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Beyond eligibility

Universal and open access support and social care

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A report to Age UK from Melanie Henwood Associates

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The views expressed in this report are those of Melanie Henwood Associates, and not necessarily those of AgeUK.

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Executive Summary

1. Age UK commissioned this study from Melanie Henwood Associates in order to better understand councils' approaches to universal and open access support for older people whose needs do not meet the eligibility threshold for publicly financed adult social care. The study examined:

   - current barriers to universal support;
   - potential levers for improvement;
   - gaps in knowledge and understanding which impede appropriate development.

2. Encouraging a 'universal offer' for all citizens regardless of whether they meet eligibility criteria has been increasingly emphasised in social care policy, but practice remains variable.

3. The research entailed examining councils' websites, exploring research and wider literature, conducting 9 interviews with key Directors of Adult Social Services (DASSs) and some other leading stakeholders, and participating in numerous email exchanges with other parties.

4. Examination of the policy and practice background identifies the centrality of the issue of eligibility in adult social care. How people gain access to publicly funded adult social care in England is a vexed question that has attracted increasing attention and scrutiny. The variability of eligibility between councils, and the resultant 'post code lottery', has been heavily criticised, and a national model has been proposed by both the Dilnot Commission and the Law Commission. This argument has been accepted by the 2012 White Paper on reforming care and support and a national eligibility threshold is to be introduced in 2015.

5. The current approach to eligibility, based on the Fair Access to Care Services (FACS) framework, has led to most councils operating at an eligibility threshold of 'substantial' needs. There is extensive research evidence of the difficulties for people with needs for care and support who do not meet such a threshold, but nonetheless require support. Revised guidance on FACS issued in 2010 emphasised the importance of addressing prevention and early intervention, in the context of community well-being and social inclusion. Subsequent policy on achieving transformation in adult social care has similarly highlighted the importance of a holistic approach that includes universal services; early intervention and prevention; choice and control, and the development of social capital.

6. The *Vision for adult social care* published by the Coalition Government in November 2010 emphasised continuity with the model of personalisation and prevention, and located this within the context of social capital and community capacity development ('active citizens and strong communities'). The White Paper amplifies these themes and emphasises the promotion of people's wellbeing and independence rather than waiting for them to reach crisis point.

7. It is apparent that the policy discourse on universal support has become more sophisticated and nuanced. Increasingly, it is recognised that 'universal support' is not synonymous with 'low level support', and indeed may be less concerned with social care *services* than with facilitating access to the resources of the community.

8. There is a parallel, and related, debate about prevention, and this has been an area in which terminology has often been imprecise. Emerging thinking has also drawn attention to

the need for a wider conceptualisation that is couched in terms of health and wellbeing. The new focus on such issues in NHS reform, and the transfer of public health functions to local authorities is widely seen to offer opportunities for addressing such matters.

9. Evidence on effectiveness in prevention is relatively thin and patchy, but *has* increased significantly in recent years, particularly from the Partnerships for Older People Projects, and from interventions with falls prevention and from telecare.

10. There are particular challenges in drawing conclusions from research that examines a wide variety of interventions (such as around befriending and other strategies to reduce social isolation), and employs different outcome measures. There are also issues of transferability when considering the evidence from studies undertaken outside the UK. The White Paper proposes the establishment of a national care and support evidence library, and it will be important that the resources of the library are accessible and clearly applicable to practice.

11. Throughout the fieldwork for this study, interviewees emphasised the fundamental challenge of resource pressures and the impact on eligibility thresholds. Indeed, it is often difficult to separate strategies to reduce costs by reducing the numbers of people requiring social care support, from a cruder approach to cost reductions through tightening of eligibility criteria. In the public perception too, these distinctions are often lost and there is considerable suspicion of policies that set out to make savings or to reduce dependency. Much of this climate has been encouraged by focusing solely on one side of the equation – that of eligibility – without paying equal attention to the other side of impact and outcomes.

12. Pressure on resources also creates difficulties for councils seeking to innovate or experiment, and the role of elected members is particularly crucial in determining whether or not councils are able to sustain their investment in adult social care. Redesigning services, and the basis on which they are commissioned, particularly in relation to the third sector, is a strategy that is being widely adopted. In addition to rationalising the investment in the third sector, this is also requiring a different mode of operation for many, and is often a difficult and time consuming process to manage. The White Paper announced additional resources to be made available to support integration of health and care and to stimulate new housing option developments. It is not clear whether this funding is sufficiently targeted to stimulate specific interventions in prevention and community based support.

13. Information, advice and signposting to support are central components of the universal offer. In the past 'signposting' has often been viewed as a euphemism for 'rationing by diversion', but the study found indications of a more positive approach being adopted. This was particularly the case where information and advice services are developed in partnership with private and voluntary agencies that are following a pro-active strategy for linking people to resources and enabling communities to take a supportive role. This approach is also associated with a greater focus on examining the outcomes of referrals for individuals. The White Paper has signalled improvements in information and advice at both national and local levels. It is important that such improvements are understood as means to ends and that the outcomes and value of these developments is adequately addressed.

14. Alongside universal services that are open to the whole community, and that people can access in different ways, there is also a layer of what some identified as 'targeted universal services', that are still provided to people that are below eligibility thresholds, but are particularly concerned with those whose needs would otherwise soon escalate. This can include, for example, a range of support concerned with avoiding isolation, or with maintaining mobility, and thereby enabling people to retain their independence. How best to target such support is an important issue and one that does not seem to be addressed by the White Paper.

15. There is a debate about the role of councils in relation to this wider range of support, and the consensus emerging from the study was very much in seeing the council as enabling or facilitating community and neighbourhood capacity. This can include pump priming activity; making more flexible use of public buildings and resources; and stimulating micro-enterprises and other community-led solutions (through models such as Local Area Coordination).

16. Throughout the study it was apparent that although there were some consistent themes about the need to develop new models and best practice, there is no single blueprint that can be applied to all councils, but it *is* possible to steer and incentivise the direction of travel.

17. Two main approaches to shaping developments were identified. The first of these concerns whether there would be merit in introducing new duties for local authorities specifically concerned with prevention and universal support. Secondly, the case for targeted resources to support innovation across the health and care economy was viewed as particularly worthwhile given the continued financial restraint which makes experimentation especially problematic.

18. The White Paper on adult care and support offers a number of reforms intended to promote wellbeing and independence and reduce the risk of people reaching crisis point. The White Paper also seeks to improve clarity and understanding around entitlements and responsibilities, particularly by improving information on care and support and by introducing greater consistency in access through a national minimum eligibility threshold for care and support in England. There are some positive developments but considerable detail is required to examine the consequences of the reforms in detail. In the conclusions of this report we identify a number of matters where it is recommended that Age UK should undertake particular scrutiny.

1. Introduction

1.1 How people get access to publicly funded social care and support is a vexed issue that in recent years has been the focus of increasing concern and debate. The current model for determining eligibility has been in existence since 2002 when guidance was issued to establish a national framework based on people's assessed needs and the risks to their independence, and identifying four bands of eligibility: critical, substantial, moderate and low (DH, 2002). Eligibility thresholds have risen with most councils now operating at substantial or above. The situation of people who are not eligible for council support, but nonetheless have some needs for care and support, is one that has been highlighted in various research evidence, and by the former social care regulator, the Commission for Social Care Inspection (CSCI).

1.2 Wherever an eligibility threshold is established there will always be people who do not meet the criteria for publicly funded support. This is also referred to as the difference between people's 'presenting needs' and their 'eligible needs', with the gap between them being the territory of 'unmet need'. It is also clear that the cliff edge that many people experience around eligibility was not an inherent feature or intention of the original FACS framework and that a combination of signposting to other services, the provision of information and advice, and access to services that do not require a test of eligibility should be part of a 'universal offer'.

1.3 In practice people's experience of such support can be highly variable. Age UK commissioned this desk-based study to explore the variables that influence developments and what steps might be taken to encourage improved access. Age UK are especially concerned with the situation of older people, but many of the issues identified in this paper have wider resonance for all adults who use or may use social care and support. The research and analysis was undertaken in spring 2012 prior to the publication of the care and support White Paper. The particular aims for the study were specified by Age UK in these terms:

- To identify the current barriers to the provision of universal services to support older people with low level care and support needs.
- To identify the potential levers which are needed to ensure that such services are provided.
- To identify where there are continuing gaps in knowledge or understanding about specific interventions which prevent them being commissioned or provided.

1.4 The study was undertaken largely as a desk-based investigation, supplemented by 9 interviews with key Directors of Adult Social Services, and with other relevant stakeholders. These were a combination of face to face and telephone interviews, depending on the practicalities of securing time in people's diaries. All interviews were confidential and individual respondents are not identified. However, the interviewees were selected to include key ADASS officers (outgoing and incoming Presidents; and the Older People's Policy Leads). Other stakeholders were contacted where they were named by interviewees, or following identification through internet and document research exploring innovative practice.

1.5 The research was undertaken at a time when the White Paper on adult care and support was imminent but not yet published. A prime purpose of the study was to assist Age UK in their response to the White Paper and in addressing related policy and practice issues. The White Paper was published on July 11th 2012 and set out a vision for care and support intended to promote wellbeing and independence and reduce the risk of people reaching crisis point. The White Paper also seeks to improve clarity and understanding around entitlements and responsibilities, particularly by improving information on care and support and by introducing greater consistency in access through a national minimum eligibility threshold for care and support in England.

2. Policy & Practice

Fair Access to Care

2.1 The current national framework for eligibility (FACS) was introduced in an attempt to ensure there was transparency of approach and clearly understood rules about who could get help such that everyone in an area gets treated fairly and consistently.

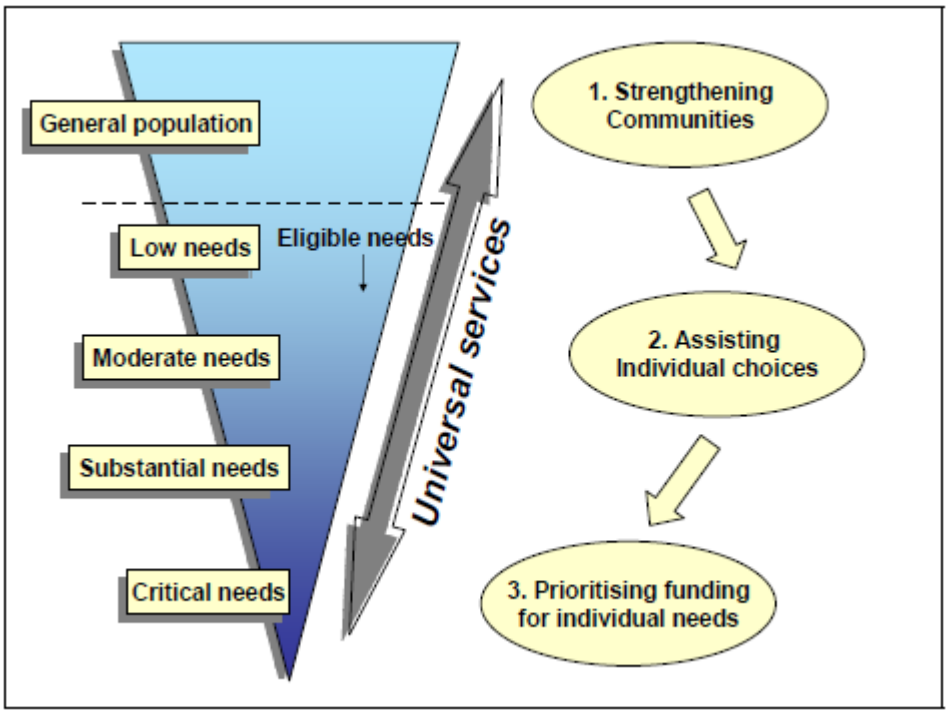
2.2 In 2007 the Commission for Social Care Inspection (CSCI) (then the regulator of social care services) identified concerns about the impact on people of councils raising their eligibility criteria (CSCI, 2007). The following year CSCI commissioned special studies to explore the issues in greater detail, and highlighted the impact of tightening criteria for people whose needs were outside eligibility and who were effectively 'lost to the system' (CSCI, 2008a). In response to the findings, the then care services Minister commissioned CSCI to undertake a review of eligibility criteria. The subsequent report made a number of recommendations for replacing the FACS framework, and also recommended better arrangements for universal support, and greater attention to prevention and reablement (CSCI, 2008b). The recommendations for replacing FACS were not taken up by government at least in part because future arrangements for the funding of adult social care were still under consideration, but revised guidance was issued in February 2010 intended to support fairer, more transparent and consistent application of eligibility criteria (DH, 2010a).

2.3 The revised guidance also emphasised the context within which FACS must operate, and particularly underlined the centrality of prevention and early intervention, and cautioned against focusing solely on eligible needs:

"Councils should therefore avoid using eligibility criteria as a way of restricting the number of people receiving any form of support to only those with the very highest needs. Rather they should consider adopting a strong preventative approach to help avoid rising levels of need and costs at a later stage. Early interventions can also improve general community well-being and wider social inclusion." (DH, 2010a, para 35).

