THE ASSOCIATION OF DIRECTORS OF ADULT SOCIAL SERVICES (ADASS)
SUBMISSION TO
THE ALL-PARTY PARLIAMENTARY LOCAL GOVERNMENT GROUP INQUIRY:
SERVICES FOR OLDER PEOPLE

1. BACKGROUND TO ADASS

1.1 The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in Local Authorities in England. As well as having statutory responsibilities for the commissioning and provision of social care, ADASS members often also share a number of responsibilities for the commissioning and provision of housing, leisure, library, culture, arts and community services within their Councils

1.2 The Association is able to bring together tremendous breadth, depth and accumulated experience on all issues covering managerial policy and professional activities of Adult Social Care departments and cross cutting issues with Children's Services departments and NHS organisations.

1.3 Our members are jointly responsible through the activities of their departments for the well-being, protection and care of thousands of vulnerable people and for the promotion of that well-being and protection through the use of direct services as well as the co-ordination of and liaison with the NHS, voluntary agencies, private companies and other public authorities.

1.4 Our members have leadership responsibilities in Local Authorities to promote local access to services and to drive partnership working to deliver better outcomes for local populations. They participate in the planning of the full range of council services and influence Health Service planning through formal and informal Local Strategic Partnership arrangements.

2. INTRODUCTION

2.1 ADASS is pleased to be provided with the opportunity to submit evidence to the APPG Inquiry into Services for Older People. Directors of Adult Social Services (DASS) as stated above have statutory responsibilities for social care but the

majority also have extended responsibilities for the commissioning and provision of housing, leisure, culture and other services within their local authorities. DASS are therefore in a prime position to promote and develop locally the well-being agenda, ensuring that all services work together to create healthy communities where older people can live independent, happy, and fulfilling lives.

2.2 Adult Social Care is at a crossroads. The changing demographics and increased expectations do not sit comfortably within a climate of financial restriction and greater demand for efficiencies. Whilst there have been some excellent examples of initiatives that have lead to efficiencies for example improved procurement and outsourcing services to the independent and third sector, we are fast moving towards a cul-de-sac where we will find it more difficult to elicit more savings yet at the same time demonstrate that Councils are committed to investing more in the well-being agenda and support to vulnerable people in our communities.

2.3 The evidence below outlines the demographic changes and their financial implications, the policy background within which Local Authorities are operating, and addresses the questions posed in the call for evidence.

3 EXECUTIVE SUMMARY

3.1 Demographic, Financial & Policy Context

(i) The changing demography of Great Britain is exerting pressure on adult social care budgets with already less money being invested in the social care of people with low to moderate needs.

(ii) The position is likely to worsen as over the next fifty years the number of people aged 65+ will increase from approximately 9 million to more than 16 million, representing over a quarter of the total population and it will be less likely that there will be extended family support.

(iii) In the immediate future the number of people aged 85+ is forecast to rise by over 2 percent each financial year between 2008 / 9 and 2010 / 11. The number of people suffering from dementia, two thirds of whom are aged 80 and over is set to increase by 38% over the next 15 years and by 154% over the next 45 years

(iii) At a time therefore of increasing demand and expectation the November 2007 Comprehensive Spending Review settlement only agreed limited and unevenly distributed growth in the statutory sector budgets and requires further substantial efficiency savings to the considerable efficiencies delivered under the Gershon Review.

(iv) Evidence from a range of studies support that earlier intervention before people reach high levels of need to be more cost effective and provide better outcomes for people and the national policy trend encourages resources to be targeted at prevention and the promotion of health and wellbeing for a wider number of people.

(v) The Wanless review predicts a rise in care costs of £14bn by 2026 if services continue to be provided along current lines lending further support for a strategic shift in the way care for older people is planned and delivered.

3.2 **Service Integration**

(i) The success of achieving integrated services is based on having common objectives, robust joint commissioning plans and strategic needs assessments that evidence the added benefits of integration.

(ii) Integration is often seen as the domain of health and social care services but there are many examples around the country of excellent joint work with leisure, housing culture and library services in promoting health and wellbeing and supporting independence.

(iii) Barriers to appropriate integration include financial challenges of one or more partners, cultural difference in organisations, different performance priorities and the challenges of health being free at the point of delivery with a means tested approach to social care, housing, benefits and other services.

