of what it may reasonably cost to meet a person's particular needs according to his/her individual circumstances" - an "**individual budget**".

> Individuals have a choice on how the budget is processed. They may opt for a direct payment, commission the service directly with providers through an individual service fund or trust or leave councils with the responsibility to commission the services. Or they can have some combination. Individual budgets provide greater clarity about the financial contribution to meeting their needs.
> *A Strategy for Self Directed Support*, page 29.

There is some concern in councils that personalisation may increase costs, at least in the short-term, with: more investment in advice, information, brokerage and personal assistants; a loss of economies of scale in the move away from bulk purchasing, possible double running costs if service users cease to use in-house services; and increased demand.

However, *A Strategy for Self Directed Support* states that "some evidence on … individual budgets … suggests that the dialogue with individuals and families can lead to more effective services that will meet people's outcomes at lower costs". It also noted that "research in England found little difference between the average cost of an individual budget and the costs of conventional social care support" (page 15) and also argued that:

> The shift to self-directed support, and thereby the promotion of independent living, should aim to reduce the multiple business processes associated with current activity to bring together different funding streams. It should be possible to achieve efficiency savings by streamlining some overlapping activity of the agencies involved. (*Ibid*, page 32).

Personalisation policies also aim to develop and build upon individuals' capacities and represent a cultural shift from dependency to personal enablement and empowerment: combined with the efficiencies noted above this should in the medium term begin to reduce unit costs. An increasing use of individual budgets will also help to focus attention on maximising the outcomes that people can achieve with the resources available to them.

<u>Question (e):</u> From the perspective of your organisation or sector, are there ways in which public sector bodies and other service providers could work better together, across existing institutional boundaries, to make significant improvements to the efficiency of service provision and the effectiveness of public spending?

The Scottish Government and the Improvement Services have promoted **shared services** in recent years but, despite seed funding, actual delivery has been very slow. Sir John Arbuthnott's ***Clyde Valley Review 09*** has provided new impetus and argued that "the solutions lie in making more strategic planned improvements than quick wins". It suggested that the previous focus on

sharing “back office” functions would not deliver as many savings as shared services between councils, and between councils and the NHS, involving Education and Social Work.

His report identified a number of strategic challenges facing Councils and Health Boards “which cannot be resolved at a local community level without a more integrated approach at a strategic level”, including: “the care of the elderly, including admission to and discharge from acute care; purchased social care services, particularly residential services for young people and those with special needs; Personalisation, its affordability and the use of mainstream service models; and Mental health and drug and alcohol services”. (p20). He recommended that

> a time limited consortium involving all eight Councils and the two Health Boards is established to consider and report on the most cost effective and sustainable way of providing these services in the Clyde Valley area. The consortium should report within a year of its first meeting (page 20).

He also called on the 8 Clyde Valley councils to work with Scotland Excel to develop a joint approach to the **procurement of social care** services and to “accelerate progress in this area” (p34).

More fundamentally, Sir John Arbuthnott recommended **integration across the NHS and Council social care**:

> I recommend that each Council and its respective Health Board works to create an integrated health and social care service. This should evolve from the community health and care partnership model. The challenge to deliver this comes from dealing head-on with the issues of accountability and devolved financial control. Integration requires: clear management lines of accountability; ensuring the link between local elected members and the service; delegating budgets governed by sound financial processes; and addressing the mismatch of pay and conditions between the health service and Council employees. (Pages 20-21)

ADSW supports this direction of travel, but has some doubts about viewing this narrowly to mean full scale public sector re-organisation, with the risks that this would divert attention and energy that is needed for modernisation and change. There is already significant scope for savings from joint planning, joint commissioning, and service realignment between the NHS and Councils. Sir John Arbuthnott called on the Scottish Government to “support the acceleration of integrated local health and community cares services by addressing the ‘grit in the system’” (page 16) and referred to the work on the Integrated Resource Framework (page 32).

The Scottish Government is funding **Integrated Resource Framework** (IRF) pilots in 4 Health Board and 12 associated local authorities in 2010-11:

> The ideas behind the Integrated Resource Framework are as simple as they are fundamental. Firstly, the framework enables partners to answer the question, “How are we using our resources?” and then to ask, “What are our resources achieving?” Based on an understanding of cost and activity information, partners can then examine patterns and variation before asking, “How can we plan and invest our resources in a different, more effective way to support shifts in the balance of care?” (Scottish Government and COSLA invitation letter, 2009)

Evidence from the *Multi-Agency Inspections of Services for Older People* (MAISOP) in Tayside and Forth Valley demonstrated an inverse correlation between the volume and quality of collaborative community health and social care provision and the use of acute services by older people. The expected shift in the balance of care is a transfer of resources from acute NHS hospital services to more (and better integrated) health and social care in the community.

