Health and Sport Committee Inquiry into Preventative Agenda
Response from Social Work Scotland

Social Work Scotland welcomes the opportunity to response to the *Call for Views on Preventative Spending*, issued by the Health and Sport Committee of the Scottish Parliament on 3 February 2017. Our response covers the four questions, as requested.

Question 1: Which areas of preventative spending/ the preventative agenda would it be most useful for the Health and Sport Committee to investigate?

Prevention may be broadly defined as: "Actions which prevent problems and ease future demand on services by intervening early, thereby delivering better outcomes and value for money." Scottish Government/COSLA (2012)[1].

We note that the remit for this inquiry is: "to seek evidence on and analyse preventative spend through a series of short inquiries on specific health-related topics", and that the Committee intends to hold "an initial evidence session where the main features and pitfalls of using preventative spend as a means of scrutinising expenditure on health can be outlined".

The first thing to say is that prevention can only be addressed effectively in relation to the health and social care system as a whole, not just "health". We assume that the wording of the inquiry remit, which refers only to "health-related topics" and "expenditure on health" is not meant to focus only on the NHS part of health and social care, for that would seriously limit the point of the investigation. From the point of view of acute NHS in-patient services, almost all of social care is "preventative", as is primary and secondary health care, and public health. Moreover, in terms of *organisations*, social care is not only provided by local authorities (not mentioned in the call for views) and now by integration authorities, but also by the third sector, and by for-profit private companies, in a "mixed economy of care" fostered by successive governments since the 1990s. Even so, the publicly funded volumes of social care are more than equalled by unpaid care provided by mainly partners and family members, and some friends and neighbours. Providing adequate support to these carers is the first task of any prevention strategy in health and social care, as the Scottish Government has recognised in the Carers (Scotland) Act 2016 due to be implemented next year[2].

Secondly, we need to recognise a **continuum of prevention**, ranging from:
(1) '**primary'** or 'upstream' approaches (including whole population approaches and/or services and interventions for people with lower level needs), through
(2) '**secondary'** approaches – typically those directed towards people with emerging or existing needs, in an attempt to stop these getting worse or to enable some recovery; and finally
(3) '**tertiary**' or 'downstream' approaches to prevention, usually targeted towards people with a range of complex needs and/or more pronounced ill-health, focused on recovery where possible or maintaining stability and preventing deterioration for as long as possible.

The term "preventative spend" can cover any of these. "Prevention" is *relative to what is being prevented*: "worse outcomes for people at greater expense than would have been the case had earlier actions been taken" (at a societal as well as individual level). At each stage in the continuum of services from universal provision to acute intervention or care, actions or investment at earlier stages can delay or prevent more acute needs occurring. "Preventative spending"

[1] National Group on Community Planning: *Embedding Prevention in Single Outcome Agreements*, 23.10.12; at: http://www.gov.scot/Resource/0040/00405037.doc
[2] Concerns remain about some significant funding gaps within the Financial Memorandum for this important legislation.

therefore has no absolute meaning; it is always relative to something being prevented. This means that it is not meaningful to seek to measure the total quantum of spend on prevention; at best, prevention spend would have to be segmented using the three categories set out above or preferably a finer classification. This is because spending on services such as home care, community nursing, and care homes, may have a preventative impact on demand for acute inpatient hospital care, yet in themselves appear mainstream in relation to other forms of prevention.

There are strong arguments, therefore, for the scope of the Committee's inquiry to be set wide; anything narrower would restrict the agenda, and also fail to address the opportunities of health and social care integration.

Question 2: How can health boards and integrative authorities overcome the (financial and political) pressures that lead to reactive spending/ a focus on fulfilling only statutory duties and targets, to initiate and maintain preventative spend?

Health and social care services in England have had to face larger spending reductions than is the case so far in Scotland. For that reason, there is now a large literature on "transformational change", service redesign, new models of care, demand management, and other forms of prevention in England. There appear to be both positive and negative lessons for Scotland, which really require a fuller analysis than we have been able to undertake here.

In our view, the main lesson from England is that there needs to be sufficient monies within the health and social care system as a whole to meet demand. The benefits of prevention are often not cashable, and when they are may not yet be available in the short term, and therefore cannot significantly offset a current funding deficit.

The health and social care system in England is in crisis. NHS providers in England overspent by £2.45 billion 2015/16, and, even after an addition £1.8 billion Sustainability and Transformation Fund, NHS trusts now forecast a net deficit of £873 million for 2016/17, which measures may reduce to about £800 million[3]. A recent analysis by the Nuffield Trust of "shifting the balance of care" in England commented:

> The NHS [in England] is undertaking a journey of transformation while experiencing the longest period of funding constraint in its history. It needs to close a £22 billion gap in its finances by 2020/21. At the same time, the underpinning fabric of social care is being dismantled, and a range of demographic and other factors are fuelling demand for NHS services. It is a herculean, and some might say impossible, task – made all the more difficult by the small amounts of available transformation funding now being used to prop up a system that is going further into the red[4].