2.4 The wider context of universal services, strengthening communities and establishing a model of support "in which all citizens can expect some level of support and those with the greatest needs can access additional help" is represented in Figure 1 below.

Figure 1: Eligibility needs in the context of the environment



Source: DH (2010), para 42.

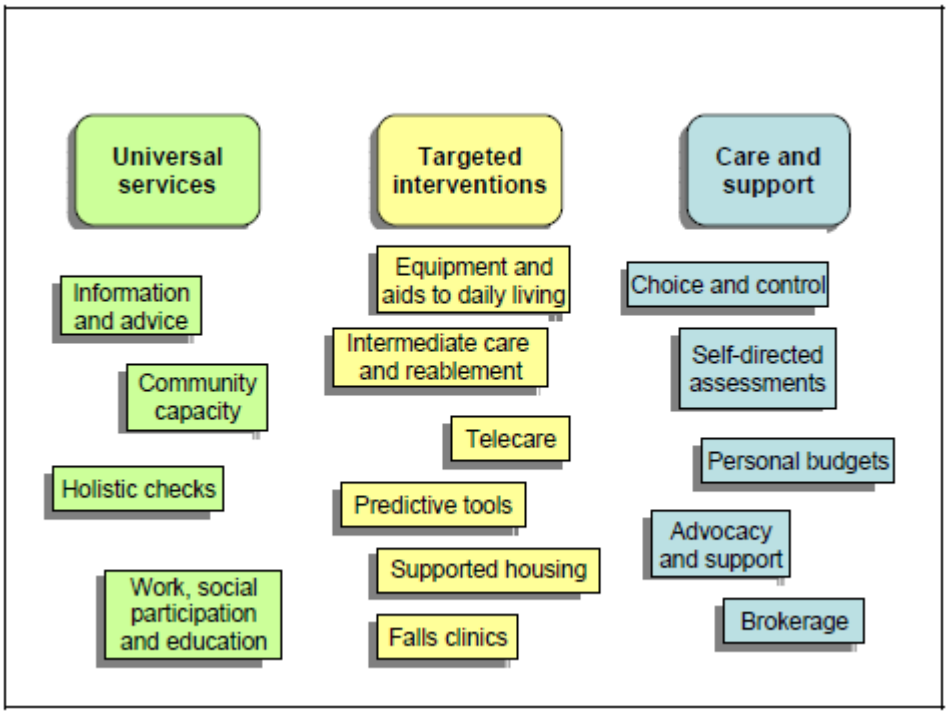
2.5 The revised guidance also addressed the issues that had been identified by CSCI around people who are funding their own care and support and reiterated that:

"Councils should consider how they can work to support high quality outcomes for all their citizens, including those funding their own care and support." (para 104)

2.6 Such support should include information and advice about other sources of support and "signposting to more universal sources of support."

2.7 In addition to universal and open-access services, the guidance also underlined the contribution of targeted interventions around prevention, early intervention and enablement. Indeed, it was envisaged that investment in such services would "become the norm", and would prevent or delay the need for more specialist social care interventions. Figure 2 below also represents this combination of approaches.

Figure 2: Types of resources and services



Source: DH (2010), Fig 1, P.17

Adult Social Care: Transformation

2.8 The revised guidance made it clear that the approach to prioritising need was to be made "in the context of *Putting People First"*. This cross-sector agreement published in 2007 had set out a shared vision and commitment to the transformation of adult social care (HM Government, 2007). The central focus of the transformation agenda had also been set out in 2006 in a White Paper which emphasised the well-being of communities and preventative approaches; giving people greater choice and control; developing innovative ways of supporting people; building community capacity, and ensuring that "everyone has access to the full range of universal services" (DH, 2006a).

2.9 A guide on the use of resources in adult social care issued by the Department of Health in 2009 set down some key questions for local authorities about efficiency and effectiveness. The document emphasised the need for a holistic approach to social care transformation and underlined the essential quadrants of universal services; early intervention and prevention; choice and control and social capital (DH, 2009). The analysis made clear that while over the past decade local authorities have used the tightening of eligibility criteria as the most common way of trying to reduce costs, in fact:

"The most effective way of reducing costs is to reduce the number of people requiring support to live at home. This is not the same as reductions due to tightening eligibility criteria." (DH, 2009, P.56)

2.10 The change of government in May 2010 and the election of the Coalition did not signal a major change of direction in social care. The programme for government published in May 2010 announced that a commission on long term care would be established, and it was subsequently established in July 2010. The terms of reference made clear that the wider context of care and support remained one of "supporting personalisation, prevention and partnership." The 'vision for adult social care' was published in November 2010 (DH, 2010b) and set out seven principles as the basis for a modern system of social care:

- Prevention.
- Personalisation.
- Partnership.
- Plurality.
- Protection.
- Productivity.
- People.

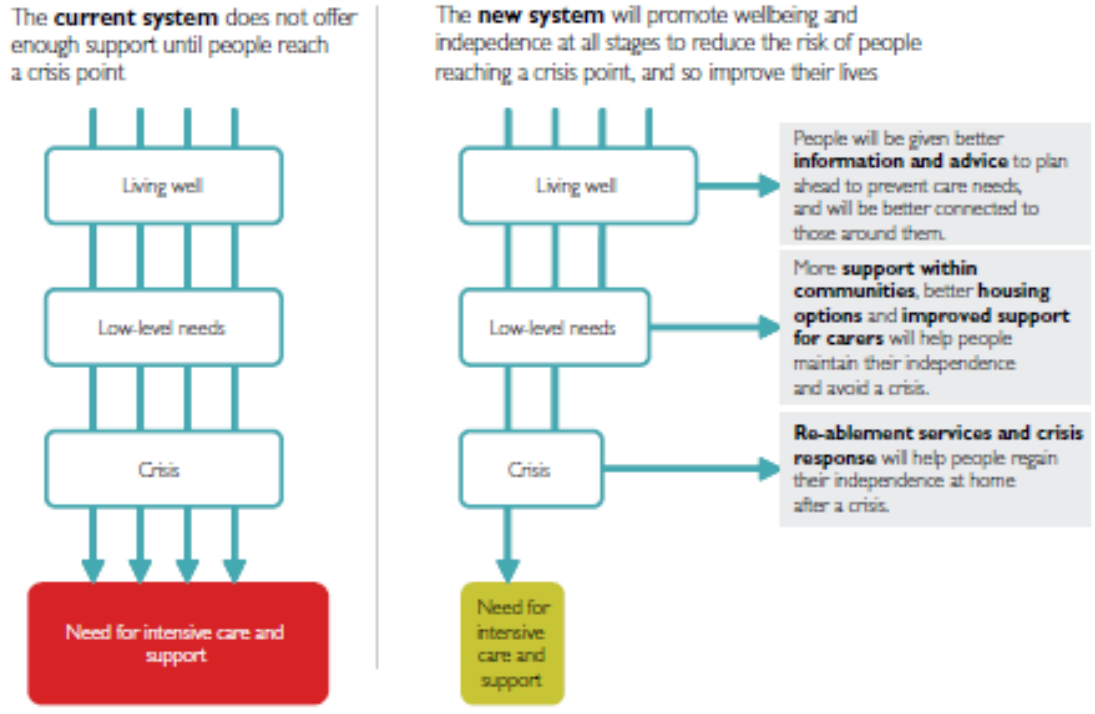
2.11 Again, these themes were notable for emphasising continuity with the general model of personalisation and transformation that had been established by the previous administration. The approach to prevention was addressed in terms that located it within a broader context of social capital and community capacity development ('active citizens and strong communities). In some respects the vision is open to criticism for a muddled approach to prevention with the view that "our first priority should be to restore an individual's independence and autonomy" (para 3.7), when it might be argued it is more logical to support people at an early stage to maintain independence. The discussion of prevention was relatively brief and while making passing reference to the potential of new technology, most of the focus of 'appropriate preventative' services was actually on reablement. Nonetheless, the vision's conclusions also stated a wider ambition:

"to foster the conditions in which communities, social enterprises and others can develop a diverse range of preventative and other support that will help to reduce isolation, improve health and well-being and, by doing so, better manage the demand for formal health and care." (DH, 2010b, para 9.3)

2.12 The report of the Commission on Funding of Care and Support (the Dilnot Commission) was published in July 2011. While focusing primarily on proposals for a new model of funding, the Commission also highlighted shortcomings with the present system whereby people experience "unacceptable variation in eligibility for services across the country", and where the provision of information and advice is poor. The Dilnot Commission accordingly recommended there should be 'a clear, national offer' underpinned by a clearer, more objective eligibility framework. This recommendation also endorsed those of the Law Commission on assessment and eligibility (Law Commission, 2011). The implications of changing to national assessment and eligibility criteria have been explored elsewhere (SCIE, 2012a). The Dilnot recommendations also supported a greater focus on prevention and early intervention.

2.13 The long awaited White Paper on care and support was published on 11th July 2012 (HM Government, 2012a), together with a progress report on funding reform (HM Government, 2012b). The White Paper offered a vision for a reformed care and support system, with "promoting people's wellbeing and independence" at its core, and represented this diagrammatically as shown in Figure 3 below:

Figure 3: The vision for reformed care and support



2.14 As indicated, this attaches greater priority – as noted in the Ministerial Foreword – to the principle that "we should do everything we can – as individuals, as communities and as a Government – to prevent, postpone and minimise people's need for formal care and support. The system should be built around the simple notion of promoting people's independence and wellbeing."

2.15 The key actions set out in the white paper that relate particularly to universal support and to prevention include the following:

- Stimulating the development of initiatives that help people share their time, talents and skills with others in their community (such as time banks).
- Developing and implementing in trailblazer areas new ways of investing in supporting people to stay active and independent, such as through Social Impact Bonds.
- Establishing a duty on local authorities to commission and provide preventive services.
- Establishing a single bank of evidence for preventive interventions in care and support to improve the way evidence is accessed and used.
- Establishing a new capital fund, worth £200 million over five years, to support the development of specialised housing for older and disabled people.
- Establishing a new national information website to provide a clear and reliable source of information on care and support, and investing £32.5 million in better local online services.
- Introducing a national minimum eligibility threshold to ensure greater national consistency in access to care and support, and portability between councils.
- The Health and Social Care Act 2012 established duties on the NHS Commissioning Board, clinical commissioning groups, Monitor, and health and wellbeing boards to promote and enable integration. The draft Care and Support Bill also sets out a duty on the local authority to promote the integration of services.
- Investing £100 million in 2013/14 and £200 million in 2014/15 in joint funding between the NHS and social care to support better integrated care and support and supporting people to maintain their independence in the community for as long as possible.

2.16 We turn now to examine the issues around universal support and prevention in greater depth before exploring the variables that shape policy and practice on the ground.

Universal Support and Prevention

2.17 The Think Local Act Personal (TLAP) partnership was established in January 2011, bringing together more than 30 umbrella and national organisations and providing a sector-wide commitment to transforming adult social care. TLAP built on the achievements and delivery of Putting People First over the previous three years. The partnership agreement, published in January 2011 (TLAP, 2011), underlined personalisation and community as "the key building blocks of a reform agenda, shaped around an individual's own expertise and resources." Accordingly, the agreement emphasised:

- Universal approaches designed for all
- Targeted support for particular groups.

2.18 Building community capacity and social capital are central to this model. The key elements have been identified by Research in Practice for Adults (RIPFA) in these terms:

- Personal and social support networks of family, friends and neighbours.
- Membership of groups.
- A welcoming and inclusive local community in which older and disabled people are able to get out and about and use universal services.
- Making a contribution – where everyone is valued for their unique talents, skills and gifts (RIPFA, 2012).

2.19 The TLAP website contains multiple case studies and examples of innovation around building community capacity. Many of these are primarily descriptive and are often accounts of work in progress. However, it is also important that initiatives are evaluated and effectiveness can be determined, as we explore below.

2.20 The *Caring for our Future* White Paper (HM Government, 2012a) does not generally refer to universal support or open access services, but it *does* emphasise the importance of strengthening support within communities, particularly to address issues of social isolation. Supportive networks are to be encouraged through initiatives such as time banks and increased volunteering.

2.21 Making the best use of resources in adult social care is important at any time, but as the Association of Directors of Adult Social Services (ADASS) has emphasised, at a time when services "are facing an extremely tough future" it is all the more important that such matters

are to the fore and that the best guidance is available to help in meeting the challenges (ADASS, 2010). 'Prevention' was identified as the first of six key areas that councils need to address (the others being recovery; continued support; efficient process; partnership, and contributions). The document identified the key components that need to be addressed for each area, together with a number of metrics to assist directors in examining their use of resources. The key components are summarised in Box 1 below.

