ADSW
ASSOCIATION OF DIRECTORS OF SOCIAL WORK

SCOTTISH PARLIAMENT FINANCE COMMITTEE
INQUIRY IN TO PREVENTATIVE SPENDING

ADSW RESPONSE

The Association of Directors of Social Work welcomes the Finance Committee's Inquiry into Preventative Spending and is pleased to respond to the call for evidence.

Social Work services support the most vulnerable people in our society, alongside the unpaid care provided mainly by family members. Local Authorities spent **£3.4 billion** (£3,409 million) in gross revenue expenditure on social work services 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% (£104m).

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). Demographic change continues to increase the need for services for older people and for people with disabilities, while social trends see growing alcohol and drug misuse and increased the numbers of children in need of care and protection.

These trends are set to continue into the future and there is a growing awareness that current social care service models, under intense pressure in the short-term, are not sustainable in the medium to longer term. This is also true for other parts of the welfare state, particularly for the NHS to which social care is closely linked.

Preventative spending to delay or avoid higher levels of need for services is potentially an important part of the solution to the funding crisis facing health and social care. The Finance Committee's Inquiry provides a timely opportunity to raise the profile of prevention and to identify the actions needed from central government, the NHS, local authorities, the third sector, and the wider community.

ADSW is keen to assist the Committee's work. Our response to the call for evidence first seeks to clarify some issues about the definition of prevention and then follows the questions set by the Committee:

The meaning of prevention

In the context of health and social care services, the term "prevention" has at least three different meanings. Each refers to services, initiatives, and spending, that:

1. Prevent or delay the need for more costly health and social care services, by reducing people's ill-health or disability, or by increasing self-care abilities and resilience;

2. Promote and improve people's quality of life, independence, engagement with the community, learning, or which create healthy and supportive environments;

3. Prevent inappropriate use of more intensive services for people with people given levels of need which could be met by lower cost services or interventions.

This third meaning of prevention is the focus of policies to "shift the balance of care", both within the NHS, between health and social care, and within social care itself. Examples include the shift from inpatient to day hospital and outpatient care; the replacement of NHS long-stay beds by local authority community care, funded partly by Resource Transfer; and the shift from increasing care home admission to more intensive care services in people's own homes.

It should be recognised that a very large proportion of local government social work expenditure, particularly in adult social care, goes on services that prevent hospital admission, or facilitate early discharge. Indeed over the last 20 years adult social care has increasingly re-focussed service on people with much higher care needs who previously would have been resident in long-stay hospitals or in nursing homes but are now resident in care homes or continuing to live at home with high intensity care packages. These trends are particularly evident in home care: client numbers per week have fallen from 74,000 in March 1999 to 68,300 at March 2009, but weekly hours increased from 375,300 to 645,806. Over this period the number of elderly clients per 1,000 population who were receiving 10 or more hours a week doubled. Increasingly, the home care service provides intensive personal care with far fewer people receiving mainly help with shopping and housework. In terms of service and budget planning, health and social care need to be looked upon as a single system.

In England, the Department of Health's 2008 guidance on "*Making a strategic shift to prevention and early intervention*" unpacks these first two senses of prevention, set out above, into "primary", "secondary" and "tertiary":