> The policy aim is to improve health and wellbeing by moving resources upstream, targeting health improvement, emphasising preventative care, and ensuring that [health and social care] services are better integrated across the care pathway, without necessarily incurring additional cost. Correspondingly, the focus for providing some aspects of care is to shift resources away from the hospital sector and towards the community and home” (Scottish Government 2010).

In the current economic climate, there is little or no prospect of new investment in community health and social care services but until these services are in place it will be difficult to unlock expenditure currently tied up by emergency admissions to acute inpatient facilities. There is unlikely to be Scottish Government temporary funding to cover **double running costs**. Rather, the expectation appears to be that the IRF pilots will demonstrate that more effective and efficient ways of allocating and utilising the existing NHS and LA budgets can release the funding required to implement change. IRF is very important initiative and it will take some time for the pilot projects to deliver.

Finally, **preventative strategies and services** offer councils and health boards significantly reduced savings in the medium and longer term through deferring or delaying people's needs for longer-term care services.

Tackling socio-economic and resulting **health inequalities** is central to the preventative agenda. As NHS Tayside's draft Health Equity Strategy states: "Poverty kills early but it also causes decades of ill health before it kills. It is caring for this ill health that costs the NHS, and the taxpayers who fund it, so much money" (*Communities in Control*, 2009, page 39).

The importance of prevention is recognised in recent Scottish Government policy documents on eligibility criteria and in the draft policy on self-directed care:

> ….social care budgets cannot meet all of the demands. It is therefore crucial that resources from all responsible sectors are combined effectively….. For independent living to be a reality, people need to have access to housing, transport, new technology, education, jobs and leisure and recreation in the community. It needs the combined efforts of people themselves, their personal networks, their communities, universal services and other sector providers.
> Scottish Government consultation paper (2010): *A Strategy for Self Directed Support*, page 15.

The paper suggests that the solution lies within community planning, supporting "social work and other local authority departments and agencies to work together and combine their funding to achieve better outcomes for people who have personal and social support needs" (page 16).

At a time when mainstream services are equally under pressure, a targeted approach to prevention is required, based on clear evidence of which services and approaches can demonstrate that they prevent or delay the need for social care support. The recent Audit Commission report in England: *Under pressure: Tackling the financial challenge for councils of an ageing population* (February 2010) recommends developing policies and interventions to specifically address "the main reasons of social care need", which for older people were identified in the Wanless Report (2006) as:

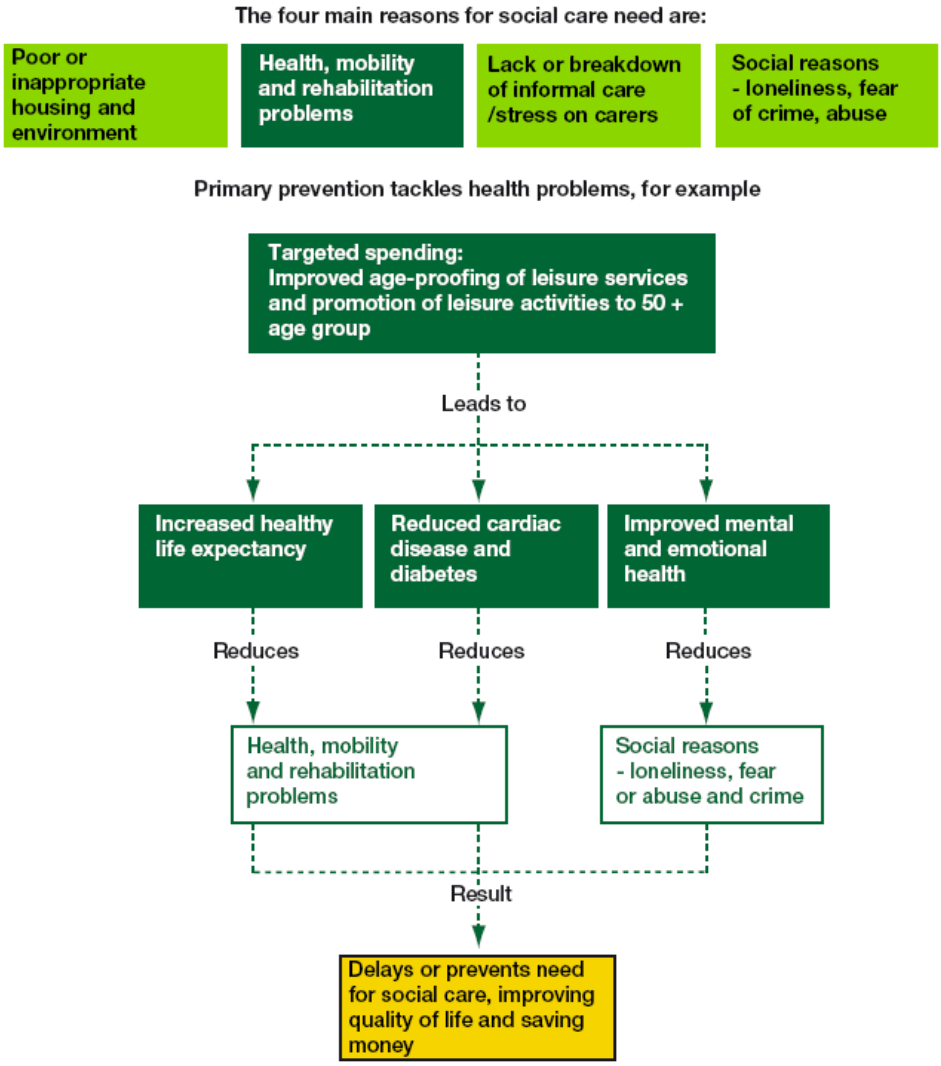
- Lack or breakdown of informal support/ stress on unpaid carer(s)
- Health, mobility, self-care problems
- Poor or inappropriate housing and environment; and
- Social isolation – loneliness, fear of crime, abuse.