2.22 ADASS published a further paper in 2012 (*All Our Tomorrows*) which made the case for 'inverting the triangle of care' and focusing more on preventative services. A successor document, published in 2012 (*The Case for Tomorrow. Facing the Beyond*) identifies the continuing challenges in meeting the needs of a growing older population. The importance of effective prevention in supportive communities, and good quality information and advice were again key themes, with implications both for local partners and for central government:

"Investing in better quality community based health, care and wellbeing services for older people is the only cost-effective way in which we can reverse the recent findings concerning poor quality care and inadequate health services across the country. Evidence about what works in practice needs to drive change in the design and style of services to be offered to promote health, wellbeing and social care for older people." (ADASS, 2012, Para 5.2).

2.23 ADASS recommended the introduction of locally based ring-fenced innovation funds to achieve a shift from acute care to community based provision, and to invest more in research and dissemination of best practice in delivering preventative services. These themes will be explored in greater depth in section 4.

Box 1

Making the best use of reducing resources: Prevention Components

- An inclusive strategy for ageing or disabled people which enables them to gain access to mainstream life as a citizen and to take active steps to prolong their independence.
- Access to information and advice which enables people to find their own solutions wherever possible and which is made easy to use. This includes enabling people to make use of all digital channels.
- Affordable and reliable practical support.
- Some telecare and simple aids to daily living made affordable and easily available to people without needing to undergo professional assessment.
- Social contact delivered through informal support networks or networks enabled through local voluntary effort.
- An operational predictive model, shared between health and social care, which identifies those most at risk of requiring greater care and support.
- Vaccination made available to those who will most benefit.
- Specific preventive services which are targeted at conditions which can have the greatest impact on whether independence can be maintained. There is strong evidence for dental care, podiatry services, incontinence services, dehydration monitoring, falls prevention and stroke recovery.
- A housing strategy which ensures that people can live affordably in their own homes for as long as possible, enables people to choose to move to smaller or more appropriate accommodation and which allows people to have their own home with support.

Source: ADASS (2010) *How to make the best use of reducing resources: a whole system approach.*

2.24 The terms 'universal support' and 'low level support' are often used interchangeably in policy discourse, but in fact they refer to different things. The debate has changed over time and become more sophisticated as understandings about the role of services and support in enabling people to remain independent and to participate in their communities has developed. Universal and 'open access' services are those that are generally available in the community for the use of all citizens. They include facilities such as public libraries and leisure centres, and while some of their services are free of charge others may carry a charge for people using them. 'Low level support' is often used to refer to such things as help with housework, shopping and odd jobs - or 'that little bit of help' (Clark, Dyer and Horwood, 1998; Raynes, Clark and Beecham, 2006) - that supports people who may not meet eligibility criteria for social care but nonetheless have some needs for personal or practical support.

2.25 Despite an emphasis on preventative services for several years, progress has arguably been slow and evidence of achievement relatively poor. In part this reflects the vagueness of terms and the lack of clarity of definition. While many services or interventions may loosely be referred to as 'prevention', it does not follow that all low level services *are* preventive. Interventions need to be able to eliminate or delay the need for social care services by supporting independence and wellbeing. The Wanless social care review (Wanless, 2006) observed:

"The key issue is how much spending on prevention can be justified and the type of preventive services most effective in reducing long-term need." (P.170)

2.26 As the report also noted, judging such cost-effectiveness is complex because of the difficulties of attributing cause and effect. The evidence base is patchy. In September 2011, the Government launched a stakeholder engagement exercise (Caring for our future, DH, 2011) to examine priorities for improving care and support. Six topics were identified where it was believed there was the greatest potential for improvement, and one of these addressed prevention and early intervention. The 'emerging thinking' on this and the other topics was published in November 2011, and the key issues once again underlined the poor understanding which surround the concepts; the lack of clear evidence and the absence of effective outcomes-based commissioning tools (Caring for our Future, 2011).

2.27 The fact that the term 'prevention' is used so widely and vaguely is unhelpful. The 'emerging thinking' headlines drew attention to the need for prevention to be viewed much more holistically in terms of health and wellbeing. Furthermore, an asset-based approach is needed that looks at outcomes more broadly and includes "tackling isolation, being able to cope with crisis and empowerment" alongside interventions that are about achieving savings and reducing the need for support. Such an approach also needs to be integrated across health and care, and other local authority boundaries. The new focus on health and wellbeing, and the transfer of public health to local authorities, creates opportunities for this wider and integrated conceptualisation to be developed, and for greater use to be made of pooled budgets and integrated provision. The continuum of prevention is sometimes distinguished in terms of 'primary' (maintaining independence and good health and promoting wellbeing); 'secondary' (early intervention), and 'tertiary' (such as intermediate care or reablement).

Box 2
Prevention and early intervention: What would 'good' look like?

Policy

- A comprehensive and well articulated prevention strategy is in place, with an accompanying performance framework that is actively managed.
- A Local Area Agreement is aligned to support the vision of prevention, efficiency and well-being.

Interventions

- Arrangements in place to deliver the 'universal offer' (i.e. advocacy and advice services available to all to enable prevention and self-management).
- Proactive approaches in place to identify older people at risk of deterioration in order to intervene early.
- A comprehensive range of non-case-managed well-being services, probably commissioned from the third sector.
- The mainstream application of telecare.
- A reasonable volume of extra-care or supported housing.
- Well functioning reablement and intermediate care services.

Source: Department of Health (2009), *Use of Resources in Adult Social Care. A guide for local authorities*. PP 63-64.

2.28 The importance of integrated and whole system approaches is also emphasised by ADASS:

"Local authorities need to do more to gear their full range of services, beyond social care, to supporting older people to live active lives in their community and thus avoid the need for substitute or acute care." (ADASS, 2012, P.7)

2.29 The guide to local authorities on use of resources (DH, 2009) explored the different approaches of local authorities to using resources to reduce the use of higher cost services, or to avoid the need for social care interventions. This included authorities that were making use of different housing options, using new technologies and working in partnership with health and other services. In highlighting good practice examples the guide outlined a framework for the best use of resources in securing a strategic shift towards prevention and early intervention. The key dimensions are summarised in Box 2 below.

Evidence of effectiveness

a) Social Capital and Prevention

2.30 As noted above, evidence about effectiveness in prevention is thin and patchy; however, the evidence base *is* developing. A recent research briefing from SCIE (Windle, Francis and Coomber, 2011) has explored the effectiveness of primary prevention in relation to social isolation and loneliness and the impact on improving people's wellbeing and reducing the need for ongoing care and support. Services were categorised in terms of one-to-one interventions, group services and wider community engagement, and as the authors note:

"The wide variety of interventions and their different outcome measures make it difficult to be certain what works for whom." (Windle, Francis and Coomber, 2011, P.5).

2.31 However, in reviewing the data available they conclude there:

"*Is good evidence that one-to-one interventions such as befriending and Community Navigators reduce loneliness and improve health and wellbeing."* (P.10)

2.32 Users of such services report high levels of satisfaction, and experience less loneliness and social isolation. People benefiting from such interventions increase their social interaction and community involvement and participation. A lot of the research that has been undertaken is not UK-based, which raises questions about transferability, although the review argued that many activities should be replicable since they are not dependent on complex organisational structures or processes and typically rely on volunteers. A programme developed by Skills for Care has supported 15 projects in England to explore community skills and assets development, and to examine the contribution of such strategic capacity building to care and support. The findings from the programme (forthcoming) provide further evidence on the contribution of social capital and how it can be encouraged through an asset-based approach that recognises the importance of mutual exchange and support.

2.33 The state of current evidence may understate the benefits of support to socially isolated or lonely older people, and there are consequent risks that commissioners may not invest sufficiently in such services particularly at times of financial restraint. This can create a vicious circle in which the failure to invest in primary prevention for lack of evidence ensures that practice-based evidence fails to develop and expand. While the evidence remains relatively patchy, the SCIE review highlights the successes:

"Social group schemes, one-to-one befriending and Community Navigator schemes all have a positive role to play in reducing loneliness and improving older people's health and wellbeing. Social group schemes and one-to-one befriending, in particular, provide invaluable companionship, while Community Navigators can help to identify older people most at risk and then refer them on to appropriate services." (SCIE, 2012b, P.5).

2.34 The role of the voluntary sector in providing such services is particularly significant and raises issues about how councils can best support and sustain such services, particularly during times of financial restraint.

2.35 The Think Local Act Personal (TLAP) partnership has urged councils to develop community-based preventative approaches, including "evidence-based investments to build community capacity to delay or avoid the need for expensive, targeted services" (TLAP, 2011, P.2). Despite 'instinctively feeling' that such an approach must be cost-effective, the need to be able to justify expenditure has led to TLAP developing the Building Community Capacity Project. Research undertaken for TLAP has explored the economics of social capital investment in respect of three types of project: time banks, befriending schemes, and community navigators (Knapp, Bauer, Perkins and Snell, 2011). The study focused on two key questions:

- Does investment in building community capacity have the potential to prevent or delay the need for social care?
- Does it have other impacts on individuals and communities that, in turn, will generate cost savings or wider economic benefits?

2.36 While the study initially set out to examine the economic case for broadly-based community development programmes, there was insufficient evidence available for this analysis. As the authors commented, many evaluations of community development have focused on processes, rather than outcomes, and have been largely concerned with qualitative rather than quantitative evidence. Similarly, the nature of community development initiatives which are rooted in the multiple objectives of local stakeholders and have many dimensions make it particularly difficult to examine cause and effect or compare outcomes between projects:

"Causal pathways are of a complex social and behavioural nature, with a range of intermediate outcomes and a long gestation period before some outcomes are even evident." (Knapp et al, 2011, P.8)

2.37 Reviewing evidence on befriending services, the study concluded "there is at least a prima facie case to support interventions". Furthermore, examples from the POPPs programme, from the Brighter Futures Group of low level support in Kent, and the Devon pilot in the LinkAgePlus programme also indicate cost-effectiveness. The modelling in the study concentrated on the effects of befriending on the mental well-being of older people and their use of health services:

"Drawing on information on a number of befriending schemes, a typical service would cost about £80 per older person, compared to savings of about £35 in the first year because of the reduced need for treatment and support for mental health needs. There could well be savings in future years too. If we then also look at quality of life improvements as a result of better mental health – using evidence from some of the POPPs pilots – their monetary value would be around £300 per person per year." (Knapp et al, 2011, P.12).

2.38 The study found that time banks, befriending and community navigators all "generated net economic benefits in quite a short time period" and that the calculations were likely to be conservative. Another study on building community capacity published by TLAP (RIPFA, 2012) observes that the debate is changing. Because of personalisation there is greater emphasis on developing services in partnership with people who use them and:

"In some instances, we need to move away from thinking about care and support in terms of services altogether. Public bodies need to work with older and disabled people within their communities to find out what they want for themselves and what they can and want to contribute." (P.1)

2.39 The emphasis on developing social capital is made both to enable better use of 'stretched public resources', but it is also argued that it offers potential for local authorities, in partnership with communities:

"to strive for more ambitious goals that might otherwise seem unrealistic in this era of spending cuts – realising stronger, happier, more functional communities in which everyone is valued and can contribute as a full and equal citizen." (P.1)

2.40 Research by the New Economics Foundation (NEF) has applied a Social Return on Investment (SROI) model to assess the impact of community development work in four communities in England (NEF, 2010). It found that for every £1 invested in community development activities, £2.16 of social and economic value is created, and "for every £1 a local authority invests in a community development worker, £6 of value is contributed by community members in volunteering time" (NEF, 2010, P.1). The value created through

development work was particularly evident in increased supportive relationships experienced by volunteers, participants in community activities and the wider community.

2.41 As noted previously, the care and support White Paper (2012) has endorsed the important contribution of social capital and observes that:

"The voluntary and community sector is uniquely placed to reach socially isolated people and connect them to befriending services and other networks of friendship and support." (P.22)

2.42 Start-up funding through the Health and Social Care Volunteering Fund is to be available to support the development of locally owned time sharing schemes.

b) Partnerships for Older People Projects (POPP)

2.43 The Partnerships for Older People Projects (POPP) are frequently cited in policy discourse, and by researchers and practitioners in support of further evidence of the effectiveness of prevention. In contrast to many prevention initiatives and evaluations, this was a significantly large programme that involved multiple projects and organisations and where independent evaluation of outcomes was inbuilt from the start. The programme was funded by the Department of Health (at a cost of £60m) from 2006-2009 and supported twenty nine local authorities as pilot sites working with health and voluntary sector partners in developing initiatives to promote health, well-being and independence, and to prevent or delay the need for higher intensity support. The POPP programme was evaluated by the Personal Social Services Research Unit (PSSRU).

2.44 The 29 sites established 146 local projects, and two thirds of these were largely 'community facing' and concerned with reducing social isolation and exclusion, or promoting healthy living among older people. The other third of projects were 'hospital facing' and largely focused on avoiding hospital admissions or supporting early discharge from hospital. In addition to these core projects, a further 530 small 'upstream' projects were commissioned from the third sector (PSSRU, 2010).

