Finance Committee
Prevention
Submission from Aberdeenshire Community Planning Partnership

Response

1. Why has the progress of reform proposed by Christie Commission been so slow?

It is recognised that there is widespread political support for prevention, however political support for withdrawing or reducing vital acute services does not always exist, as these decisions are viewed as unpalatable. Political pressure may sometimes call for retention of the ‘status quo’ service provision – meaning that funds cannot be reallocated to preventative work. Resource management has been the key driver for change, rather than the principle of prevention, which means that priorities change as demand level fluctuates.

All stakeholders have to be realistic about how quickly results will be realised from a preventative approach – often funding comes with short, time-limited strings to result in a mainstreaming of preventive work. Cultural change can often take years to become fully embedded and sustainability funding for projects is difficult to secure.

The incentivisation of CP directed budgets has added workload and bureaucracy, rather than an obvious shift to prevention. It can be difficult to use budgets within overly ambitious timescales (which are not set locally) and funding is often announced late in the day, when partners have already committed resources to other activity. Evaluating and mapping current spend to decide how and where to shift resources is both time and resource intensive and further support would be welcomed.

Definition of preventive spend

Progress has been hindered by the lack of an agreed working definition which would describe all relevant preventive work of partners e.g. spending that seeks to not only prevent negative social outcomes arising, but also aims to eliminate or lessen the impact of negative social outcomes once they have arisen. Nationally there seems to be no established definition in use that would capture all the examples. Perhaps a need for tighter definition of preventive spend along with guidance and direction from Scottish Government would drive forward change. Agreeing the desired impact of preventive spend, e.g. reducing health inequalities/ narrowing the gap between those experiencing the best and worst outcomes, improving population health in a cost-effective way has also been challenging historically with partners having different views on desired outcomes. Case studies to highlight examples of preventive approaches within the context of the range of priority areas identified by Community Planning Partnerships across Scotland may also be helpful. In practice, a key risk of preventive strategies, which are often too broad in aim and accountability, is that the strategies cannot be a priority for any of the partners.
2. **What are the main barriers to change and how do we address them in order to accelerate the rate of progress?**

**Structure of the public sector**
Historically the structure of the public sector has been more effective at reacting to social problems rather than by seeking to tackle their root causes. This can change over time by ensuring that professional roles within the public sector are focused more on addressing the root causes of social problems in Scotland rather than simply responding to the various presentations of these problems.

**Disinvestment & Funding**
Disinvestment decisions have been challenging. There is a need for more robust national and local processes for making the major decisions about disinvestment - a decision making tool/matrix may assist CPPs in making these challenging decisions using a robust evidence base that can be used to challenge existing thinking. Shifting spend to preventative services (which potentially may only see improved outcomes in the next generations) can be perceived as ‘high risk’ in relatively risk averse public sector organisations.

Colleagues working locally need support to engage with communities around disinvestment decisions. It is anticipated the participation requests under the Community Empowerment Act may assist in improving links between services and communities in this area.

On-going low level funding is required to support projects/initiatives already underway (for example, travel expenses, petrol etc.) to achieve the long-term benefits. Contracts with major service providers are often inflexible and unresponsive, limiting change. For example, as a result of Health and Social Care Integration some services can now be accessed more locally, however, public transport contracts cannot always be amended to accommodate these changes – resulting in increased demand on passenger transport groups and difficulties for individuals in accessing health care services.

**Difficulty in attributing outcomes to preventive spend/Assessing costs and benefits of preventative interventions**
Assessing the outcomes of preventative measures can be challenging. It can be difficult attributing outcomes to a particular intervention. It can also be difficult to tell what would have happened to an individual in the absence of a particular intervention. This makes developing a robust evidence base difficult, particularly when services/support are received from a range of services simultaneously. A public sector body that makes a successful investment in preventative spending may not be that same body that derives the benefit and in the longer term may be reluctant to commit resources where they don’t drive a direct benefit. However, a culture of shared responsibility may get round this potential problem and improvement in joint resourcing/shared budgets may help.

Behavioural change is crucial but often difficult to quantify and implement and more focus needs to be placed on influencing behaviours around healthy lifestyle choices.
Community Kitchen style initiatives have been extremely successful locally in changing attitudes to healthy eating and lifestyle choices (including diet, weight, exercise, mental health and budget management) with a wide range of service users.

Evidence
Until relatively recently the evidence base has not provided sufficiently clear direction, although this is now changing with the publication a number of key reports. Strong and growing evidence is available on the cost-effectiveness of preventive interventions. However, there are limitations in the evidence base in relation to community-led, asset-based approaches. These create uncertainty about the nature of investment and relative priority that local partners should attach to community-led approaches to planning and delivering prevention. In addition there is a risk that community-led approaches could widen health inequalities because the assets in communities that are important for health are themselves unequally distributed across communities.

Whilst much of the international literature on prevention focuses on Early Years interventions which contribute to cross-cutting beneficial outcomes across a range of policy areas, a stronger focus on evaluation of impacts on health inequalities needs to be incorporated into the evidence base. However generally the benefits of early intervention are very clearly evidenced and well understood. The focus should now be on effective implementation rather than on further discussion or evidence gathering.