(iv) If all barriers were removed there would be seamless access to core services, supported by both generic and specialist workers from one source that concentrates on the needs of the individual. This would be beneficial to customers who would receive services close to home and through a single access point. They would also benefit from being seen from a holistic point of view rather than having to attend separate services and waiting and in some cases considerable times to be seen. Removing these barriers would enable people to see the service being provided and not the different organisations providing separate unconnected services, which is confusing and costly to provide for both organisations and for the people using them.

3.3 **Involving Older People**

(i) There are a range of mechanisms where older people are already playing a strong role in care in the community, for example, inclusion on local Boards and forums and indeed there are many examples where older people are extensively engaged in delivering care themselves through their voluntary work. In most voluntary day centres around the Country the gap in years between the users and many of the volunteers is small.

(ii) The contribution and value of older people, their experiences, learning, knowledge and traditional values should be harnessed in areas such intergenerational issues. It is therefore regretted that Lifelong Learning resources have been so drastically targeted towards young people. There is a strong case for investment in the talents and experience of Older People.

3.4 **Minimum Standards**

(i) A national minimum standard for care would be in line with many other developments in approach to quality assurance. Although national minimum standards in care should ideally cover all aspects of social care this would be

difficult to monitor and review particularly with regard to informal care arrangements such as family care and potentially for the less formal arrangements that may arise from direct payments and individual budgets.

(ii) A key challenge is whether the proliferation of national standards will erode local autonomy within local government, and raises issues for further debate. For example, would the development and enforcement of national standards remove the right to local administrations to determine proportionate spend on health and social care, and conversely would it therefore remove the current postcode lottery?

(iii) Local Government finance system delivers differential funds to authorities and along with local decisions / prioritisation mean that moves to establish any form of entitlement through common resource allocation models would be likely to require a review of the whole system of local government finance.

(iv) The Commission for Social Care Inspection guidelines should provide the consistency and standards for care and all public, independent and voluntary sector providers should comply with these standards.

3.5 Investment in Prevention

(i) ADASS strongly believes that investment in prevention; early intervention and community-based services will result in a change to existing typical patient pathways, diminishing the current high demand for acute crisis orientated services. In partnership health and social care organisations must take bold measures to redirect resources towards community-based services in order to promote health and well-being and ultimately diminish the future requirement for costly acute services whether they relate to physical or mental ill health.

(ii) Evidence is emerging to support an invest to save approach but the lead time for achievement of savings causes a problem with the need to fund investment in prevention up front.

(iii) Moving funding away from acute services towards preventative is fraught with difficulties. When resources are stretched to the limit it is clear that those in the most acute and immediate need should and will receive scarce resources in order that their needs are met.

(iv) Government pump priming of preventative services for mid term periods may be an option that should be seriously considered.

4 DEMOGRAPHICS AND FINANCES

4.1 Great Britain's population profile is ageing as the post Second World War baby boomers near retirement and their families grow progressively older. Additionally people are living longer but are less likely to have the support of a local extended family. Over the next fifty years the number of people aged 65+ will increase from approximately 9 million to more than 16 million, representing over a quarter of the total population, and whilst we are less likely to have extended family support there are still more than 6 million carers looking after family, partners and friends. In the

immediate future the number of people aged 85+ is forecast to rise by over 2 percent each financial year between 2008 / 9 and 2010 / 11. The number of people suffering from dementia, two thirds of whom are aged 80 and over is set to double within a single generation (the next 30 years) and to treble in cost. Dementia is a hugely expensive illness not only with regard to health and social care budgets but also the cost of lost earnings of carers and consequent lost tax revenue to the Exchequer. In sum, changing demographics are already exerting pressure on adult social care budgets and, consequently already less money is being invested in the social care of people with low to moderate needs.

4.2 The channelling of resources to those with greatest need whilst discharging our wider responsibilities is challenging local and health authorities across the country. At a time of increasing demand and expectation the Comprehensive Spending Review settlement announced in November 2007 has not made future decision making any easier. The settlement has for the next three years agreed limited and unevenly distributed growth in statutory sector budgets but requires further substantial efficiency savings.