2.45 Over the three years of the POPP programme 264,000 older people used the project services. The average age of these people was 75, and almost one third were aged at least 85. While 60% of people aged over 85 were using tertiary care services, a third also accessed primary prevention. As the researchers comment:

"This suggests that services focused toward early intervention are being used by the total older person population, not simply those in younger age groups." (PSSRU, 2010, P.3)

2.46 The outcomes of the project are summarised in Box 3 below. The evaluation found improved outcomes for people across a wide range of indicators. The impact on quality of life was difficult to assess, as the researchers observed, particularly because "many users were very old and frail and likely to experience deteriorating well-being in any case." Similarly, although services could provide valued help, they were:

"unlikely to have a striking impact on their overall quality of life, as other factors, such as poverty, illness or bereavement, were more likely to be critical here." (PSSRU, 2010, P.4)

2.47 Evaluation of health-related quality of life used a standardised questionnaire before and after the POPP involvement to assess such things as people's mobility; self-care capacity; ability to undertake usual activities; levels of pain or discomfort; and anxiety or depression. The findings differed between different types of POPP project, with the greatest improvements (12%) reported by older people receiving practical help. The evaluation team commented that this represented:

"A far higher change in their [health related quality of life] than might be expected from such simple focused services. It could be argued that those services that provide simple aids and adaptations can change the ease of self-care. A grab-rail attached to a lavatory, bath or shower can make washing easier. Similarly, providing gardening services or making simple repairs can reduce user anxiety. Such projects appear to have a notable impact on users' [health related quality of life], with their change in this respect 6% greater than that of the overall sample and 16% greater than that of the quasi-control group." (PSSRU, 2009, P.156).

2.48 An equivalent level of improvement was reported following interventions providing exercise, while smaller improvements (3-4%) were found for people using projects offering community support, proactive case coordination and specialist falls programmes.

2.49 The cost-effectiveness of interventions was also evaluated. Establishing the costs of projects was not always straightforward because of inaccuracy of reporting or missing data and the evaluation is cautious in interpreting the results. Nonetheless,

"Within the context of this research, POPP projects can be recommended as a cost-effective policy option." (PSSRU, 2009, P.189)

2.50 Considered as a programme overall it was judged that there is a very high probability (86%) that POPP was cost-effective compared with usual care. In the case of projects focusing on practical support, there was a 98% chance of cost-effectiveness and:

"Commissioners putting in place such projects could be reasonably confident that only around 0.2 projects in ten would not be cost-effective."

Box 3

Outcomes of the POPP programme

- Staff involved in the projects believed the POPP projects achieved improved quality of life and well-being for the older people involved.
- People had easier access to a greater range of services and were more aware of them.
- The POPP projects provided a point of referral onto other services as required.
- The health-related quality of life of a sample of 1,529 older people was assessed using a standardised questionnaire before and after the intervention, and compared with a sample of people from the British Household Panel Survey.
- Impact varied with the type of project but improvements were generally found in health-related quality of life compared to the comparison group, and a 12% increase was found for people receiving practical help.
- The POPP projects were able to maximise people's receipt of state benefits by signposting them towards benefits such as Attendance Allowance.
- The total cost of the programme was £50.7m. The cost per individual user ranged from £4 per week for primary prevention projects to £7 for secondary prevention.
- POPP projects focused on avoiding emergency hospital admissions had a significant effect. "£1 additional spend on POPP projects would lead to approximately a £1.20 reduction in required spending on emergency bed occupants."
- Community facing services showed increasing returns against economies of scale (the larger the project, the greater the saving). Funding these services would save £1 for every £1 spent.
- Considering the POPP projects overall, there was a very high probability (86%) that the programme was cost-effective compared with usual care.
- Projects focused on improving well-being by providing practical help (small housing repairs, gardening, limited assistive technology or shopping) found that for an extra £5,000 spend per person (£96.15 per week) there is a 98% probability of cost-effectiveness compared with usual care.
- Hospital overnight stays were reduced by 47%, and use of Accident and Emergency departments by 29%. Highest cost reductions were achieved by projects focusing on hospital discharge.

Source: PSSRU (2009) *National Evaluation of Partnerships for Older People Projects Final Report.*

2.51 These findings are clearly important. The emphasis of recent years on developing prevention and well-being support has largely been on the assumption that there *would* be cost-savings. The evidence that this *is* the case and that such services can also offer improved outcomes, greater satisfaction, and reduce the need for hospital and higher dependency services is important for commissioners, although it needs to be viewed alongside further emerging evidence such as from the Whole System Demonstrator programme (see below). However, the outcomes that were achieved were the result of pump-priming prevention and early intervention projects, and in order to secure change of this nature new models of commissioning and development are required:

...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." (PSSRU, 2009, P.262)

2.52 Such changes also cannot be achieved overnight and it takes time to establish new services and get them running, especially when multiple partners are involved.

c) Falls Prevention

2.53 Falls and fractures are a major risk for many older people, with one in three people aged over 65 and one in two aged over 80 falling each year. Evidence indicates that a falls prevention strategy could reduce the number of falls by up to 30 per cent. In addition to the direct consequences of falls in fractures and injuries, it is well evidenced that the psychological impact can also be significant, leading to loss of confidence and independence, and increased isolation (NHS Confederation briefing, 2012).

2.54 Falls and fracture prevention initiatives typically involve exercise and mobility programmes for older people to improve balance and coordination, together with raising awareness of environmental risk factors and dealing with trip-hazards in the home. Ensuring that people who *do* experience falls and fractures are able to benefit from subsequent reablement is importance, as is assessment to identify risks of future falls.

2.55 Because of the impact of falls on both health and care systems, successful interventions are most likely to involve integrated multidisciplinary approaches.

d) Telecare

2.56 Telecare is another area in which there has been considerable interest and where the potential for supporting people to remain independent while also offering savings to services is attractive. The previous administration sought to encourage development through the Preventative Technologies Grant (totally £80 million over two years from 2006/07, and paid to all local authorities). The accompanying circular described the purpose of the grant as being:

"..to initiate a change in the design and delivery of health, social care and housing services and prevention strategies to enhance and maintain the well-being and independence of individuals." (DH, 2006b)

2.57 More recently the Government's vision for adult social care observed:

"New technology opens up new horizons for care. From community alarms to sophisticated communications systems, telecare can help people stay in their own homes and live independently for longer." (DH, 2010b, para 3.9)

2.58 The Care Services Efficiency Delivery (CSED) programme[1] operated by the Department of Health until March 2011 developed a range of tools and products to support the expansion of telecare. The use of telecare is fast expanding but often in a piecemeal rather than strategic manner. CSED advice on implementing telecare to achieve efficiencies observed in 2009:

"Yet whilst individual pieces of technology can help individual users, experience suggests ***that an integrated approach is needed to deliver real benefits and efficiencies across the whole of a council's adult care system.*** *Instead of ad hoc add-ons, best practice telecare is part of an authority's mainstream care system."* (CSED, 2009, P.2).

2.59 Various councils (notably North Yorkshire and Essex) have been cited as exemplars of best practice in the use of telecare, and local practice is explored in greater depth in Section 3.

2.60 The Whole System Demonstrator (WSD) programme was established in 2008 with funding from the Department of Health. The programme was to explore the use of technology in helping people to manage their own health and maintain independence. This is the largest ever randomised control trial of this approach, involving more than 6,000 people across

[1] http://www.csed.dh.gov.uk/AT/

Cornwall, Kent and Newham. Independent evaluation was undertaken by the Nuffield Trust, and the findings are expected to significantly improve the evidence base, and to inform better targeting of interventions to achieve better outcomes and cost-effectiveness.

2.61 The first findings from the WSD programme have focused on telehealth and its role in preventing emergency hospital admissions (Steventon and Bardsley, 2012; Whole System Demonstrator Team, 2012). Telehealth is not the same as telecare (although the terms are often – mistakenly – used interchangeably), and it provides technology to help people with chronic health problems to manage their condition and live independently (e.g. through measuring blood pressure or blood glucose levels and transmitting the results remotely to health care professionals). The WSD research is one of the largest telehealth studies ever conducted and compared the experiences of 1,570 people using telehealth with similar numbers in a control group receiving usual care. The patients all had chronic obstructive pulmonary disease (COPD), diabetes or heart failure.

2.62 The study found 'significantly fewer' (43%) intervention patients admitted to hospital compared with control patients (48%), and fewer deaths over 12 months (4.6% of intervention patients, compared with 8.3% of control group patients). However, the authors are cautious about the findings at this stage, given that it is unclear "whether effects are attributable to the technology itself or attributable to how it is implemented." Furthermore, although emergency admissions were 20 per cent fewer for the Telehealth patients "these reductions were from a low base" (Steventon and Bardsley, 2012, P.3).

2.63 The trial did not find reduced hospital costs associated with the use of Telehealth: "This does not mean that telehealth does not have an impact on costs, only that the differences observed in this trial could have been the effect of chance." Nonetheless, the authors conclude that the reduced mortality observed "will be an important motivator to invest in these interventions and similar technologies" (Whole System Demonstrator Team, 2012, P.7).

2.64 Further findings from the Whole System Demonstrator programme are planned and it is hoped these will illuminate further aspects of technology use in both health and social care services, and the impact on cost effectiveness, quality of life, and patient and carer experience, alongside organisational changes.

2.65 The White Paper acknowledges the important role of assistive technology and telecare in supporting people's independence. The "incentives and support for widespread adoption of assistive technology" will be set out "later this year" (P.28).

Conclusions

2.66 This introductory section has set the scene for exploring the issues around the development of universal and open access support for older people, and located this discussion within the wider context of social care policy in general, and prevention in particular. Some of the key findings can be highlighted:

- Much of the debate around adult social care focuses on matters of eligibility and the consequences for people whose needs do not meet the threshold criteria.
- From the outset, the eligibility framework (Fair Access to Care Services) was not intended to be all or nothing, but was meant to be located within a wider context addressing prevention, community well being and social inclusion. In practice councils varied substantially in their approach to such matters and wider agendas.
- The change of government in 2010 did not signal a significant change of direction in adult social care and there is major continuity of key themes such as the emphasis on health and wellbeing and the importance of prevention. These themes have been further underlined by the White Paper published in July 2012.
- In developing their local approaches to adult care and support councils are increasingly aware of the importance of making the best use of resources and investing in services that may reduce or avoid people's needs for more costly and intensive interventions.
- The evidence base on effective prevention in universal and low level services is patchy but growing.
- There is evidence to support interventions such as time banks, befriending and community navigators.
- Evaluation using a model of Social Return on Investment indicates that community development activity and the growth of social capital is also cost effective.
- The Partnerships for Older People Projects (POPPs) covering a wide range of hospital-facing and community-facing initiatives have also been found to be cost effective.
- Falls prevention strategies are believed to be able to reduce falls by up to 30%.
- Telecare is also believed to be cost-effective, particularly when it is strategic and mainstream rather than ad hoc. Evidence from the largest evaluation of telecare and telehealth is beginning to emerge from the Whole System Demonstrator programme and initial findings have focused on telehealth aspects which have recorded reduced hospital admissions and mortality.

2.67 We turn now to explore the perspectives and experience of key stakeholders and local councils in developing their approaches to support.

3. Universal and Open Access Support

3.1 Interviews and discussions took place with 9 key respondents. Most of these were Directors of Adult Social Services (DASSs), but some were senior managers or front-line practitioners responsible for particular innovations; some discussions also took place with external commentators. Individuals are not identified in what follows. All respondents were extremely willing to engage with the study and to explore the factors that can support good practice and innovation.

3.2 The ADASS document *The Case for Tomorrow* (2012) had been recently published at the time the fieldwork was taking place, and formed an important context for discussions. Respondents were fully aware of the challenges in care and support for older people, including those around support for people who do not meet eligibility criteria. Discussions were wide-ranging, but a number of themes recurred. Before turning to examine some of the developing models of support and how these might be encouraged, we begin by exploring some of the barriers and pressures facing councils.

Barriers and Pressures

3.3 The ADASS budget survey published in June 2012 found Directors of Adult Social Services in England taking £890 million out of the social care budget between April 2012 and March 2013 (ADASS, 2012b). The majority of these planned reductions are being achieved by service redesign and efficiency, and through increased charges, with only 12.7% saved by reducing services. A large part of this redesign of services is concerned with prevention and recovery services.

3.4 The argument that social care is under-funded is one that has been made forcefully over several years. Such assessments are not only made by those working in the sector, but also by independent reviews. The Wanless report remarked that “evidence of inadequacies in current social care provision is not hard to find” (Wanless, 2006, P.2), while the report of the Dilnot Commission also stated a conviction “that the current social care system is inadequately funded” (Dilnot, 2011, P.14). Throughout the fieldwork respondents emphasised the fundamental challenge posed by resources and the knock-on impact on councils raising their eligibility thresholds, and the following comments are typical of many that were made:

"Directors, with elected members and Chief Executives have had to make some really tough decisions around how they're going to balance their budget (...) if we weren't in these austere times, the majority if not all of those local authorities wouldn't have changed their eligibility criteria."