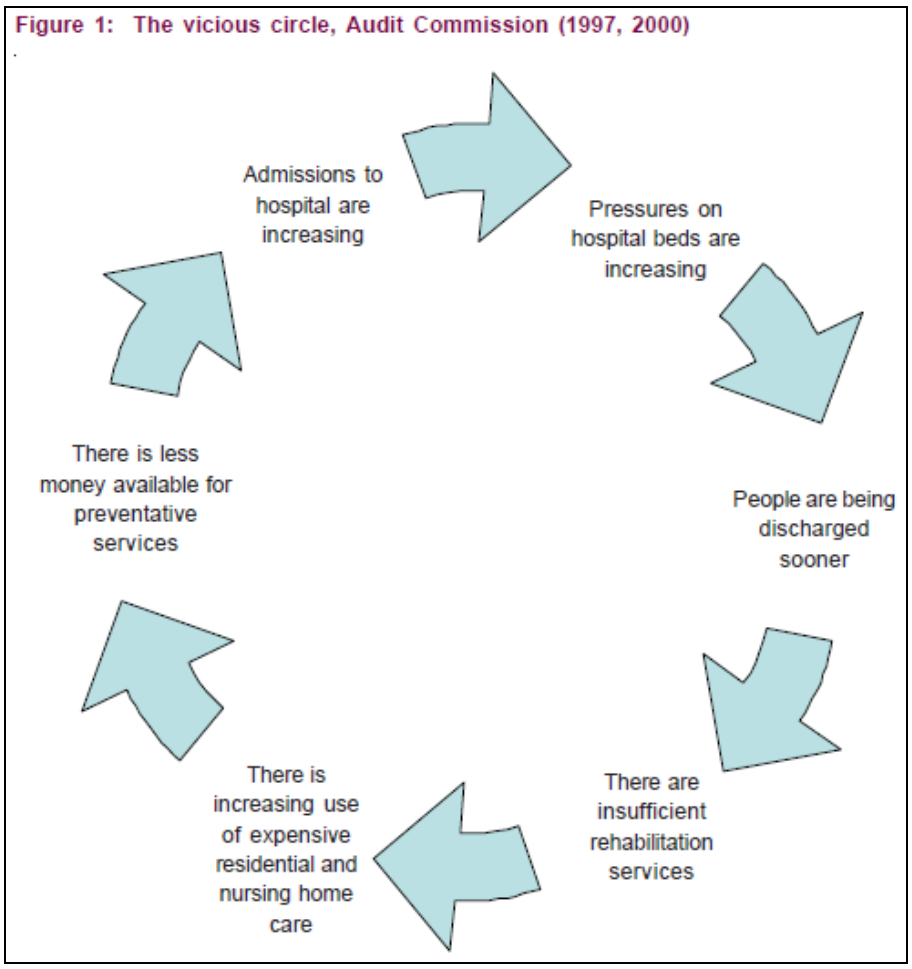
Type	Target group and aims	Example interventions
Primary prevention/ promoting wellbeing	Aimed at people who have little or no particular social care needs or symptoms of illness. The focus is therefore on maintaining independence and good health and promoting wellbeing.	Interventions include combating ageism, providing universal access to good quality information, supporting safer neighbourhoods, promoting health and active lifestyles, delivering practical services etc.
Secondary prevention/ early intervention	Aims to identify people at risk and to halt or slow down any deterioration, and actively seek to improve their situation.	Interventions include screening and case finding to identify individuals at risk of specific health conditions or events (such as strokes, or falls) or those who have existing low level social care needs.
Tertiary prevention	Aimed at minimising disability or deterioration from established health conditions or complex social care needs. The focus here is on maximising people's functioning and independence.	Interventions such as rehabilitation/enablement services and joint case management of people with complex needs.

Responses to the Finance Committee's consultation questions

Question 1: How can public spending best be focussed over the longer term in trying to prevent, rather than deal with, negative social outcomes?

The difficulty is that public spending can only cease dealing with negative social outcomes when they have been successfully prevented from occurring. But, particularly in periods of financial retrenchment, preventative services are likely to be those that are squeezed to protect spending on acute, high need cases. This is because most recipients of preventative services have lower levels of need currently, even if, without low level support, these needs will increase, eventually putting even more pressure on acute services.

These pressures therefore form a **vicious circle**, described for health and social care in England in Figure 1 below:



Clearly, there is a need to spend *both* to deal with negative social outcomes *and* on preventative services with evidenced effectiveness. Where there is insufficient money to *do both* at the required levels, then potential solutions include:

1. **Prioritisation** – deciding that dealing with some negative social outcomes are less important than others. UK and Scottish Ministers have already indicated their wish to prioritise health expenditure. ADSW believes that (i) "health" is a wider concept than simply the NHS and should include the social care and other local government expenditure on which the NHS depends. (ii) Prioritisation should not exempt health and social care from continuing to find efficiencies; for the NHS in Scotland these should include identifying opportunities from the work in England by McKinsey & Co (March 2009) commissioned by the Department of Health.