4.3 This settlement is against a backdrop of the King's Fund report prepared by Sir Derek Wanless which projects that as a result of the changing demographics, care costs will rise from £10bn in 2002 to £24bn in 2026 if services continue to be delivered along current lines. Projecting the level of resources required to provide care for those with relatively low needs, as required in the 'Our Health Our Care Our Say' White Paper increases the costs in 2026 to £31bn. It is this White Paper that has informed the context for the local authority circular Transforming Social Care published in January 2008. The consultation responses to the White Paper confirmed that people want adult social care to make provision for a range of needs with a greater focus on using preventative approaches to promote independence and well-being, To make this happen' Putting People First' calls for the sector to develop a new shared vision following a clear direction:

'to make personalisation, including a strategic shift towards early intervention and prevention, the cornerstone of public services. In social care this means that every person across the spectrum of need having choice and control over the shape of his or her support, in the most appropriate setting.'

4.4 The Circular continues by recognising that whilst, nationally more people are being supported to live independently at home, at the same time resources are increasingly targeted at those with the greatest need. This is despite emerging evidence from the Partnerships for Older People Projects (POPPs) and other studies and trials that indicate that earlier interventions before people reach high levels of need may be more cost effective for the social care system and provide better outcomes for individuals

4.5 In summary resources in the short term are likely to decrease and demand and expectation will continue to increase at a rate that outstrips any projected moderate growth in the longer term. We need a change to the traditional model of service provision, alongside a fundamental review of the way in which long-term care is funded as promised by the forthcoming Green Paper for reform of adult care and support.

5 THE POLICY BACKGROUND

(i) The Governments policy intentions for older people can be taken from numerous publications

5.1 Putting People First 2008

(i) The Department of Health and its partners want to achieve the transformation of social care to deliver support tailored to individuals and local populations irrespective of their circumstances or levels of need. Councils will be supported to make substantial progress on transforming their services over the next three years with performance across health and social care measured against relevant performance indicators.

(ii) Some Council's have been piloting the introduction of individual budgets and self-directed support and there is much development work being undertaken beyond the pilot authorities.

(iii) In relation to the Individual Budgets Pilot Programme run by the Dept of Health, in many of the 13 Individual Budget pilot sites, a significant number of older people have been allocated their own budgets and through support services provided are managing and arranging their own care. The West Sussex pilot site is offering Individual Budgets to older people only and last year exceeded their pilot target of older people who had consented to take up an Individual Budget.

(iv) In Lincolnshire where individual budgets were piloted across all age groups and disabilities there was a significant take up by older people and their carers who were keen to explore better ways of meeting their needs. For example one couple where a husband supported his wife decided to employ someone to undertake practical household tasks such as cleaning, washing and ironing so that the husband could provide the personal care his wife needed. Respite was provided by the same personal assistant, taking his wife to concerts that she loved and her husband hated, leaving him to pursue his hobbies and interests.

5.2 The National Service Framework for Older People 2001

(i) This outlines the government's 10-year strategy to integrate health and social care services for older people and promote independence, good health and culture change to ensure older people are treated with dignity respect and fairness

5.3 A New Ambition for Old Age: next steps in implementing the NSF for Older People 2006

(i) Provided new focus to work to carry forward the NSF with the aim that within 5 years older people and their families will have confidence that in all care settings, older people will be treated with respect for their dignity and their human rights, outcomes will be improved for older people's health, independence and well-being and money might be saved by reducing the overall demand for expensive hospital and long term care services

5.4 **Opportunity Age 2005**

(i) A national government strategy looking at approaches and relationships that will meet the future needs of an older society, which focuses upon 'active ageing as part of the community' and 'independence and control'

5.5 **Our Health Our Care Our Say (White Paper 2006)**

(i) Outlines the key health and social care challenges and a change in approach to meet these focussing upon services being designed around specific needs of the individual, better prevention, more choice, fewer inequalities, more support for those with long-term needs

5.6 **Lifetime Homes, Lifetime neighbourhoods: Housing in an ageing Society 2008**

(i) Promotes new standards to ensure homes are built to age friendly designs and new social housing to 'Lifetime Homes' standards. It announces a new drive with local planners to look at how new developments; neighbourhoods, towns and cities can be better designed for older people.

5.7 **No Secrets**

(i) This was published in 2000 and provides guidance to the statutory agencies on how vulnerable people should be protected. The co-ordination responsibility rests with the Local Authority.

6 HOW FAR HAS SERVICE INTEGRATION PROGRESSED AND WHAT KEY ELEMENTS NEED TO BE IN PLACE TO DEVELOP INTEGRATED SERVICES? WHAT WOULD SERVICES LOOK LIKE IF ALL THE BARRIERS WERE REMOVED ?