"It is very hard to do these things at a time when resources are being squeezed, and when councils have got to make difficult decisions and they've got statutory responsibilities there'll be a tendency to drop the non-statutory things."

"I think what's difficult is resources are so tied up in delivering existing services that actually it is quite a juggling act for authorities to free-up existing resources to do these things differently."

3.5 However, respondents also acknowledged that the issue was not simply about resources, that it had become apparent that service models were not working and that merely focusing on people who met eligibility criteria was not sustainable, as these comments highlight:

"We're getting the sense that just concentrating on eligibility wasn't working. I think there was a combination of things going on because not all the thinking is borne out of the austerity (...) It was becoming clear, even in the period of growth, that we were serving less and less people."

3.6 The argument that the system is inadequately funded was frequently linked to an understanding that there will always be finite resources, but that demographic pressures create a particularly challenging environment. The growth of the older population is the most significant – and frequently discussed – aspect of this, but there *are* wider demographic factors, as these respondents acknowledged:

"Also, actually it's not just all to do with the older population. We know that medical advances, particularly for young people, are now meaning that a lot of younger people who are disabled are living longer – which is fantastic. And equally, those younger adults are living longer and being cared for and supported in the community."

"Learning disabilities – the financial pressure from learning disabilities, in my area certainly, is two to three times greater than the financial pressure from older people (...) about half our financial pressure is people who can no longer live with their parents. They've had some support – maybe some day centre – but suddenly we've got to cater for their whole support and where they live and all their day to day support that historically their parents did."

3.7 How local councils manage these demands against their available resources is mediated by multiple factors, but the influence of local political priorities is crucial. This Director of adult services observed:

"Local authorities prioritise things differently. So one of the reasons why I think I've managed to avoid some of the really difficult decisions that other local authorities have had is because the politicians here really wanted to support the continued investment in adult social care."

Nonetheless, protecting adult care was looking harder to achieve with the requirement to find additional savings:

"[elected members] are in an impossible position. I think in 12 months time – I really can't see where they're going to make the savings without significantly impacting on some of the services they provide to older people now."

3.8 Another Director also highlighted the increasing pressures over time:

"Local authorities are between a rock and a hard place on this, and even in areas that have managed to do things largely by service redesign you know, we're getting to the point where what else can we do, and there will be cuts.

3.9 As another also pointed out, those councils that had already begun to redesign their services before resource pressures began to bite were in a stronger position than those who had not been so strategic in approach:

"We started before the really hard austerity, so we've got the commitment. But just to start trying it out now when a lot of people are doing the 'slash and burn' stuff...."

3.10 All respondents recognised the tensions between adopting a broad universal approach to care and support, while also managing resources. The use of FACS eligibility criteria as a lever to manage demand was frequently referenced although it was acknowledged that this was a crude approach in itself. While some mechanism is needed to ensure that people with care needs are identified and supported, increasingly this can only function within a wider strategy based around a universal offer

Information and Signposting

3.11 As we explored in Section 2, guidance on FACS has emphasised the importance of councils providing information and advice for all citizens, as well as signposting to other sources of support (including universal and open access services). Work undertaken in 2009 by I&DeA explored emerging practice in local authority areas:

"Current provision of information, advice and advocacy has developed from a multiplicity of separate initiatives, largely as an adjunct to other initiatives rather than as part of a coherent services strategy. All local authority areas therefore have an array of services but largely these are not at present strategically ordered or coherent." (I&DeA, 2009, P.6)

3.12 Both practice and thinking were reported to be 'developing rapidly'. It was understood that initial energies had focused on developing the mechanism and cultural change required by the transformation agenda, but had subsequently engaged on a broader front "including strategy and practice in relation to information, advice and advocacy and related work in community capacity building".

3.13 Research commissioned in the same year by ADASS, the Local Government Association (LGA), and the Social Care Institute for Excellence (SCIE) reported a mixed picture. While acknowledging improvements in the quality and accessibility of information about adult social care, nonetheless:

"..persistent problems remain including limited information, highly variable responses, poor web sites, information written for professional rather than lay audiences; and people have specific needs that require more than just an information bank." (Hudson and Henwood, 2009).

3.14 In a follow-up study on information, advice and advocacy (IAA) it was noted:

"The pathway to information and advice is rarely smooth; partly because of the complexity of IAA needs and the variety of organisations involved in providing different parts of the picture, people often struggle to get the right information and may go through multiple steps before finding the right point of access." (Henwood and Hudson, 2009, P.22).

3.15 A qualitative investigation commissioned by the Putting People First Consortium explored the decisions and destinations of people who self-fund residential care and found mixed but largely negative experiences. Typically self-funders described being given a list of local care homes they might wish to make use of, and little else. Some people had found their way to other sources of information (such as through Counsel and Care) and reported more

positive experiences. The study underlined the need for information and advice to be available through a variety of accessible and non-stigmatising routes, and offering a range of approaches (electronic, telephone, written, face to face etc). It was observed that:

"On the basis of people's reported experiences it is doubtful that the local authority is the organisation best placed to provide such flexible and independent advice when they are simultaneously acting as gatekeepers to limit publicly funded support." (Henwood (2011), P.48).

3.16 'Signposting' has also had something of a bad press and has often been seen as a euphemism for doing little or nothing. The exploration of eligibility and self-funding carried out by CSCI classified signposting under the heading of 'rationing by diversion' (CSCI, 2008). In the six councils that were the focus of in-depth fieldwork for the CSCI study it was clear that signposting was associated with greater reliance on the contribution of the third sector, but little was known about the effectiveness of signposting to these voluntary and community services.

"There is typically no follow-up for people signposted elsewhere and no means to gauge the effectiveness of signposting and other strategies, or to feed this information back to the planning and commissioning processes." (CSCI, 2008a, P.137).

3.17 In the course of the research for the present study, observations by interviewees suggested a more positive approach to signposting being developed in partnership with the private and voluntary sector, and providing a route to universal support. For example:

"Sure Start to Later Life is very much about signposting – information provision, groups working together (...) and they get together and talk about what they can change – rather than relying on the local authority – what they can change and how they can change that."

"Looking at how people don't come into the system, but are supported through communities and through universal services much more."

And

"The first issue is about information and advice, because there is a whole set of things out there that anybody can use, but that older people may not know about (...) so for anybody living in an area there's probably something that would interest them going on. So some of that is the local authority's role in terms of making sure their websites have got good up to date information, or the local libraries notice boards (...) we have a role in helping people find them, but we're not the only people."

3.18 As respondents recognised, 'how you set things up can have an impact on what people find out', so having a flexible and user-friendly information portal, and multiple ways of accessing information is vital. Being able to gain access to multiple organisations and services by ringing one number or going on a single website is increasingly favoured as a strategy. Some councils are also developing models with the voluntary sector that people can access without having to contact the council, as this person described:

"It's intended to be a different stream to our council's customer service centre (...) it's for people who don't want to phone the council – who don't need or want to phone the council. And actually, to help the customer service centre not have to deal with things they're only going to signpost back to the voluntary sector."

3.19 Whereas 'signposting' was previously often used as a pejorative term and implied councils doing very little for people whose needs did not meet eligibility criteria, respondents described approaches that were more proactive, for example:

"I'm sure there are people who think that there are some older people who could do with a bit more support, but most people who come to us will get signposted to something, rather than being told you're not eligible – go away."

And

"It's not a sense of saying to people you don't qualify for services, it's saying what would you like and we can see if we can link you up or support you with this."

As part of this shift, there is also greater attention being paid to following up such referrals and identifying outcomes.

3.20 The social care White Paper recognises the importance of better national and local information in helping people to better understand the options available to them, and helping them to prepare for their care and support. From April 2013 the Government will provide "a clear, universal and authoritative source of national information about the health, care and support system" (P.30). This will create a single web portal for health and care that will consolidate existing national on-line services. In addition, 'radical improvement' of online information and support services is to be supported by £32.5 million of start-up funding over two years from 2014/15:

"The Government will legislate to ensure that local authorities provide a comprehensive information and advice service. All local authorities currently provide information on care and support to their local populations, usually through a mixture of web-based, telephone

and face-to-face services. However, we know that the coverage and quality of this information is highly variable."

3.21 The understanding of what is meant by 'universal' support has arguably become more sophisticated and nuanced. The inference is *not* that all 'low level' services should be freely provided, but rather it is about understanding what resources are available to people 'pre-eligibility', and for those who have financial means which take them over the threshold for publicly subsidised support. As this person observed:

"Universal increasingly comes to mean those people that are paying for their own higher level care, and in [this authority] that was driven by a political debate that you can't pay taxes all your life, and then pay for care, and then have the State saying 'we're not doing anything for you chum'."

3.22 Accordingly to this analysis, universal support is not about lowering eligibility, but rather is "rooted in a different approach than eligibility", and within a wider community context:

"..where increasingly 'universal' is how do you take your duties at a whole population level?"

3.23 As another respondent observed, this approach is crucially different from a model that is concerned with *services*, and takes a different tack:

"The only alternative is to get in earlier and in a more universal way, but with things that don't look like services. I think where preventative work has fallen down before – it's often because it has been an attempt to offer a lighter touch version of a service (...) so I think the early intervention isn't the same as an early service."

3.24 Another respondent drew a distinction between universal services such as libraries, leisure centres, community halls and other local activities "that are available to anyone, and they might go through the council and they might not"; and 'targeted universal services'. This latter category of support has a more focused preventative component, as described below:

"Anybody could get them but they're particularly targeted at certain people, and that would be things like lunch clubs or maybe community alarms (...) which are pre-eligibility services."

3.25 The logic of targeting such services, or directing certain people towards such help, was expressed succinctly:

"Most areas have got their eligibility set at substantial, but obviously you don't want people to be just below substantial and then drop into substantial straightaway because there was nothing on offer."

Conclusions

3.26 This section has drawn on research literature and on the qualitative evidence from interviews conducted for the study to explore approaches to universal and open access support. The key messages are highlighted below:

- The pressure on resources for adult social care is a constant feature of local experience and creates significant challenges for councils trying to manage demands without focusing solely on eligibility.
- Local political priorities are an important variable in how councils can respond to pressures. Councils use different strategies to try to avoid cuts including service redesign.
- Approaches to signposting and information appear to be developing rapidly. The initial focus of transformation was on the processes of personalisation, but attention has increasingly shifted to information and advice, and wider community capacity building.
- Good practice appears to be associated with information and advice functions being developed in partnership with voluntary and third sector organisations to provide easy routes to universal services without the need to directly involve local councils.

3.27 The understanding of universal support is nuanced and some councils have a more sophisticated approach that addresses both open access support directed at the whole community, and pre-eligibility support targeted at people who may otherwise need social care support before long. Early intervention is not necessarily the same as an early 'service'.

4. Prevention

4.1. In Section 2 we explored some of the evidence base around prevention in social care. In the course of the fieldwork interviews it was apparent that both knowledge of, and frustration with, this evidence was a recurrent theme. Respondents cited the ADASS document (*The Case for Tomorrow*) and its call for government to put more resources into research and dissemination of best practice in preventative services. As some interviewees pointed out, more research is needed, but people also need to be more aware of the evidence that currently exists, as this comment highlights:

"With the exception of telecare, and some vague evidence around reablement and intermediate care, there's not a lot of evidence out there that preventative services actually work!"

4.2. In some respects, the lack of evidence also reflects the general uncertainty of terminology:

"The evidence is there on Telecare, that's a definite (...) but I don't think we have ever really established a database of what would be perceived as preventative services."

4.3. Without such evidence, making the economic case for further investment in prevention can be problematic, as these comments recognise :

"I haven't got the evidence base around it. I don't think there is enough evidence to support us economically on it."

"It's really difficult because these are hard times for people to invest in preventative services, and if you haven't got the evidence it saves you money – then it's really difficult. But sometimes it is about redirecting resources that are already spent on non-eligible things."

4.4. As other interviewees remarked, making the business case for prevention can be further complicated by the fact that savings do not necessarily accrue to the commissioners making the investment. An approach that is able to look at savings across the health and care economy is likely to necessitate an integrated approach across health, care and other local partners. One person observed:

"[I have concluded] that there's no prevention without integration, there's only kind of cost-shunting."

4.5. The White Paper has acknowledged the need for greater clarity around the evidence base and announced plans to launch a national care and support evidence library in 2013:

"We will make use of existing evidence and available information about particular interventions (...) We will also focus on options for identifying and addressing significant gaps in the evidence base where new research may be needed." (P.26)

4.6. It will be important that the evidence library is more than a clearing house for research, and that it offers interpretation and analysis of evidence. The research evidence in social care is often highly academic and can be very difficult for practitioners to interpret and apply.