2. **Reduce the cost of services dealing with negative social outcomes**. The big ticket candidates are institutional services such as prisons and hospitals. For many types of offence, prisons perform far worse in terms of reconviction rates than community based disposals (Scottish Government, 2010: *Reconviction Rates*). Councils are already taking cost reduction opportunities in social care, building on a range of initiatives in recent years, including:

- greater **externalisation** (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);
- significant **procurement** improvements (including the development of national care contracts for expensive resources such children's secure accommodation, regional procurement for residential schools, increased use of tendering, and a switch from block to spot purchasing and framework agreements to support greater use of direct payments to clients and "self-directed care");
- **Service redesign**, including: **new models of care,** particularly to free up expenditure currently locked up in residential care by developing more supported housing and intensive support at home; changes to **staffing mix** to free up the time of the most qualified and experienced staff; more use of **call centres** for initial customer access; streamlined **business processes**, supported by **investment in ICT**; reviewing **high cost care packages**, **reducing unit cost**

variations; increasing **productivity** and better management of **sickness absence** with related reductions in the use of agency staff and overtime.

3. **Find other sources of funding** – for social care this primarily means increasing **charges to service users**. 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 to increase means-tested charges for some services for non-elderly adults.

4. **Develop other resources in the community**: promote the involvement of **socially responsible private firms** in supporting social care initiatives, develop **local community resources**, and 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.

Councils are already 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 and lower costs. The major constraints are time, learning from others what works, and finding resources to identify, lead and support innovation and change management. However, the evidence is that, due to the scale of the public expenditure downturn, all these workstreams and initiatives are in hand to deliver cost reductions *to be taken as savings*, not to free up funds for reinvestment in preventative services.

Question 2: What evidence can you provide from the UK and abroad to show that promoting preventative spending has been effective?

ADSW's knowledge of the evidence on the cost-effectiveness of preventative spending is inevitably incomplete – in this section we summarise some of the main evidence of which we are aware: much of this comes from England where prevention is a major element in government policy for the NHS and adult social care, and therefore in government funded social research. To help ensure dissemination of all the available evidence on prevention, **we recommend that the Scottish Government be asked to commission a literature review on the effectiveness of preventative initiatives**.

As social care services increasing were targeted at higher end of need, following the community care reforms of the early 1990s, concerns about the loss of "low level" services prompted research. In 1998 The Joseph Rowntree Foundation found that:

> …'low level' services, like help with housework, gardening, laundry, and home maintenance and repairs, both enhance quality of life for older people and help them maintain their independence. It found that keeping a well-maintained house was central to many older people's sense of well-being and of being part of society, as well as to their confidence about coping at home (Clarke & Dyer 1998).

The King's Fund commissioned a comprehensive review of the cost-effectiveness of Preventive Social Care in 2006 as part of the major Wanless Social Care Review. It found "a paucity of quantified information about the effectiveness of preventive services". Key findings are worth quoting fairly fully (Curry 2006, some emphasis added):

- There is a strong financial case for **reducing hospitalisation** (particularly through **falls**) and for reducing the rate of institutionalisation by **maintaining independence**. However, the evidence as to what is effective in bringing about these reductions is rarely quantitative.
- There is a wealth of qualitative information to suggest that **low-level interventions** are highly valued by older people and that they can be effective in maintaining independence. However, there is a lack of robust evidence indicating that such low-level interventions are cost effective. Some evidence obtained through small-scale trials suggests that small interventions, such as **issuing older people with slippers that fit properly**, could save millions of pounds through preventing falls and reducing the rate of institutionalisation. However, establishing a direct causal relationship between such interventions and long-term financial savings has proved problematic.

- There is a lack of consensus over the cost effectiveness of **intermediate care**. Generic intermediate care has frequently been found to be not cost effective, although some studies have found that generic intermediate care is effective in reducing lengths of stay through facilitating timely discharge. There is stronger evidence for the cost effectiveness of intermediate care services that target specific groups/illnesses/events such as stroke and falls.
- Evidence for secondary **stroke prevention** services is perhaps the strongest, and most widely quantified, body of research. However, interventions vary widely as to their cost effectiveness. There is some evidence that primary prevention strategies (such as smoking cessation and reduced salt intake) have potential to reduce the incidence of stroke.
- Quantified evidence for **wider community services** has not been identified, although there is some effectiveness evidence around public health interventions, such as **smoking cessation**. Smoking cessation services tend to be relatively cost effective but it has seemingly proved too complex to measure the cost effectiveness of community services that are essential for an independent life and social inclusion (such as **public transport** and **other amenities**).