Very large reductions in English local government funding have inevitably reduced social care spending, despite it being prioritised in many areas, and the number of people receiving care. The Institute for Fiscal Studies recently stated that councils' net expenditure on adult social services in England "has fallen in real terms by almost 20% since 2009–10" when measured on a consistent basis[5]. While Scottish spend on social care has been largely maintained until now, at least in cash terms, the Accounts Commission[6] warned in September 2016 that "current approaches to

[3] The King's Fund Quarterly Monitoring Report 22, March 2017, at: http://qmr.kingsfund.org.uk/2017/22/overview

[4] Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J, Thorlb R and Lombardo S (2017), *Shifting the balance of care: great expectations*. Research report. Nuffield Trust. At: https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-summary-web-final.pdf

[5] Institute for Fiscal Studies, February 2017; see: https://www.ifs.org.uk/publications/8811

[6] Accounts Commission (2016): *Social work in Scotland*; at: http://www.audit-scotland.gov.uk/report/social-work-in-scotland

delivering social work services will not be sustainable in the long term. There are risks that reducing costs further could affect the quality of services":

> Councils' social work departments are facing significant challenges because of a combination of financial pressures caused by a real-terms reduction in overall council spending, demographic change, and the cost of implementing new legislation and policies. If councils and IJBs continue to provide services in the same way, we have estimated that these changes require councils' social work spending to increase by between £510 and £667 million by 2020 (16–21 per cent increase).

The Nuffield Trust's analysis in England found that "a significant shift in care" from hospital to community care

> will require additional supporting facilities in the community, appropriate workforce and strong analytical capacity. These are frequently lacking and rely heavily on additional investment, which is not available.(page 5)
>
> What is clear is that to avoid hospital admissions and accelerate discharges, there must be sufficient capacity and funding of alternative forms of care in the community. Without this investment, analysis suggests that the NHS will need to expand, not contract, its bed capacity. (page 15).

We have described the current health and social care funding crisis in England because it is a possible future for Scotland that we need to avoid.

In an ideal world a reduction in acute services would be undertaken after investment had been made in replacement services in the community, or in primary prevention, within sufficient timescales for their effect in reducing demand for acute services to be manifest. That would mean double running costs for varying periods depending where on the prevention continuum the investments were being made. That clearly is not possible given the macroeconomic policy of the UK Government and the approach being taken to the deficit created by the response to the global financial crash in 2008. The Scottish Government did provide some change funds for health and social care, which were initially largely used to fund prevention initiatives, but as budget pressures grew such funds were increasing used to support mainstream care services and have now been incorporated within normal funding.

Integration Joint Boards, Health Boards and Local Authorities continue to support third sector and community capacity building among other preventative measures, but is extremely difficult to fund prevention at the right scale while at the same time meeting acute needs even if these might have been prevented by earlier intervention. There is no obvious way to break this vicious circle without failing to meet some acute need and risking casualties[7]. A wider public debate is needed about how society should meet the increasing costs of health and social care, due to mainly to the ageing population but also affected by rising inequalities; inevitably this means debating the form and scale of taxation, the role of the state, economic policy, and what sort of society we wish to live in. Political leadership is therefore essential.

<u>Question 3</u>: How could spend that is deemed to be preventative be identified and tracked more effectively? What is required in terms of data, evidence and evaluation to test interventions for producing 'best value for money'?

Our answer to Question 1 suggested some scepticism that preventative expenditure can be identified and monitored as a single quantum. In any event, it is more important that evidence is systematically collected on the effectiveness and cost of prevention initiatives, and on their impact on people' wellbeing. Equally important is the dissemination of prevention research, and its ease of accessibility for others to learn what works, including the often important contextual factors, and what doesn't work.

[7] There is tentative evidence in England that otherwise unexplained increases in mortality are due to failures in the health and social care system. See published research summarised on the London School of Tropical Medicine website:
https://www.lshtm.ac.uk/newsevents/news/2017/excess_deaths_2015_failures_health_social_care.html

In recent years there have been many useful publications in the UK on prevention in health and social care, although relatively few provide robust information on the return on investment[8]. It is very important that Integration Joint Boards, Health Boards and Local Authorities in Scotland are able to access good research on what forms of prevention work for particular sets of objectives and circumstances. What is needed is a clearing house function which can grade the strength of evidence for particular preventative initiatives, and disseminate results in a way that can be used locally. The *What Works Scotland* programme[9] brings together academics and public bodies to promote evidence-based decision-making about public service development and reform. We suggest that the Health and Sport Committee may wish to take evidence from What Works Scotland on what role they could play in a clearing house function for prevention evidence and evaluation.

Question 4: How can the shift of spending from reactive/acute services to primary/ preventative services be speeded up and/or incentivised?

Integration Joint Boards need to be supported in commissioning acute NHS services in such a way as to reduce in-patient bed complements over time, so that resources can be re-directed to the expansion of those primary care, community health, and social care services that are necessary to reduce demand for acute in-patient bed admissions, and for which the evidence shows have the greatest effects. The Committee may wish to invite Integration Joint Board Chief Officers to supply information on such developments within their localities, and to evidence the opportunities as well as identify obstacles and barriers that need to be overcome.

However, in-patient bed reduction to fund community based services is likely only to realise sufficient funds if enough beds/ wards within hospitals are reduced to free up resources. This is likely to be perceived as a cut by local populations, who may find themselves with much further to travel when they need to use hospitals, or visit families or friends in hospital. Local and national politicians will need to be convinced that such reductions are necessary to the future sustainability of the NHS and social care, and be prepared to argue that case with their electorates.

[8] An exception is a Kings Fund paper which reviewed nine key areas that can improve public health and reduce inequalities: the best start in life; healthy schools and pupils; helping people find good jobs and stay in work; active and safe travel; warmer and safer homes; access to green and open spaces and the role of leisure services; strong communities, wellbeing and resilience; public protection and regulatory services; and health and spatial planning. See: David Buck and Sarah Gregory (2013): *Improving the public's health - A resource for local authorities*. The Kings Fund. Available at: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/improving-the-publics-health-kingsfund-dec13.pdf

[9] http://whatworksscotland.ac.uk/the-project/