4.7. The political climate in councils can make a significant difference to the approach adopted. Particularly at a time of increased pressure on resources, there is limited room for innovation unless elected members are prepared to trust officers to take some risks and test out different strategies, as this person described:

"If you're told [by members] we're narrowing down to statutory only services, or we're going to reduce our council tax this year, or whatever – actually your room for manoeuvre is limited. In authorities where there a slightly different way of thinking which allows you the room, and will accept trying something with a slightly bigger risk, then you've got more scope."

4.8. As we noted in Section 2, terminology around prevention is often vague and poorly defined. Much depends on "what you mean by prevention, and what you are trying to prevent". It is important therefore that prevention is addressed strategically, as this comment described:

"So we have got evidence that falls prevention prevents hospital admissions, and actually prevents people going on to develop higher care needs. We have got evidence that additional services known to prevent hospital admission can do just that, and also prevent higher needs. We have got evidence that enablement home care makes a difference and stops people going on to need care. We have got evidence that Telecare can help people live independently."

4.9. Much of what is included in the above definition would apply to people who are already on the radar or are meeting eligibility criteria and receiving some level of support. The more challenging aspect is to identify what preventive support needs to be offered pre-eligibility (or through 'low level' support) to achieve similar outcomes. However, the outcome measures for this type of prevention will be different – not everything will be demonstrable in preventing high level needs developing or preventing people going into hospital or

residential care, but sometimes outcomes are also about "people not feeling isolated and having a better life."

4.10. How the concept of prevention is framed may need to be redefined. The conventional approach of primary; secondary and tertiary levels of prevention is seen by some as a highly medicalised model. Moreover, as this interviewee explained, it is a particularly negative way of understanding interventions:

"I think the term prevention is really unhelpful (...) the idea that there is preventative stuff and then if prevention fails, there's reactive stuff is really unhelpful (...) a sort of negative concept – it's trying to avoid something."

4.11. Instead – and drawing on the insights from the *Caring for our Future* engagement,

"Things that appeared to be most likely to be effectively preventative were much more positively framed around people's strengths; assets; resilience and empowerment and how they might connect with other people around them. So my feeling is that we need to stop seeing that kind of staged process of (...) the preventable and the not-preventable."

4.12. An alternative model might be to see every service or intervention as "having a supportive element" but being more holistic in approaching prevention rather than in terms which invoke a medicalised model. This wider perspective includes, for example, such dimensions as tackling isolation and supporting people's social networks and relationships. While such elements can be seen as vital in terms of quality of life, there is also an important aspect of supporting people's continued independence:

"Any intervention that inadvertently reduces people's self-care capacity, and reduces the likelihood of people being connected into a supportive network is less cost-effective than an intervention that doesn't do that."

4.13. Supporting people to reconnect with their community and to overcome isolation is likely to imply a very different model of 'prevention' than an offer of low level support. The holistic focus which is more about relationships and less about 'care' reflects "somebody's whole life rather than just their interaction with one service or another." Another interviewee similarly described a model of 'wellbeing and health':

"Looking at how we support older people in their communities to support each other."

And

"It's all under the preventative umbrella, because the more people can do for themselves. And we've got a strong belief that feeling good about things is all part of the wellbeing stuff, and if you can avoid the isolation and some of the triggers that help people deteriorate quicker."

4.14. A discussion paper from In Control and others has observed that:

"Expensive and limited professional-led services are not the only way of meeting most social care needs (...). Most people with social care needs are not eligible for support – they support themselves. Many social care needs such as isolation or social exclusion, are not 'fixable' with a service." (In Control, 2012, P.3)

4.15. Support with housing might also be viewed within this preventative approach, particularly where people are struggling with some of the practicalities of maintenance and small repairs. As this interviewee acknowledged, investment in such support as a preventative strategy may not be significantly informed by clear academic-based evidence,

"But there is evidence that if you help people with those things it can help them stay independent."

4.16. The White Paper addressed the housing implications of care and support and noted that the draft Care and Support Bill will set out new duties on local authorities to ensure that adult social care and housing departments work together, particularly supporting adaptations and home repair services (P.27). In addition, a new care and support housing fund is to provide £200 million of capital funding over five years from 2013/14 "to encourage providers to develop new accommodation options for older people and disabled adults."

4.17. Anything that helps people feel better able to cope, and more confident in coping, is likely to support them in remaining independent. It is important therefore that the evidence of what happens to people following signposting to services or access to support can be identified. Box 4 below provides an example of outcome monitoring in one authority.

Box 4
Reviewing outcomes of information, advice and advocacy service

Breakdown of outcomes recorded by information, advice and advocacy service with follow-up calls for 10% of users.	
Client knows where to go for help	30%
More choice and control	26%
More able to access the right services/universal services	24%
More able to take part, use services, volunteer	7%
People feeling safer	4%
People managing conditions better	4%
Carers getting information they need	3%
Carers helped to carry on caring	1%
Changes made to clients' environment (falls prevention etc)	1%

4.18. Some of the provision of support that is offered 'pre-eligibility' is offering more than is apparent on first sight. Lunch clubs are one such example. The idea of a lunch club where older people come to a community resource in order to eat together can appear anachronistic, and the concepts of personalisation and facilitating choice and control would often suggest encouraging alternative models – such as supporting people to meet up in local cafés or pubs, and using regular community facilities. However, sometimes lunch clubs are serving a wider purpose:

"But actually, some of the lunch clubs, it's not just the lunch that people are going for (...) one of the things that the people who attend most value is the exercise they do when they get there."

And as another interviewee described:

"Actually what we did was we tried to work with existing community groups where eating was part of a range of things that they might do."

4.19. Such support, provided through the voluntary sector, can work out cheaper than a standard day centre and can offer something to people who may be lonely or isolated, while also having low or moderate needs for some support. The potential for exercise (such as Tai Chi) to be of value in falls prevention and maintaining mobility is an added benefit:

"It's not just the fact that you're going somewhere for lunch when you could have gone to Sainsbury's café with your friend Joan. You wouldn't have got your falls prevention advice; you wouldn't have got the exercise class etc."

4.20. Box 5 describes a case study in a council reviewing its approach to day services and lunch clubs.

Box 5

Re-shaping day activities and lunch clubs: A case study

Day activities and lunch clubs are popular and reach large numbers of people in an area who might not have access to other services. A review undertaken in a county council found most people using the service to be aged 75+ and socially isolated, describing the lunch club as their only social activity. More than 3,000 older people attended at least one day a week, and more than 800 (mainly older) volunteers were also involved in the services, with almost one in five clubs run entirely by volunteers. Some 5-10% of users appear to be FACS eligible. Services are believed to offer a good investment but have developed incrementally and without a clear rationale. There is believed to be scope for better value for money and improved outcomes for service users and for carers who also benefit from the support.

In view of the high numbers of older people attending services each week, there is believed to be great potential for using the services to address health and wellbeing outcomes, and for improving networking and information sharing between local services. Contract specifications have been revised to address health outcomes and to introduce or expand healthy living programmes. It is intended that commissioning will support groups to become more self-reliant and sustainable, and that a more modern model of service delivery will achieve outcomes linked to health and wellbeing strategies.

4.21. In addition to the added value that can be offered through this model of 'lunch club plus', a further benefit can be identified in the engagement of people who volunteer to help in the organisation and provision of the service, and are able to contribute their time and experience as well as benefiting from the engagement and activity, as this DASS described:

"The other thing we've found is there are, I think, 820 older people who volunteer in lunch clubs, and that is helping to keep them going, because they are volunteering. So it's not just about the people who go, it's about the people who volunteer."

4.22. Reshaping the nature of the offer available to local people has major implications for the way in which services are commissioned, particularly from the third sector. We explore this in more detail below when considering the development and support of innovation.

Community and Neighbourhoods

4.23. The debate about prevention is increasingly being located in a wider context of community and neighbourhoods, and is linking to the public health agenda and the new opportunities offered by Joint Strategic Needs Assessments (JSNAs) and the Joint Health and Wellbeing Strategy (JHWS), being developed under the auspices of local Health and Wellbeing Boards (HWBs) (Department of Health, 2010c; Department of Health 2012). The focus on wellbeing has implications for the wider council that go considerably beyond the remit of adult social care, but which nonetheless can make a significant contribution to maintaining people's independence. Interviewees described what this shift means in practice:

"Our view on prevention is probably far and wide (...) it's not just in adult social care, it's the wider agenda. It is the open spaces, you know, it is some of the things around alcohol, drugs, eating properly, keeping warm, housing etc."

"What we're trying to do more in my area now is try to do far more with communities than we've ever done before. So for example, we're about to launch a brand new initiative based on a neighbourhood approach which is primarily focused on health (...) we're looking at approaches to change behaviour."

4.24. While some of this is the traditional model of public health, others are adopting a wider approach, as this respondent explained:

"It's about befriending; it's about supporting people with low level mental health problems – primarily older people. Some of that was just simple things like people not having the confidence to go out the front door. People not having the confidence to travel in the borough, so that was having a mentor or somebody with them who would walk, help them get out and do the garden and have a structured programme, or get out on the bus and sit with them on the bus, you know, and get out to activities."

4.25. In some locations the model of the 'cooperative council' has been adopted.[2] As this person described:

"I think that is where you put your biggest effort – in communities and community resilience (...) I've got the active communities team for the whole Council (...) so everything we do, from libraries to parks, we put it through a cooperative prism."

4.26. Enabling older people to access the community and related cultural facilities is of direct relevance to prevention and social inclusion. Some of the co-production and consultation methods that have been developed in adult social care are being adapted for wider application to the local council. The development of 'community hubs' is one such example where existing buildings and resources (such as libraries) are being redefined for wider use:

"We would look at three kind of core buildings, but the others that are at the moment called libraries – services could be provided in different ways by different people in different places to meet the needs of that community."

4.27. Libraries are already used for many more functions than in the past, and for older people the availability of internet access and 'silver surfers clubs' is again potentially an important element of universal support:

"It is about the people who aren't at the very pinnacle of needing care. And I think that all the local authority will be doing shortly is doing that bit – the very top bit. But the bottom bit, we will have facilitated, and devolved the budgets to communities that will be developing what's needed for their communities."

4.28. Another DASS similarly pointed to the importance of supporting and developing social capital, while recognising that there is often considerable activity happening spontaneously and through volunteers:

"There are people who are doing all sorts of things out there (...) making it happen in their local community because they see a need and they do it. And there's something about 'so, what's the council role in that, or what's the voluntary sector role in that actually?' Sometimes it is about enabling it to happen."

[2] The Co-operative Councils Network is a group of Labour-led local authorities that are adopting cooperative approaches to transform the delivery of local public services.

4.29. Part of the role of the local authority is about being able to identify where such activity and social capital exists, and putting in place initiatives or a bit of pump priming that might encourage its development, for example:

"We need to think more flexibly about venues. We've just changed our library opening hours, so not all the libraries are open every day, so there are buildings, and we've offered them to the voluntary sector to use on days when they're closed (...) If you want to encourage the community capital bit, that's one of the things you can do."

4.30. Using resources flexibly and enabling things to happen locally can have significant effects, without requiring a major investment to establish. As this person remarked, it is about doing things differently:

"It's how you do it, and I think it's what you do to enable things to happen (...) and a lot of things don't cost much money. They may need a venue; there might be willing partners. And also there's a mix between paid work and volunteering work."

4.31. Interviewees described approaches to pump priming and stimulating social enterprises or micro-business by competitive bidding processes that would support services concerned with a range of objectives such as:

- Promoting independence and physical and mental wellbeing
- Reducing preventable ill health and disability
- Supporting and sustaining carers
- Supporting people to be active citizens
- Promoting community cohesion and social inclusion (including of hard to reach sections of the community)
- Encouraging self-reliance and volunteering
- Reducing demand on formal health and care services.

Innovation

4.32. Having some 'licence to experiment' can be invaluable in supporting and stimulating innovative models of support. Changing patterns of support can, however, be challenging and difficult to achieve. Several interviewees described the experience of reforming the nature of the relationship between the council and the voluntary sector, and moving away

from a grant funding model towards one much more strategically focused. Nowhere had this journey been without difficulty, although the end result was viewed positively.

4.33. In some situations a fairly traditional third sector and a paternalistic council had combined to create a culture in which it was expected that 'the council would provide', while elsewhere there has been a shift in recommissioning what the voluntary sector can provide. This interviewee described the transition from 'traditional lunch clubs and day centres' provided by the voluntary sector:

"We were consulting with a view to significantly cutting (...) and from an officer perspective – professionally – we would not have wanted these services as they were because they were traditional, and I think I would say our voluntary sector here was quite institutionalised (...) but they had always been supported politically, so it was very difficult to get some shift and change in the system."