Similar views were expressed by Research in Practice for Adults in their "evidence cluster" on prevention (RIPFA, 2006). The Wanless Report included the recommendation that:

> Given the difficulty of collecting robust evidence about the impact of low-level preventive services, a proactive approach should be encouraged whereby certain promising intervention could be implemented and formally evaluated during roll-out (Wanless, 2006, page 172)

This advice was followed in England in the Department of Health's **Partnerships for Older People Projects** (POPPS). Partnerships in 29 local authorities developed 146 core projects (with a further 530 smaller projects being developed by the third sector) between 2006 and 2009 to promote health, well-being and independence, and prevent or delay the need for higher intensity or institutional care. The Department of Health provided £60m in funding, and nearly 265,000 people used POPPS services. The POPPS were evaluated by academics at the Personal Social Services Research Unit using a wide range of research methods:

- The reduction in **hospital emergency bed days** resulted in considerable savings, to the extent that for every extra £1 spent on the POPP services, there has been approximately a £1.20 additional benefit in savings on emergency bed days….**Overnight hospital stays** were reduced by 47% and use of **Accident & Emergency** departments by 29%. Reductions were also seen in physiotherapy/occupational therapy and clinic or **outpatient appointments** with a total cost reduction of £2,166 per person
- A practical example of what works is pro-active **case coordination** services, where visits to A&E departments fell by 60%, hospital overnight stays were reduced by 48%, phone calls to GPs fell by 28%, visits to practice nurses reduced by 25% and GP appointments reduced by 10%
- Efficiency gains in health service use appear to have been achieved without any adverse impact on the use of social care resources
- The overwhelming majority of the **POPP projects have been sustained**, with only 3% being closed – either because they did not deliver the intended outcomes or because local strategic priorities had changed […]
- POPP services appear to have improved users' **quality of life**, varying with the nature of individual projects; those providing services to individuals with complex needs were particularly successful, but low-level preventive projects also had an impact
- All local projects **involved older people** in their design and management, although to varying degrees, including as members of steering or programme boards, in staff recruitment panels, as volunteers or in the evaluation
- Improved **relationships** with health agencies and the voluntary sector in the locality were generally reported as a result of partnership working, although there were some difficulties securing the involvement of GPs. (Windle et al, 2010, with added emphasis in bold).

The PSSRU findings raise issues about organisational boundaries between health and social care:

> This evidence of the POPP projects leading to cost-reductions in secondary, primary and social care was similarly demonstrated by many of the local evaluations. The main difficulty for sites was translating the evidenced cost-reduction into a cost saving. Moving monies around the health and social care system was a huge challenge, and proved an insurmountable one where budgets were the responsibility of more than one organisation. For instance, monies could be moved from residential care budgets to home care budgets within a local authority, but a claim for monies by a

> local authority from either primary or secondary health care budgets did not prove possible. (Page 8).

The evaluation concluded that:

> The POPP programme … has shown that small services providing practical help and emotional support to older people can significantly affect their health and well-being, alongside more sizeable services expressly directed to avoiding their need for hospital. Most of the older people using POPP services had relatively high levels of need, but they nonetheless experienced improved outcomes and reported greater satisfaction than the comparison group, as a result of using these services. […]
>
> These gains were secured by pump-priming prevention and early intervention projects. Their cost-effectiveness gains cannot be fully realised unless cashable savings can be released and re-invested in such projects. Initially, only marginal savings may be identified. **Some degree of financial systems reform is likely to be necessary to support the decommissioning of services in one part of the health and local government system alongside the re-investment of resources elsewhere**. From the results of this evaluation, it can be argued that the approach piloted by the POPP programme should be sustained, using the programme's learning to target investment to maximise individual and systems benefits. The realisation of the **cost-effectiveness gains will be dependent, however, on the introduction of systems to support decommissioning and reinvestment**. (page 10, emphasis added)

In Scotland, such strategic decommissioning urgent needs to redress the imbalance between the high levels of acute NHS hospital provision and less well-funded community health and social care. This is a significant political challenge that needs leadership, public debate and engagement, to be successful. Otherwise we will continue to be stuck in the **vicious circle** identified by the Audit Commission.

The Scottish Government is dealing with these issues partly by 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.