6.1 The starting point for achieving integrated services is to identify common objectives and outcomes, sustainable community strategies and LAAs can be effective vehicles to do this, and then ensure that robust joint commissioning strategies are in place which identify the service areas where outcomes could be improved through integration. ADASS has been involved in the Department of Health's world Class Commissioning programme and it is clear from this that most commissioning should be locally driven and fully involve all stakeholders in the health and well-being agenda e.g. NHS, adult social care, housing, public health, leisure, education as well as other relevant stakeholders.

6.2 Joint strategic needs assessments (JSNA) will identify the local needs and population trends in each area and joint commissioning strategies will follow on.

6.3 The success of the JSNA and joint commissioning will in part depend on the willingness of stakeholders to engage in and own the process, agreeing shared aims and objectives and committing resources. Strong local leadership will clearly be essential to bring about cultural change and a change in the way in which services are provided.

6.4 Recent reorganisations both within Local Authority social services and PCTs are likely to have delayed the timescales for achieving integrated services. Although these reorganisations will assist future PCT and LA integration, a period of consolidation is now required.

6.5 Integration is often seen in the context of adult social care and health services focusing on those people at greatest risk of loosing their independence as a critical event may either lead to their admission to hospital or permanent residential or nursing home care. There are many examples around the country of excellent 'intermediate care' services that demonstrate the realization of the potential effectiveness of integrated approached for people facing such critical points in their lives.

6.6 It is important however that we do not loose sight of the value of other partners and the benefits that integrated working with them can provide including those in the voluntary sector. For example in 2007 Lincolnshire County Council undertook a major engagement and consultation exercise with elderly and disabled people and their carers to identify what were their priorities for improving their quality of life. Of the eight identified as priorities, reducing social isolation, improving public transport and access to supported housing were in the top four. None of these will be delivered solely by the Adult Social Care department, but working with others they can be.

6.7 Other barriers to appropriate integration include financial challenges of one or more partners, cultural difference in organisations, different performance priorities and the challenges of health being free at the point of delivery with a means tested approach to social care, housing, benefits and other services.

6.8 Around the country there are many examples of integrated services and joint strategic planning. For example Leeds has an older people's strategic partnership and already in operation an integrated mental health rapid response team and health service staff working alongside social care staff in day services. Warwickshire has joint strategies for carers' services and older people's mental health services setting the scene for the next 5 years and implementation plans for these strategies are now being developed.

6.9 If integrated services are to succeed it is vital that the partners involved agree a shared value base at the outset. For example Leeds has developed an ethos that drives their Older Peoples Strategy:

- to work to ensure full participation of older people in the decisions and processes which affect their lives
- to use social approach to challenge barriers faced by older people to independence, inclusion and equality
- to maintain and promote older peoples independence for as long as possible
- to deliver care and support close to where people live or within their own homes
- to extend choice for older people within the context of flexible accessible services
- that older people should be treated with respect and dignity at all times
- there should be an holistic approach to care and support, joining up different elements across professions and agencies

- good practice should be shared across the city, across agencies, organisations and professions
- a positive view of old age should be promoted and older people enabled to lead active healthy and involved lives as citizens of the city.

6.10 The benefit of integrated services does not only apply to health and social care services but other services that have a role in promoting well-being. There are many examples up and down the Country of how other service have joined up and integrated, for example, many Local Authorities have integrated library and one stop shops where citizens can pay their Council Tax, review benefits, learn more about service provision as well as accessing library services. We also have many good examples of mobile benefits services, integrating with primary care to undertake health checks etc.

6.11 If all barriers were removed, there would be seamless access to core services, supported by both generic and specialist workers from one source that concentrates on the needs of the individual. This would be beneficial to customers who would receive services close to home and through a single access point. They would also benefit from being seen from a holistic point of view rather than having to attend separate services and waiting and in some cases considerable times to be seen. Removing these barriers would enable customers to see the service being provided and not the many separate organisations providing separate unconnected services, which is confusing and costly to provide for both organisations and for the customers using them.

7 DO YOU HAVE IDEAS FOR AND EXAMPLES OF USING OLDER PEOPLE'S TIME AND EXPERIENCE TO SUPPORT CARE IN COMMUNITIES, AND ARE THERE IMAGIANITIVE WAYS OF FORMALISING THESE IN ORDER TO RECOGNISE THEM AS PART OF THE CARE SYSTEM ?