4.34. Some councils acknowledge that this was an issue that should have been tackled 'some time ago', but it was typically the combination of fiscal pressure and the realisation that more had to be done to manage the flow of people into the care system, that provided the leverage for reshaping the offer from the voluntary sector (a model with fewer buildings and more capacity for services to reach out). However, the radical change required by financial pressures also meant that "fearsome opposition" often resulted because of the simultaneous impact of reducing money in the system and finding an alternative model of support.

4.35. Change is often painful, and particularly so when it threatens long-established practices and ways of working, as this person remarked:

"The investment the groups had in staying the same, the investment in the system and in carrying on in the same way is very big, so we were looking for all sorts of different ways to shift."

4.36. The challenges are particularly evident in local areas that have a large voluntary and third sector of variable quality, with significant dependency on statutory funding, and where the overlap and duplication between groups is substantial. In another authority an interviewee described a similar review of services that had been undertaken with the voluntary sector, but with less apparent confrontation:

"We reviewed the efficacy of a lot of the voluntary sector infrastructure we had and we had to scale it back (...) we give less money to some organisations, and one or two have been

decommissioned, but on the whole we've still got a really good infrastructure because we worked with the sector to work out what worked best."

4.37. The reshaping of the voluntary sector often features the promotion of a model based around 'community hubs', as these interviewees described:

"We got these voluntary organisations to come up with proposals about who was going to be the hub and how they were going to engage with the wider community, not just around having their existing voluntary organisations but how they could develop outreach alternative services."

And

"(...) we were re-shaping the advice offer to make it one comprehensive offer. What we had was lots of groups doing the same thing in quasi competition with each other (...) they have to provide something which joins up with the other groups."

4.38. As we have noted earlier in the paper, telecare is increasingly seen as an important part of the package in supporting people in the community and as part of a preventative strategy. Some councils have taken this further in developing a universal service, and several interviewees pointed to practice in Hillingdon as one such exemplar. The experience in Hillingdon was also highlighted at the ADASS 2012 spring seminar as part of the strategy for managing demand for social care. Box 6 summarises some key features.

4.39. The Hillingdon model is notable for being available free of charge to people aged over 85, whether or not they are FACS eligible, and also being available at a relatively modest charge to self-funders. Analysis of referrals indicates a high proportion of people are receiving the basic (Level one) service, and are self-referring (and are likely to be outside FACS eligibility).

Box 6

Telecare in Hillingdon

- The TeleCareLine in the London borough of Hillingdon operates as part of the strategy to enable people to remain living in their own homes.
- The impact is expected in:
  - Preventing/delaying entry to residential care.
  - Preventing people needing on-going care.
  - Supporting confidence building during reablement.
- TeleCareLine is part of the mainstream offer for all clients in adult social care.
- TeleCareLine is free of charge for people aged over 85; FACS eligible, and for the first 6 weeks of a reablement package.
- TeleCareLine is available to self-funders at a cost of £1.13 to £12 per week (depending on the level of service).
- 2011/12 outcomes demonstrate reduced residential placements, and reduced homecare hours.
- Analysis of a sample of 195 people using an enhanced package of support in 2011 found:
  - 48% delaying demand for further services.
  - 10% enabled delay in residential placement.
  - 42% facilitated smaller homecare package.
- TeleCareLine is increasingly focused on engagement with the NHS and a strategic direction towards a TeleHealthCare service.

Source: Presentation by Linda Sanders, Corporate Director Social Care, Health & Housing, London Borough of Hillingdon, ADASS Spring Seminar 2012.

4.40. An evaluation of the cost-effectiveness of telecare by FACE Recording and Measurement Systems, and a research team at University College London (Clifford et al, 2012) concludes that "very substantial savings are achievable through the widespread targeted use of telecare." For a typical council serving around 250,000 people the savings are estimated between £3m (short term) and £7.8m (medium term); representing 7.4% - 19.4% of the total older people's social care budget. Such findings are based on existing social care clients (i.e. those meeting FACS eligibility criteria), and further evaluations of a more open access approach to telecare for older people (such as in Hillingdon) is required to examine the evidence of telecare preventing or delaying people needing additional social care support. However, the FACE study concludes that:

"The provision of telecare needs to be perceived as a mainstream activity, not an add-on."

4.41. This implies that consideration of the use of telecare become parts of the routine assessment of need, and the potential for making telecare available to people who do not meet other eligibility criteria requires a significant cultural shift, as this interviewee observed:

"The hardest thing is changing the mindset (...) because lots of the staff are used to having to hold things back and give it only when needed, so this is really bucking the trend (...) the hardest thing has been helping staff feel confident in promoting it, because we know it works best if it's put in before a crisis."

4.42. Some other innovative approaches are associated with outreach models also focused on people who are below eligibility thresholds. One such model was described by an interviewee:

"The focus was to provide a preventative service to self-funders, and to BME communities, hard to reach communities, and also to provide a review services to people who don't qualify for services."

4.43. In this authority, people whose needs are assessed at low or moderate are automatically reviewed and signposted to services that might be appropriate for them, as well as being given a benefit check to maximise economic well being. In addition to promoting independence, the objective is to add to community resilience, reducing the need for dependence on services at an early stage. Box 7 presents the key outcomes from reviewing people with low level needs, and the following statement summarises the outcomes review:

"The team will continue to complete telephone reviews and the process of collating information and developing knowledge of resources is ongoing. The professional expertise possessed by the workers has been of great benefit to the quality and findings of the reviews. The review outcomes indicate that people require a variety of information and services. At the same time, accessing voluntary and community organisations is reliant upon ensuring that a person feels safe in their home and the community, and that information on transport options is also provided."

Box 7

Outcomes of reviewing low level needs

- 211 telephone reviews were carried out in 2011/12.
- The target number was 408 reviews; the shortfall of 197 reflected 80 people subsequently meeting eligibility criteria and receiving support, and underlined the importance of reviews being undertaken in a timely manner following initial assessment.
- Other reasons for reviews not being completed included people having moved into residential or nursing care; having moved away; people had died, and some 30% were deemed not to be contactable.
- Following review every person is sent a letter summarising the needs identified and possible support options available.
- One third of reviews resulted in referrals to preventive services including Occupational Therapy and Assistive Technology.
- Follow-up six week reviews evidence that 91% of people have made use of the information provided, and 79% had accessed services to which they were signposted.
- Team has worked closely to identify self-funding residents in care homes and conducted information and advice surgeries in the homes.

4.44. Signposting people with low needs to occupational therapy was identified as particularly beneficial:

"People may not actually need any other services from the Council but having some OT aids in the home. We look at falls and falls prevention as well."

4.45. Linking to some of the local pharmacies had been particularly productive and has enabled people to by-pass waiting lists for OT assessments and instead purchase the aids and equipment they require directly. Isolation was identified as the other major area of need, and people were linked up with day centres and clubs and "what's happening across the borough."

4.46. To have maximum preventative impact it is imperative that reviews can be carried out quickly in order to provide maximum opportunity for people to access information or services and to avert their needs increasing to substantial or critical levels.

4.47. It is also believed that the review system offers added value in being able to identify potential safeguarding issues that would not otherwise be picked up where people are not in touch with the social care system:

"We've had some older people living on estates and they've been victims of gangs (...) or people just feeling intimidated and not wanting to go outside their front door. So we've raised quite a few safeguarding referrals where people have been safeguarded and we've got Safer Neighbourhoods teams involved."

4.48. It was recognised in this authority that it might be some time before it would be possible to demonstrate real preventative impact and cost-effectiveness, but meanwhile it was apparent that the initiative was extremely popular and the wider community had been highly supportive and welcoming. It was also believed that there is scope for widening the remit and getting some buy-in from GP consortia (people who are frequent attenders at their GP surgery may often have social care needs rather than health needs which might be detected and addressed through a review system), and linking the model more directly to the Joint Health and Wellbeing Strategy.

4.49. The potential for a model such as this to be more widely adopted by other councils was also identified, and it was seen as a more humane approach to managing eligibility thresholds, as this person observed:

"(There will be) a lot more people who are actually not qualifying for services but needing some support, and if they're not provided with the support and information, then I think it's quite remiss really. So I'm hoping this becomes a model that people look to."

4.50. Certainly this is an interesting approach, and one which also offers greater satisfaction for the review staff having the chance to 'get back to the grassroots' and 'do what I trained to do'. However, it might be argued that the use of social worker skills to undertake this work represents an expensive resource, depending on how much more it offers than an information and advice service, and whether the outcomes achieved are significantly different, as this person observed:

"I think for most areas, if you looked at all the money that is spent on things that are information or advice of some kind, and how inefficient they are, plus the resources that highly qualified social workers expend in conversations which are so tied up with gatekeeping they're not of use to anyone."

4.51. The particular example of the review of people judged not to meet eligibility criteria is an attempt to separate the gatekeeping function since the decision about eligibility has already been made. The case for using social workers in this way was argued by this interviewee:

"The critical thing for me (...) is where do you deploy social workers? Do you deploy them at the front end, and actually put your skilled resource in to stop people coming into the system and get them linked up with what's out there to keep them at home (...) or do you put them at the end? (...) And my instinct is that we should deploy at the front end."

4.52. Whether the outcomes achieved for people are significantly better than from other models of information, advice and signposting is – as yet – unclear, but the follow up of clients with subsequent telephone interviews is beginning to address such questions.

4.53. One way forward that is expanding in many areas is through the emergence of micro-enterprises and community-led solutions. These produce highly personalised responses to people's needs, but importantly they build on people's existing skills and networks, and:

"They provide the potential to form bridges between the goal of individually tailored services and a desire to encourage communities to contribute more to the local health and care economy by becoming more supportive and inclusive." (NHS Confederation, 2012)

4.54. The idea of early intervention starting with 'planning advice and navigation' is one that is being developed through models such as Local Area Coordination, as this interviewee commented:

"I am a big fan of the Local Area Coordination model which I think combines the idea of services that are there – it doesn't replace services but they are last on the list – an open door; a conversation that looks at what else is around people and what their goals in life are and how they might best achieve them."

4.55. Local Area Coordination (LAC) is being tested and developed in some councils (with pilots in Middlesbrough, Derby City, Stroud, and Cumbria), having originated in Western Australia. It is a model that focuses on community assets and "the skills, gifts and resources that individuals, families and communities already bring" (Fox, 2012). Box 8 summarises the key objectives.

Box 8

Objectives of Local Area Coordination

- Support people to identify their vision for a good life and their plans for getting there.
- Understand and utilise personal, family and community gifts, strengths and interests - support people to stay strong.
- Access accurate, timely and relevant information from a variety of sources – choice and control.
- Support people to identify and develop personal networks.
- Support people to have a voice – self advocacy, advocating alongside people or advocate for people.
- Support people to develop practical (non service) responses to needs.
- Build partnerships with and between individuals, families, communities and services.
- Support people to access and control resources or services where this is needed or eligible.
- Link people with existing community resources.
- Participate in and contribute to building inclusive communities through partnerships with local businesses, community, voluntary and third sector organisations.
- Identify gaps in community opportunities and form partnerships to actively develop local communities and resources – community building
- Promote opportunities for contribution and leadership.

Source: Clark S and Broad R (2011), *Local Area Coordination in England*, Inclusion North.

4.56. The pilot in Middlesbrough Council began in 2009 and is to be embedded as part of the core offer of adult social care. The Development Manager has identified the most important tool of the approach as the ability to ask the right question:

"The question isn't hard, it isn't difficult to understand and it isn't overly complicated with jargon or officialise; it's not loaded but it does open up a whole world of possibility and changes the emphasis of power and control placing it firmly with the individual, their families and their community. 'What would make a good life for you'?"

"Local Area Coordination has helped individuals to become more confident in their own ability to achieve, building self-esteem and changing attitudes to what getting involved in community life might actually mean for them. Helping communities to help themselves." (Taylor, 2012, pp 29-30)

4.57. An independent evaluation of the early Middlesbrough experience of LAC confirmed "largely positive" results, and in particular LAC:

- "Can make its focus the results that people want to achieve;
- Provides a universal service that is available without the need to satisfy any eligibility criteria based on need;
- Can offer support without time limits;
- Can provide different types of support including practical help;
- Has built up a detailed knowledge of local resources and directs people towards these;
- Can work more flexibly and creatively;
- Provides a 'one-stop' approach dealing with all of a person's situation." (Peter Fletcher Associates, 2011, P.5).

4.58. The evaluation recommended that in Middlesbrough LAC should become a key part of the way that people can access services and

"It should also form the core of the Council's response to those people who fall outside the current eligibility for social services support." (P.7)

4.59. A 'relatively underdeveloped' feature of the early months of the pilot was judged to be the emphasis on building social capital and social inclusion. Without this it was believed that "opportunities are being missed to develop more innovative forms of locally based support and to fully integrate people using the service into the local community." Findings from both the Australian experience with LAC and that of Scotland indicate that providing small grants to local groups and individuals "can be an important means of building local capacity and developing local solutions" (P.80).

From innovation to mainstream?