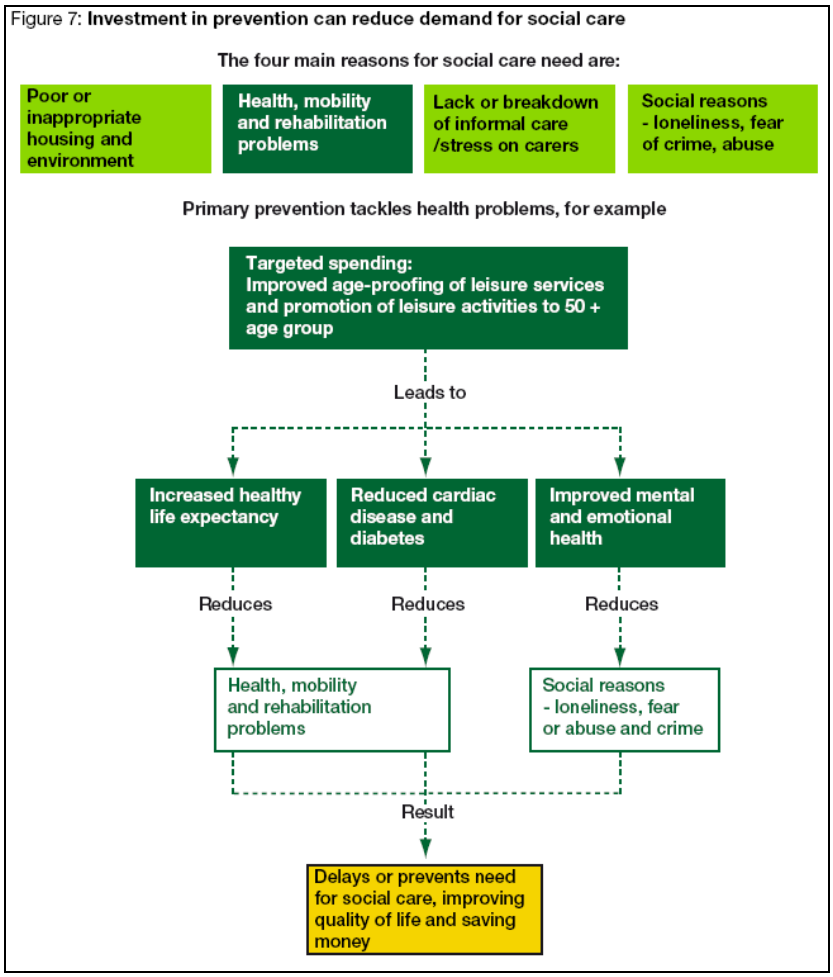
> The policy aim is to improve health and wellbeing by moving resources upstream, targeting health improvement, emphasising preventative care, and ensuring that [health and social care] services are better integrated across the care pathway, without necessarily incurring additional cost. Correspondingly, 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.

The PSSRU research noted the importance of targeting prevention and early intervention on groups of people most likely to benefit form them. A 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 below.



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

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.

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 recent *Marmot Strategic Review of Health Inequalities in England post-2010* identified **early years services** and **ill-health prevention** among 20 recommendations supporting six policy objectives to tackle the social gradient in health:

Policy Objective A:	Give every child the best start in life
Policy Objective B:	Enable all children, young people and adults to maximise their capabilities and have control over their lives.
Policy Objective C:	Create fair employment and good work for all
Policy Objective D:	Ensure healthy standard of living for all
Policy Objective E:	Create and develop healthy and sustainable places and communities
Policy Objective F:	Strengthen the role and impact of ill health prevention

Marmot's Executive Summary states:

> The importance of investing in the early years is key to preventing ill health later in life, as is investing in healthy schools and healthy employment as well as more traditional forms of ill-health prevention such as drug treatment and smoking cessation programmes. The accumulation of experiences a child receives shapes the outcomes and choices they will make when they become adults.
>
> Prevention of ill health has traditionally been the responsibility of the NHS, but we put prevention in the context of the social determinants of health. Hence, all our recommendations require involvement of a range of stakeholders. Local and national decisions made in schools, the workplace, at home, and in government services all have the potential to help or hinder ill-health prevention.
>
> At present only 4 per cent of NHS funding is spent on prevention. Yet, the evidence shows that partnership working between primary care, local authorities and the third sector to deliver effective universal and targeted preventive interventions can bring important benefits.