7.1 We need to recognize the value of the contribution that older people can make within society, their experiences, learning, knowledge and traditional values are often not harnessed and intergenerational issues are a key issue between children/youths and older people and there is a necessity for NHS and Local Authorities to work together to breakdown barriers. Whilst there are obvious examples in anti-social behavior other opportunities include young carers of adults, alcohol harm reduction and drugs.

7.2 Older People are extensively engaged in delivering care themselves through their voluntary work. In most voluntary Day Centres around the Country the gap in years between the users and many of the volunteers is small. It will be important for the forthcoming White Paper on Empowerment both to acknowledge and address the distinctive contribution which many Older People make. That contribution needs to be sustained and developed through training. In that context it is regretted that Lifelong Learning resources have been so drastically targeted towards young people. There is a case for investment in the talents and experience of Older People.

7.3 There are many mechanisms where older people can play a strong role in care in the community, for example, inclusion on local Boards and forums. One model

which has been successful in Halton Council is the Youth Parliament and such models should also be considered for older people where their views and aspirations can be heard more forcibly within a democratic framework. Warwickshire has created an Older People's Partnership Board, which has 5 older people representing each Warwickshire locality. Board members were part of the consultation process in developing the older people's strategy and will oversee and monitor performance of the implementation plan to ensure that all actions arising from the strategy are achieved.

7.4 Warwickshire involves older people in the recruitment process for social care staff and they play an important role in stakeholder events. One of Warwickshire's Compact areas of focus is volunteering and community action, with the agreement to strengthen the supporting agencies that provide a volunteering infrastructure that can meet the opportunities, challenges and demands for community action and the active citizenship agenda.

7.5 Through its Community Partners Programme Wandsworth trains older people who have experience of using services to assess and evaluate the quality of care service and to undertake mystery shopping exercises.

7.6 In Leeds many 'neighborhood networks' are led by older people with a high percentage of older people working as volunteers. Older people are now carrying out dignity audits in care homes. Leeds are currently planning an Older People's Information Store to which older people will be actively contribute thereby making it interactive.

7.7 Through the Dept of Health's Partnerships for Older People Projects (POPP) a number of local authorities have involved older people in the design, implementation and evaluation of their POPP projects. Calderdale Council for example, through their healthy ageing programme, has developed a Neighbourhood Network Scheme offering a range of activities which has been set up and run by older people. Croydon Council has developed a mobile unit, a POP STOP, providing information and support for older people and carers and older people themselves, through a local voluntary sector organisation, are providing much of that information. Finally, Gloucestershire Council through their POPP Pilot, has involved older people in the evaluation, planning and inspection of local services.

8 SHOULD THERE BE A NATIONAL MINIMUM STANDARDS FOR CARE, AND IF THERE SHOULD WHAT CATEGORIES OF CARE – HEALTH, PERSONAL, INFORMAL SHOULD IT APPLY TO ?

8.1 A national minimum standard for care would be in line with many other developments in approach to Quality Assurance. For example safeguarding, the National Dementia Strategy and the Carers' Strategy that are both in development and the National Service Frameworks for Health that are already in existence.

8.2 Although national minimum standards in care should ideally cover all aspects and social care this would clearly be difficult to monitor and review particularly with regard to informal care arrangements such as family care and also potentially for

the less formal arrangements that may arise from direct payments and individual budgets.

8.3 One of the critical issues around standards is clarity in terms of consequences for failing to meet them – both what this means in terms of how LA's hold providers to account and how the LA's are themselves held to account.

8.4 Another challenge is whether the proliferation of national standards will erode local autonomy within local government, would the development and enforcement of national standards remove the right to local administrations to determine proportionate spend on health and social care, and conversely would it therefore remove the current postcode lottery?

8.5 Local Government finance system delivers differential funds to authorities and along with local decisions / prioritisation mean that moves to establish any form of entitlement through common resource allocation models would be likely to require a review of the whole system of local government finance.

8.6 Warrington Borough Council has taken a proactive approach to raising standards amongst its core providers. With in the region of eighty percent of care provided externally they have developed and promoted a regular provider forum, which has standards as a key agenda item.

8.7 Using information from complaints and feedback the commissioning and contracting approach, has used a system of enhanced payments only for those providers who meet the appropriate standards. Over a two-year period the percentage of providers achieving this standard has risen from 16 to 74.