Social care needs for other groups, such as children and families, would include other factors, such as drug and alcohol addictions, and associated preventative strategies. The Audit Commission's example of a targeted intervention for older people is shown in the slide overleaf.

The Audit Commission concluded that:

> An increasing older population doesn't just mean increasing need for social care. An ageing population provides opportunities to support and develop communities that demand less from tightened public resources. Wellbeing services can reduce demands on care services, and many older people are themselves carers. Coordinating the contribution of other services – including housing, leisure and culture, and transport, as well as other partners – is vital in supporting prevention and wellbeing.

Figure 7: **Investment in prevention can reduce demand for social care**



From: Audit Commission (February 2010): *Under pressure: Tackling the financial challenge for councils of an ageing population* Figure 7, page 39.

Other strands in the development of preventative services include:

- **Case finding and early intervention**, to target work with families with children, or older people at risk of emergency hospital admission, or people with dementia, where early intervention work can reduce the longer-term impacts;
- **Supported housing**, and **housing support**;
- **Equipment**, **assistive technologies** and **telecare** (covered in our response to Question (d));
- **Falls prevention** programmes;
- Joint health and social care **intensive care management** of people with long-term conditions or complex needs;
- Strategies to develop **health promotion**, **community resilience**, and **social capital** (partly covered in our response to Question (c));
- **Access to work**, particularly for adults with mental health problems or disabilities, and young people leaving care.

Question (f): Are there more fundamental changes to organisational structures or the way public services are provided which you see as essential or desirable in addressing the budgetary challenges facing the public sector in the short or medium term?

This has been covered in our response to Question (e) above.

Question (g): In the context of the remit and timescale of the Review and of the need for practical options, are there particular key issues which you consider should be addressed by the Panel for the purposes of its report?

The single most important challenge concerns the difficulty of redirecting resources – locked up in current services and models of care in the NHS as well as in Councils – towards early intervention and prevention, community capacity building, and new models of care such as re-ablement and personalisation.

First, there needs to be **greater national visibility for what works**. Individual councils and health boards need ready access to information about what initiatives work in terms of cost reduction, so that they can learn from others and implement successful ideas much more quickly. Much is being achieved already – by bodies such as the Improvement Service, within social care services by the Joint Improvement Team (JIT), by networks around particular workstreams such as the Integrated Resource Framework for health and social care, and by ADSW and other networks. However, significant enhancement to existing web-based clearing house functions is required to reduce duplication of effort and to cover the full cost reduction work programme described in our responses to the earlier questions.

Secondly, the public sector needs support to think and act strategically. Public expenditure reductions are likely to cover more than one Spending Review period and it will be important to balance short-term measures with work that has a **medium or longer term focus**, such as the strategic investments required now in support to carers and preventative services.

Thirdly, linked to this, dedicated "spend-to-save" **investment funding** will be needed to sustain initiatives that can deliver savings in the medium term or longer term: some could be repaid from future savings, and some will be on-off expenditure on double running costs

Fourthly, there needs to be a greater understanding of the interdependency between different parts of the public sector, to reduce **unintended consequences** of selective disinvestment, and to maximise joint opportunities.

Fifthly, there is a clear need for **consistent communications** by central and local government politicians about the challenges that public services face and the reasons for changes.

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