Marmot argues that "*health inequalities are a matter of social justice*", but the report also makes a compelling economic case (each point of which is supported by referenced research):

> If everyone in England had the same death rates as the most advantaged, people who are currently dying prematurely as a result of health inequalities would, in total, have enjoyed between 1.3 and 2.5 million extra years of life. They would, in addition, have had a further 2.8 million years free of limiting illness or disability. It is estimated that inequality in illness accounts for productivity losses of £31-33 billion per year, lost taxes and higher welfare payments in the range of £20-32 billion per year, and additional NHS healthcare costs associated with inequality are well in excess of £5.5 billion per year. If no action is taken, the cost of treating the various illnesses that result from inequalities in the level of obesity alone will rise from £2 billion per year to nearly £5 billion per year in 2025.

The detailed report states that "the evidence that does exist suggests that ill health prevention generally does work and can reduce costs to the health system…. **statins**, **paediatric immunizations**, and **smoking cessation** have been found to be among the most cost-effective ill health preventions" (page 141). **Drug treatment programmes**, and both population-wide and targeted interventions on **smoking**, **alcohol reduction**, and **obesity** are also recommended (pages 142-146).

"Social care services are by and large delivered to people with social and health disadvantage, a large proportion of whom are already ill and/or disabled. Social work and social care have established experience of working with marginalised groups, and may play an important role in promoting individual and community health and wellbeing". (Coren et al 2010). In work intended to complement the Marmot Review, the Social Care Institute for Excellence (SCIE) reviewed research findings for social care impacts on health inequalities, via impacts on health and wellbeing for four disadvantaged groups of social care service users. The evidence was stronger for **early years programmes** (eg Sure Start) and for **extra care housing for older people**, than for **kinship care** for looked-after children, or **parenting programmes for parents with learning disabilities**, although there were some positive findings in all four areas, depending on levels of support and resources (Coren et al 2010).

Finally, 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

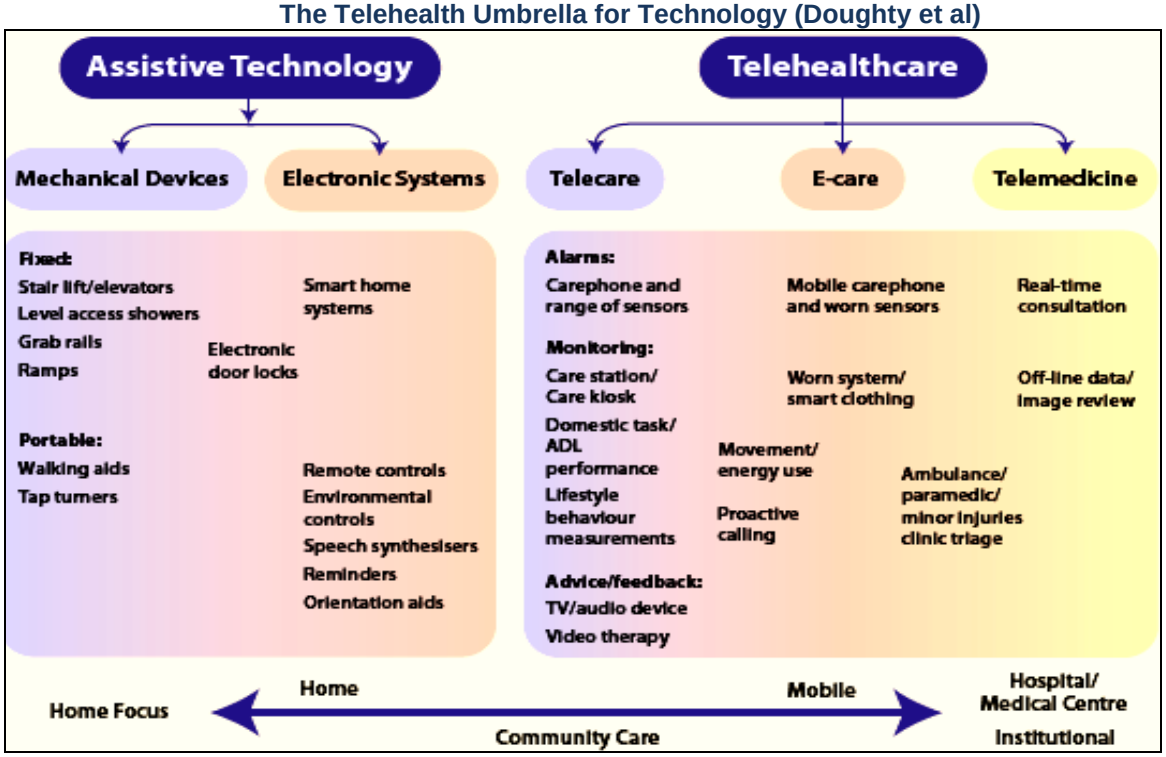
> The most significant finding has been the Care Services Efficiency Delivery (CSED) programme studies on re-ablement domiciliary care services, where up to 50% of older people who were offered a short-term package of re-ablement based care did not require further social care support at the end of their 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.