8.8 Additionally, Warrington has used the approach to intervene with providers falling below the standard and has worked with them on a cooperative basis following contractual default. Using close monitoring this has enabled clients to be afforded better care standards and the council to clarify its raised expectations of quality.

8.9 Setting standards, particularly in the area of dignity is assisted by a mature approach to market management and cooperative working with the independent sector.

8.10 Induction and training are provided to external staff alongside internal recruits in order to both facilitate standard setting and create efficiencies. Feedback from providers is good and has been most enthusiastic from the small number with which the council has worked to address the need to raise standards. Regular contact is made with the local market in order to outline emerging needs and themes taking into account significant issues such as skills for care, safeguarding and future needs.

8.11 The Commission for Social Care Inspection guidelines really should provide the consistency and standards for care and all public, independent and voluntary sector providers should comply with these standards. However, the introduction of direct payments has the potential to provide a two-tier system with opportunities to monitor standards of care.

8.12 In addition, as the Independent Safeguarding Act does not require a direct payment recipient to undertake a Criminal Record Bureau check on their support worker means that vulnerable older people could be open to abuse. This is however strongly resisted by many service user groups as eroding choice and control and (for example in the case of family carers) unnecessary and productive of bureaucracy. With the introduction of the personalisation agenda and individual budgets there is clearly a need to establish good practice in this area.

9 WHAT SHOULD BE THE CORE OBJECTIVES AND KEY COMPONENTS OF SERVICES FOR OLDER PEOPLE THAT ARE DESIGNED AROUND THE INDIVIDUAL ?

9.1 The objectives of any service should be that it delivers against the outcomes set out in the White Paper OHOCOS, meeting the individual's needs, providing quality services and value for money. Services should be local, accessible, joined up and give customers choice and control. The components of the service would depend on the needs they were required to meet.

9.2 For people with dementia *"We want people to remember the infinite human variation and take a person centered approach to quality of care"*. There is a plea for *"people to really understand and respect the person living with dementia and their family."* The approach to supporting people with dementia should come from the perspective of the person being a citizen first and a person with dementia second. There needs to be an emphasis on individual needs assessment and person centered care that maximises independence and social inclusion.

9.3 People with dementia have said services must provide a joined up seamless service through early diagnosis to end of life care. People should get help and support at whatever point the diagnosis is made and in whatever setting.

(i) **Information:** People need information in a variety of ways, not just in paper form, but face to face, especially when first diagnosed. They need regular access to information that is specific and uses clear language, given by people who are competent. Carers need to be informed how they can access services. One-stop shops that could provide a range of information and signpost people to different services have been suggested.

(ii) **Early diagnosis:** There is strong support for the idea that people should have a right to be assessed promptly when they have certain symptoms; far too often this was not happening at present. Many find it very difficult to get a clear diagnosis, though some – more likely to be people with dementia themselves - did not always welcome the labeling that a diagnosis brought.

(iii) **Care Pathways:** Post diagnosis there should be an entitlement of a clear pathway with options for support. For carers it is important to have knowledge about available choices. They want the same person available for them to come back to for some time as "diagnosis is not an event", ideally to act as a navigator around support services and further advice; roles like key worker, care broker and advocate were mentioned. People need "s*upport along the journey* ".

(iv) **Acute hospital care:** The experience of many people with dementia in acute hospitals once their physical needs are met is poor. Care is poorly co-ordinated and symptoms misunderstood, reflecting a generally low level of understanding about dementia amongst acute care staff.

(v) **Home base support:** More innovative, flexible and person-centred service provision is required to enable people with dementia to remain living in their own homes. In particular, more specialist home care services with staff trained to work with people with dementia, providing longer time slots and visits based on need, e.g. late evening. This can be undertaken on an invest to save basis.

10 WHAT ARE THE REASONS THAT RESOURCES ARE NOT GOING INTO PREVENTATIVE SERVICES AND HOW CAN WE SHIFT FROM THE CURRENT PRIORITY GIVEN TO HEALTH FUNDING ? HOW CAN LOCAL GOVERNMENT MAKE A ROBUST CASE FOR CHANGE AND HOW CAN LONGER-TERM EFFICIENCY BENEFITS OF INVESTMENT IN PREVENTION BE EVALUATED AND MEASURED ?

10.1 ADASS strongly believes that investment in prevention; early intervention and community-based services will result in a change to existing typical patient pathways, diminishing the current high demand for acute crisis orientated services. We believe that, in partnership health and social care organisations must take bold measures to redirect resources towards community-based services in order to promote health and well-being and ultimately diminish the future requirement for costly acute services whether they relate to physical or mental ill health.