4.60. There are multiple examples of innovation and good practice in adult social care. Many of these are disseminated through the Social Care Efficiency Network (http://www.socialcare.improvementefficiency.org.uk), although much of the focus is – understandably – on supporting people who have been assessed as eligible for social care support. An equivalent focus is required to focus on defining and developing the 'universal offer' for all citizens, regardless of whether they meet eligibility criteria.

4.61. On the basis of all the discussions conducted for this research it is clear that although there are consistent themes about developing new models and best practice, there is no single blueprint, or 'one size fits all' approach that can be applied to all councils:

"Because every locality is different; everybody's demographics are different, and priorities can be different as well. But I think what we should be doing is promoting the values, the principles and examples, so people can flex them according to their local circumstances."

4.62. Examples of local practice can be important in spreading ideas and thinking, but each council has to work through the practical implications in their own context, particularly when this entails remodelling services, changing contract specifications and the relationship with the third sector, and developing and nurturing social capital.

4.63. In this section we have explored the links between universal support and prevention and ways in which councils are addressing this interface. The key findings can be summarised:

- The relative lack of evidence on prevention is often cited as a reason for limited development and difficulties in making a persuasive business case. While further evidence of what works *is* required, there *is* now a growing body of evidence to support a range of interventions.
- The establishment of a national care and support evidence library in 2013 should provide further help for commissioners in identifying effective support to sustain people's independence. However, it will be vital that such evidence is accessible and can be applied in practice.
- The concept of 'prevention' may need to be reframed. Some of the more positive developments are concerned less with 'care' than with supporting relationships and social networks. Supporting people to engage with their communities implies a different model of prevention than might be associated with 'low level support', and might be seen as an asset-based rather than deficit-focused approach.
- Supporting community resilience and wellbeing is consistent with the new public health agenda and there are opportunities for addressing universal support across neighbourhoods. Whole systems approaches across council departments and between health and care are vital in addressing these wider dimensions.
- Models such as Local Area Coordination have proven value in connecting and expanding social capital and community capacity.

- Reshaping the universal offer has implications for how services are commissioned and what providers – particularly the third sector – are able to offer. Moving from a traditional model – often based around buildings – to a more flexible outreach model can be challenging.
- Innovative models of support increasingly need to offer added value; the challenge is to ensure that opportunities to address prevention are embedded in services so that multiple objectives can be addressed (such as lunch clubs offering an exercise class).
- The case for widespread adoption of telecare as an integral part of a universal offer is being explored in some authorities. Further evaluation is required of the impact of such support being offered to people before they are FACS-eligible (such as in Hillingdon).

4.64. In the final section of the paper we turn to address the key conclusions to emerge and to consider how best to progress the debate about universal support for older people with low or moderate support needs.

5. Conclusions and & Moving Forward

5.1. The fieldwork for this paper was not designed to provide a representative sample of local councils. Rather, it was targeted at discussing some of the major issues around questions of universal and open access support with leading members of ADASS, and some other key stakeholders and commentators in adult social care, and providing a snapshot of the state of play. There was a striking degree of consistency in the central messages and reflections, as has been explored in earlier sections of the report, and this was also the case in addressing ways forward and considering how best to support development.

5.2. There were three central objectives for the research, and we consider each of these below.

- To identify the current barriers to the provision of universal services to support older people with low level care and support needs.
- To identify the potential levers which are needed to ensure that such services are provided.
- To identify where there are continuing gaps in knowledge or understanding about specific interventions which prevent them being commissioned or provided.

Barriers to universal support and gaps in knowledge

5.3. It was evident in the course of the discussions undertaken for this report that the understanding and definitions attached to 'universal support' or the 'universal offer' can vary considerably. Perhaps the most important conclusion is that discussion of universal *services* may be less than helpful. It is vital that strategies to support older people to remain healthy and actively involved in their communities start from those same communities, and develop the social capital and resources that will enable wider participation and inclusion. Equally, it is mistaken to assume that people who have needs below eligibility thresholds automatically require 'low level services'. Meeting needs for universal support is not – primarily - about providing a 'lite' version of services accessed via eligibility criteria. As the reflections and examples highlighted in the paper have underlined, effective pre-eligibility support that can be readily accessed works best when it taps into the resources and assets of the local community. The role of the local council is primarily in facilitating, stimulating and pump priming those resources, and in supporting signposting and navigational support to enable people to access them. The challenge is – as In Control

have argued – in "redesigning the front end of social care" (In Control, 2012). Moving to an asset-based framework would require a community development and capacity building focus to be integral, and could result in a system with less of a cliff edge between people who meet eligibility criteria for social care and those who don't (SCIE, 2012a).

5.4. Sometimes, support *does* require services, but these need to be seen more widely than conventional social care provision. Rather, a whole council approach, and indeed an approach that goes across the health and care economy and encompasses all aspects of health and wellbeing within communities, is likely to be the best focus of support for all citizens.

5.5. In addition to universal and open access support is a related layer of targeted interventions that are still directed towards people who are below eligibility thresholds but who may be at particular risk of crossing them in the near future. Targeted prevention is therefore aimed at maintaining people in their communities and enabling them to make full use of facilities that will significantly delay or avoid the need for mainstream social care support. This targeted (but pre-eligibility) prevention includes, for example, a range of support for people at risk of isolation and depression, or people at risk of falling because of poor mobility. Such support needs to be directed towards increasing resilience, *not* with creating dependence on services or accelerating the journey towards care.

5.6. What are the barriers to developing this model more systematically? Many interviewees referred to the importance of having good evidence on prevention to back up and steer their strategies, and TLAP and ADASS have reiterated the importance of further research and dissemination of best practice in prevention. However, the argument that there is insufficient evidence of effectiveness in prevention is not a legitimate reason for failure to invest. It is clear that there already exists a growing body of experience to support a range of interventions (which many councils are adopting), and further evidence needs to build by councils ensuring they monitor and evaluate their approaches and any new developments. As some of the examples cited in the report indicate, this needs to include evaluation of the impact and effectiveness of information and advice strategies and the outcomes of signposting in enabling people to participate in their communities and access facilities.

5.7. Some of the barriers and potential impediments to adopting 'whole population' strategies are also evident in the resources available in the community, and the readiness of some of the charities and voluntary sector bodies to develop a new offer and way of operating. We have explored the challenges of service redesign and reshaping commissioning. It is vital that major changes to the relationship between councils and the voluntary sector are

approached in a way that is strategically directed and outcome driven, but it is unlikely that such restructuring can always be achieved without some overall reduction in support to the third sector, and such remodelling is therefore challenging.

Levers and Incentives

5.8. What needs to happen to spread good practice in addressing universal support? Interviewees recognised that local practice is essentially a matter for local determination and a prescriptive approach cannot be followed, but on the other hand 'a bit more of a push' *could* probably be given in some direction, and while the reform of the law around adult social care is being addressed, additional duties could be introduced for example:

"I think there could be more of a duty (...) at the moment it's statutory that we do the higher needs stuff, but it's completely discretionary whether we do the lower need stuff. There's good practice (...) but maybe there should be more of a duty to prevent things that are preventable and help people to recover."

5.9. At the same time it was recognised that such additional responsibilities would not be warmly welcomed unless accompanied by reform of funding for social care.

5.10. Another interviewee also made a similar point:

"I think there is an argument for trying to put prevention on the same footing legally as the duty to meet eligible needs (...) I think there is a need to create an individual entitlement for preventative interventions, which isn't the same as saying everybody should have a right to services."

5.11. Enabling open access to a 'navigation planning conversation' would be a significant part of such an entitlement. This would imply – at least in some areas – a very different approach to information and advice provision, which was not solely concerned with signposting to services but also with supporting and developing social capital.

5.12. Pressure on budgets is undoubtedly a factor that can make it particularly problematic for councils to have room to experiment, or to persuade elected members of the value of this wider preventative focus. Whether additional resources might be targeted was also something addressed by several interviewees. The ADASS document (2012a) argued the case for incentivising community based care and wellbeing services, and for establishing 'ring-fenced innovation funds' as the mechanism for achieving a transfer of resources.

Ring-fencing of money is rarely favoured in local government and is in tension with local democracy and decision making, but as this interviewee pointed out:

"There's something about whether you might target additional money. So the money that came through the NHS was targeted on adult social care, so there's something where it's not exactly ring-fencing, but it is an acceptable form of getting money where it needs to be."

5.13. Another respondent pointed to the past successes of transitional grant funding to assist with transformational change and argued the case for using a similar strategy to introduce some further leverage particularly with encouraging independent sector providers to develop new models:

"If we are wanting to stimulate alternative models and the whole preventative stuff (...) the Government should be putting some money up-front so that we can use that to incentivise councils, because I think particularly given the current financial climate it is very hard to find the money."

5.14. Several interviewees emphasised that there is considerable innovation and experimentation going on across the country in attempts to find the best combination of universal and targeted support, and to address prevention in order to get the optimal use of resources. There is also recognition of the opportunities for addressing these matters across the health and social care economy, for example:

"Councils need to use the new opportunities of the health and wellbeing structures and duties to get alongside the very real issues facing the health of their place (...) we have to take the chance to develop public health into not just an analysis of need, but also helping assess what would make a change and how we are doing by way of impact analysis."

And

"I'd also align this [prevention] with the broader duties of population planning that are in the current Health and Social Care Act (...) and your responsibilities for democratic oversight of the whole system including the NHS."

5.15. Other interviewees similarly emphasised the importance of taking a broad view that encompasses health, care and housing outcomes:

"Then actually some of those more relationship and less medical and less care-based interventions, I think, become things that you can commission for because you can show evidence of actual savings to a number of services."

5.16. One of the implications of taking a whole system approach of this nature is the need to align outcomes frameworks and outcomes measures across service boundaries. As this interviewee argued:

"A really good test of integration is probably not what happens at area level, or whether budgets are pooled (...) but are you able to issue a contract and is anybody able to provide a home-based health and wellbeing service, which was paid by results across those domains and therefore could only be delivered by a partnership."

5.17. The same person also argued that the central issue is not a lack of innovative interventions, "but we need innovative systems change about how those fit together."

5.18. Finally, the debate about who gets social care (and how it is funded) has arguably, and unhelpfully, focused sharply on the question of eligibility, with much less attention paid to the responsibility towards the wider population and what happens to people who do not meet the eligibility threshold but still need care or support. There needs to be a shift in the paradigm about how social care is defined, and the respective responsibilities of the individual, councils, and the wider community. There might then be potential for a more constructive debate about what people want to be supported to achieve in their lives, how services and wider resources enable them to reach those goals, and which models of intervention offer the best outcomes, as this interviewee concluded:

"I think ADASS has been very consistent that 'less of the same' will not deliver, so we have been promoting the universal and preventative approach. I worry that the agenda is still dominated by eligibility criteria; I would much rather be judged by the impact on the population than by input measures."

5.19 For some years policy on adult social care has emphasised the importance of addressing prevention, and of addressing universal support for people who are outside eligibility criteria or are self-funding. It is arguable that this emphasis has – in itself - had relatively limited effect. Does the White Paper on care and support offer a new approach to addressing these matters? Much detail remains to be developed, but the conclusions from this study suggest that the verdict at this stage is mixed. Certainly the White Paper addresses some important aspects of universal support and prevention, however a number of questions remain, and it is recommended that Age UK directs particular scrutiny to the following issues:

- Establishing a national eligibility threshold for eligibility for social care in 2015 is welcome and should improve fairness in access. However, it will be important that this

national threshold is not a cliff edge – what steps will be taken to ensure that people who do not meet the threshold are nonetheless properly directed towards other sources of help and support?

- Improved information and advice on social care is important, but developing a national portal and providing investment to improve local authorities' online information and support services must be seen as means to ends. How will the effectiveness of these strategies be assessed and how will connections be made between information provision and individual outcomes of signposting?
- How will the focus on improving support within communities and developing better prevention distinguish between universal support including the use of services such as transport, leisure and libraries, and the need to target pre-eligibility intervention?
- New duties on local authorities to commission and provide preventive services are welcome, but how will local authorities be held to account for their performance and against what criteria?
- Will the new national care and support evidence library address both quantitative and qualitative evidence including evidence on the contribution of social capital and community networks?
- How will the resources of the national care and support evidence library be made accessible, understandable and capable of application by commissioners and front line practitioners?
- Additional resources are to be transferred from the health system to support integration of health, care and support. How might this funding be targeted to leverage specific investment in innovation, community based support and prevention?
- Strengthening support within communities is of vital importance and can make a particular contribution to promoting social inclusion of older people. Much of this is small scale, takes time to develop and can be challenging to sustain. What more can be done to both spread good practice and further support social capital and community assets?
- When publishing the 2013/14 Public Health and Adult Social Care Outcomes Frameworks Outcome Frameworks in the autumn, how will the Government ensure that wellbeing measures include softer, asset-based approaches alongside quantitative indicators?

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