Other areas of prevention that have not been covered in our response to Question 2 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**;
- Joint health and social care **intensive care management** of people with long-term conditions or complex needs;
- **Access to work, particularly for adults with mental health problems or disabilities, and** young people leaving care.

Question 3: The Finance Committee has recommended that the Scottish Government continue to direct its spend towards preventative programmes. Which programmes should be prioritised?

Priorities should reflect the preventative programmes that offer the large scale, well-evidenced benefits in terms of outcomes, including the prospects of savings. Without a more systematic appraisal of that evidence it is difficult to offer a definitive answer, but leading candidates for social care include **support to carers**, **early years services**, **support for young people in transition** from care, **drug treatment** programmes, public health initiatives on **alcohol misuse** and **obesity**, **reablement**, **rehabilitation**, and **telecare**.

Support to carers should be one of the highest priorities. Partners and family members provide the majority of personal and other social care in Scotland, as in the rest of the UK, and the loss of a carer, or the breakdown of that care, is one of the major triggers for high intensity health and social care. It is essential on economic as well as moral grounds that carers receive the support they need.

Question 4: To what extent is preventative spending effective in addressing the financial impact of demographic change?

Where preventative spending is effective, it will reduce future spending below what would otherwise have been needed. Demographic change increases future need to spend. What is not clear is whether the future sums saved preventatively are larger or lesser than the additional funding needed for demography.

The growth in local authority social care spending on older peoples' services required to meet demographic pressure is **2.6% per year** over the six years to 2016-17 before inflation (ADSW calculation). These costing are based on the reasonably reliable future population projections for older people produced by the General Register Office (Scotland), although it should be noted that previous projections have tended to under-estimate increased longevity and therefore the numbers of the very elderly age-groups whose need for health and social care services is greatest. No such reliable estimates exist for numbers of people with learning or physical disabilities, despite evidence that numbers are increasing due to greater survival at birth and in all age-groups (NHS Health Scotland, 2004).

Estimates for future numbers of adults with learning disabilities in England prepared by the University of Lancaster in 2008 depend on the rationing strategy adopted; nevertheless all estimates are far higher than the 1% per year assumed in the Scottish Executive's *The Same As You* strategy 2000:

Numbers of adults with learning disabilities.

Average annual percentage increases, 2011-15 (5-year period)

	Estimation range		
Rationing scenario	**High**	**Medium**	**Low**
New entrants with Critical or Substantial Needs Only	2.9%	1.8%	1.2%
New entrants with Critical or Substantial Needs and 50% of New entrants with Moderate Needs	4.7%	3.6%	3.0%
New entrants with Critical, Substantial or Moderate needs	6.2%	5.0%	4.6%

Derived from Emerson (2008), University of Lancaster

These are significant increases in demand, as are those for addictions, child protection, and children in need. Consequently, large scale savings from prevention would need to be delivered over this period to offset them, alongside the large scale savings required by public expenditure reductions.

<u>Question 5</u>: What are the main barriers to trying to focus spending on preventing, rather than dealing with, negative social outcomes? Is a focus on preventative spending less likely in the current financial climate?

If the words "social outcomes" were replaced in the first question by "climate change", say, then the answer to this question would need to include: a human nature that is rooted in past evolutionary pressures to deal with the present and the short-term, powerful vested interests, and imperfections of knowledge and rationality. The same general barriers apply to preventing negative social outcomes. More specific barriers can be found in each area of social expenditure.