10.2 Evidence is emerging to support an invest to save approach but the lead time for achievement of savings causes a problem with the need to fund investment in prevention up front.

10.3 Moving funding away from acute services towards preventative is however fraught with difficulties. When resources are stretched to the limit it is quite clear that those in the most acute and immediate need should and will receive scarce resources in order that their needs are met. Who could argue that given a choice someone with a life threatening heart condition should be turned down for surgery in favour of the budget being spent on healthy eating literature? Likewise the care for a person in the final stages of dementia not funded with the money being spent on a social club instead.

10.4 As in most areas of public sector work, investment in prevention requires long-term vision followed by a long-term strategy that is very certainly matched by long-term resource commitments.

10.5 Funding may be agreed for preventative services at points where the budget is looking good but may be the first to be withdrawn when finances become tight thereby negating any long-term benefits. The degree of squeeze on council budgets at the present time makes new investment in prevention unlikely at this time. The current healthy state of many PCT budgets has led to recent investment in preventative services in some areas of the country.

10.6 Government pump priming of preventative services for mid term periods may be an option that should be seriously considered. Could a mechanism be developed whereby resources gained from acute sector efficiency savings be moved to community based services and preventative services? At present one of the key issues is that action taken in one sector may result in savings in another sector so attaining a method to secure a funding transfer or motivation to invest can be low e.g. investment in social care to prevent hospital admission.

10.7 Investment in longitudinal cohort based research into the benefits of preventative services would be extremely useful to ensure that most effective forms of prevention are funded.

10.8 The Care Services Efficiency Delivery Programme (CSED) is a DH efficiency programme established originally in 2004 to assist CSSRs meets "Gershon" efficiency saving targets. ADASS played an important role in the governance of CSED with the co-chair of ADASS Resources committee acting as co-chair (with LGA) of the CSED steering board. ADASS acted in support of CSED in a number of ways, some examples of which are listed below.

10.9 **The Opportunity Assessment for CSED programme - post Gershon**

(i) The CSED programme will be extended into the CSR 07 period and ADASS has played an important part in shaping the development of the efficiency programme for 2008 – 2011. This took place through a detailed assessment of efficiency opportunities required to help CSSRs meet the efficiency savings requirements of the CSR settlement. These are essential to assist Councils meet the demographic growth expected during this period. The co-chair of ADASS Resources committee acted as co-chair (again with LGA) of an overseeing stakeholder panel. Ten directors of Social Services were members of this group and, in addition to their governance role, directly participated in a major envisioning exercise that was used to shape and prioritise the future programme, ensuring that the needs of user groups were fully represented.

(ii) A large group of Assistant Directors (operational and finance) as well as business managers representing ADASS regional branches were also involved in the envisioning work. The proposed CSED programme emphasizes the importance of prevention, reablement and new models of support, including assistive technology and housing based solutions. These themes are especially important to older people, not only because older people's service represent the largest area of adult service spend but also because older people's services often bear the brunt of financial pressures and older people with lower levels of need are typically the largest group affected by increases in eligibility thresholds.

10.10 **Homecare Re-ablement**

(i) In support of the need to examine the potential benefits of Homecare re-ablement, CSED engaged with a large number of CSSRs to produce a discussion document on the subject. The ADSS Older Peoples' committee was supportive of this work and provided valuable guidance and comment on the direction following the launch of the discussion document.

(iii) The further work, supported by ADASS led CSED to commission a retrospective longitudinal study, which proved the value of re-ablement schemes by establishing evidence of the duration of benefit, displaying to councils the value in starting a new service or improving an existing one.

(iv) The study also gathered further information to inform the specification for a prospective study which aims to identify features that will maximise benefits, assess the impact of re-ablement activities on other areas of social care and health and determine what factors impact on the success of homecare re-ablement schemes.

(v) ADASS have indicated that they wish to continue their interest and involvement on this work to help CSSRs maximise the benefit for service users of homecare re-ablement schemes.

(vi) The CSED showed that by the end of 2006, sixty Local Authorities had re-ablement services of some kind with a further ten in the process of establishing such a service. Of these some were jointly funded, commissioned and managed by the Local Authority and PCT partners and some were funded, commissioned and managed by the Local Authority alone e.g. the Wandsworth Scheme outlined below.

(vii) The Wandsworth scheme is funded by Adult Social Services and provided by the in-house home care service. It began as a pilot in April 2006 and plans are now underway to create from the in-house team a permanent Intake and Reablement Service linked to the Councils statutory community care assessment process. All new home care referrals will in the first instance receive up to six weeks home care from the I &R service whose staff will be specifically trained in reablement and able to comprehensively assess over a period of time. At the end of this period people requiring on going home care will be referred to external providers.

10.11 **Transforming Community Equipment Services (TCES**)

(i) The objective of the Transforming Community Equipment and Wheelchair Services programme is to deliver an improved and efficient new model of service delivery that has users and carers at its heart.

(ii) A new conceptual model has been developed which is currently being successfully piloted with councils in the North West. ADASS and CSED are carrying out a joint review of the programme's financial model. The ADASS Resources sub Committee set up a review team of Finance Directors to undertake this joint review. This is seen as an important step to validate and confirm the benefits, cashable and non-cashable of the new model to all CSSRs throughout England.

10.12 **Front End Information**

(i) CSED and the North West branch of ADASS have been successfully collaborating on a project to examine the potential efficiencies and service improvements achievable by enhancing the quality of information available on council websites.

(ii) The work is being piloted primarily by Stockport Council (with 12 other regional councils in support) and will optimise the information on the council's website improving access for service users and reducing inappropriate calls to contact centres. Initial results have proved very positive and it is hoped that proven and validated benefits will be rolled out nationally.

10.13 **Putting People First**

(i) The shared ambition of the cross-government ministerial concordat - *putting people first* (PPF) is a radical reform of public services, enabling people to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual needs for independence, well-being and dignity.

(ii) The first programme board is due to take place on 7 May, which will include ADASS and other key stakeholders to oversee the personalisation agenda and the activities of CSED under John Bolton as the Senior Responsible Officer to oversee the transformation of social care.

(iii) The *putting people first* agenda and the transformation of the way in which care services are commissioned and delivered is a priority for ADASS. The Association through the President's team, personalisation leads, policy networks and regions will be working with the signatories to the concordat and other stakeholders to take this agenda forward. ADASS will work to ensure that those in need of health and social care services, including people able to fund their own services, have information, choice and control over the services they use and are able to shape services to meet their individual needs.

(iv) One of the ways to move the prevention agenda forward is to agree joint priorities and indicators between LAs and PCTs and to hold them jointly accountable. Currently Health services are under pressure to perform and achieve on the acute agenda for example the recent NHS vital signs (which had a strong focus on the acute end within its high level national requirements) targets demonstrated this. Differences in priorities and performance measurement indicators between local authorities and the NHS have in the past led to difficulties in agreeing and honouring joint funding arrangements. Local area agreements and sustainable community strategies offer an opportunity to come to cross over agreement to focus on preventative activity but there needs to be a formal resources plan with contributions from all parties to back these plans.

(v) It is suggested that the current regime of inspection and focus on PAF indicators does not lend itself to measuring volume and quality of preventative services. If LAs are seeking to be less risk averse and with PCTs investing more in community based prevention services, for example supporting local social networks, then regulators will need to fundamentally review how this approach is assessed.

11 CONCLUSION

11.1 In a climate of changing demographics, restrictions on public expenditure and rising expectations there must be a change in the way that care services are

provided. ADASS strongly supports the intentions of the forthcoming Green Paper to stimulate a public debate on and determine how, care for older people should be funded and provided in the future.

11.2 Integration is not just about structural change and integration of Social Services and PCT's. We need to recognise the key interface across the Public and Voluntary Sectors and ensure that the wellbeing and personalisation agenda is at the core.

11.3 New models of engaging older people are required and we need to harness their experience and knowledge to improve outcomes for older people and carers. We recognise that standards of care are improving incrementally, however, we need to ensure that we have a fair payment system to avoid future financial meltdown of our systems. At the same time we need to adequately protect vulnerable people through new legislation and ADASS have already put forward a seven point plan to address these matters.

11.4 Prevention should have greater profile as demonstrated in our submission we have evidence to suggest that prevention delays chronic conditions, improves outcomes and is a more efficient way of providing services.

11.5 ADASS is in a strong position to influence change and we believe that Social Services Directors should play a greater role in the future of commissioning services for older people within the NHS and Public Sector.

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