The financial downturn makes current levels of preventative spending harder to sustain, yet alone the shift towards prevention that is required. As we noted under Question 2, the recent *Strategic Review of Health Inequalities in England* (Marmot 2010) recommended "prioritis[ing] investment in ill health prevention and health promotion across government departments to reduce the social gradient [of ill-health]" but noted that in the NHS "*public health budgets are … often seen as the first budgets to raid when wider organisational budgets are pressurised*" (page 141). A recent Social Care Institute for Excellence (SCIE) research briefing on *The contribution of social work and social care to the reduction of health inequalities* (Coren 2010) found that:

> The social care sector is not resourced to pay attention to some of the core social determinants of health and, in particular, to money and housing. For example, programmes aimed at supporting parents cannot compensate for low incomes and environmental deficiencies. … Reduced budgets and increased caseloads within professional social work have discouraged involvement in debt counselling, community engagement and other social determinants of healthy living. (Pages 17-18)

In social care, many commentators have noted that councils tighten eligibility criteria in response to tighter finances. Scottish Government/COSLA guidance criteria on eligibility for social care for older people and adults (SG 2009), and similar revised guidance in England (DH 2010), stress the importance of continuing to provide advice, lower level social care services, engagement with mainstream services and local community resources, in order to assist people to meet needs which would otherwise fall below eligibility thresholds, but which, without assistance, are likely to worsen, and cost more in the medium to long-term.

But, reduced budgets are very likely to mean that local authorities will struggle to fund services for people assessed with critical and substantial needs, so funding for preventative responses for people with currently moderate or low social care needs is very likely to be cut. Evidence from England (Audit Commission, 2008) is that this is a false economy.

<u>Question 6</u>: How do we ensure that we monitor the impact of preventative spending over the longer term and shape budgets accordingly?

It is far from easy to establish systems to monitor the impact of preventative spending. Prevention is about outcomes that more often relate to the medium or long term, than to the present or short-term. The measurement of outcomes is at a fairly early stage, despite significant effort over the last 10 years by academics and by central and local government across the UK, and abroad. The most effective outcomes measures are based on longitudinal research, not routine statistics, and this proves expensive and time-consuming. That is not an argument against such research, for the same is true for other areas of welfare state spending, such as testing the cost-effectiveness of drugs and medical or surgical interventions.

Attempts to collect routine statistics on outcomes – such as the Scottish Government's Community Care Outcomes Framework – necessarily use proxies for outcomes: these are not always satisfactory as measurable indicators of unmeasured wider outcomes. Some proxy measures are useful for measuring progress and those recently proposed by the Department of Health in England (January 2010) for prevention and early intervention for older people are given below [ADSW comments in brackets added]:

- [reducing] proportion of overall budget spent on institutional care;
- [reducing] number of long-term placements made straight from hospital;
- [reducing] emergency admissions per head of population;

- [reducing] lengths of stay for key pathways (e.g. stroke, chronic obstructive pulmonary disease, dementia);
- [reducing] delayed transfers of care;
- [reducing] admissions to long-term care per head of population;
- [increasing – but measures unclear] achieving independence for older people through rehabilitation/ intermediate care;
- [reducing] incidence of fractured neck of femur; and
- [increasing] number of patients registered with GPs as having dementia, as a percentage of the expected local 65+ population with dementia.

Notwithstanding measurement problems, there is a growing body of research evidence in the UK about the effectiveness of particular types of health and social care preventative initiatives, services and spend. As already noted, the Scottish Government could usefully commission a literature review of published studies of preventative spend in health, social work and social care: this would help disseminate the findings, and build knowledge of "what works" to be translated into practical action on the ground. It would also help identify major gaps in the knowledge base.

Collaboration between government health departments for England, Scotland, Wales and Northern Ireland could also assist the avoidance of duplication in research funding and help target such funds on issues that could deliver the greatest benefit.

Question 7: Is the effectiveness of a preventative spending programme influenced by whether the relevant services are provided by the public, private or voluntary sector?

We have no information on this issue but suspect that there will be some preventative initiatives that need to be hosted by the public sector, and some by the voluntary sector, but there will be others which could be hosted by either sector, or by the private sector.

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