Data
Data to inform strategic decision making is not always timeously available or reliable. In addition, Scottish Government require partners to report on a plethora of priorities and targets, many of which are not related to prevention. This leads to focussing on activities that require to be reported on rather than those which will fundamentally address the range of challenging social problems in Scotland.

3. How do we ensure that the necessary culture change and greater levels of integration take place?

Strong and effective leadership at Community Planning Partnership level and within individual partner organisations is crucial to achieving greater levels of integration. The integration of Health & Social Care will help demonstrate that integration can be effective in delivering high quality care. CPPs should be encouraged to focus less on the operational detail of delivery.

The Community Empowerment Act will have a key role to play in ensuring that the necessary cultural and structural changes occur. The statutory powers within the Act provide greater impetus for partners to have a clear focus on the areas of greatest need and the toughest challenges – which cannot be tackled through single service actions. This empowers partners to make tough choices when prioritising resources – however, as previously mentioned, this may not always be welcomed.

The requirement within the Act for all partners to work more collaboratively with communities and other agencies/organisations/services will result in a cultural shift in
how our services are designed and delivered. The gathering and sharing of key
information on the needs and aspirations of communities is key to achieving
integration. For example, Landscape Services have a clear understanding of how
their service provision impacts on National Outcomes (e.g. Health, Sustainable
Places, Natural Environment).

However, the Community Empowerment Act will present some challenges for public
sector organisations in managing the expectations of communities and helping
communities understand both their rights and responsibilities. Support will be
required to ensure that partners are fully aware of their statutory obligations.

The Act will result in increased accountability for services/partners, which will
hopefully drive forward integration and greater partnership-working. Accountability,
however, must provide an opportunity for local services to influence the changes
required on a national scale.

4. How do we create a culture of innovation?

There are significant challenges in implementing a culture of innovation across the
entire public sector. What comes with a commitment to innovation is a need to
recognise that even drawing on increasing robust evidence we won’t always get in
‘right’ first time and acceptance of considered ‘risk taking’.

A stronger learning culture is also required within the public sector where partners
learn from interventions that prove to be ineffective. Building on existing best practice
and creating a knowledge bank of the processes around developing successful
innovative approaches in other areas will help to improve leadership, (e.g. the types
of behaviours, structures, goals and people required).

Increased autonomy for local areas to develop and deliver their own solutions, whilst
benefitting from strategic support, will allow service provision to be delivered
according to local needs. Organisational structures can be bureaucratic and slow –
which makes responsive service provision difficult.

Aberdeenshire Alcohol and Drugs Partnership have invested resource in community
forums to help drive innovations in service delivery. This investment has raised
awareness of their service activity within several communities in Aberdeenshire and
encouraged community members to take new ideas forward locally. An innovative
approach has also been used by the ADP in transferring power over financial
decisions to the forums, enabling community members to be involved in participatory
budgeting.

5. What opportunities does digital technology provide in reforming the
delivery of public services towards prevention?

Digital technology presents opportunities in reforming the delivery of public service,
particular the way in which we engage with communities. The Aberdeenshire Alcohol
and Drugs Partnership have had success in using a new website based interactive
tool aimed at parents and young children,
http://aberdeenadp.org.uk/meetthehendersons/games.htm - including tying in with more traditional forms of engagement (e.g. stickers in school books).

Telehealthcare has the potential to delivery some services/support at a more local level, particularly in more rural areas of Aberdeenshire (where there are some issues regarding access/transport to healthcare providers). However, there are some limitations due to the broadband infrastructure within Aberdeenshire that limits its usefulness and we must be careful to ensure that it is supplemented by traditional forms of service delivery where necessary (digital by choice as opposed to digital first forms of service provision).

Cost savings released through the switch to digital service provision could potentially be shifted to preventative spend, for example improved efficiency through effective travel and time management and shared, single point assessment.

We are examining ways to use digital tools for Participatory Budgeting exercises within the next 12-18 months, which will help to improve dialogue with communities around how budgets are currently spent and their priorities for the future.

6. How should community planning be developed to support service integration and the focus on prevention?

Community Planning Partnerships should hold their own partners and the Scottish Government to account for their approach to prevention, particularly in relation to the local priorities determined by the CPP.

In Aberdeenshire, lead partnerships for SOA priorities are required to report annually to the CP Board to evidence progress in delivering the outcomes in the SOA. This is done through the use of a consistent template where partnerships detail where joint resourcing and preventative activities are taking place. However, learning needs to be shared more widely between and within CPPs and risk taking encouraged and supported. CPPs also need to work towards aligned budget and priority setting, to ensure that priorities are reflected within partner’s plans.

The statutory guidance/regulations on the Community Empowerment Act need to reflect the focus on prevention and integration included within existing documents, best-practice and current evidence. Clearer direction from and integration with the Scottish Government strategic outcomes and National Performance Framework is required to support service integration and the focus on prevention.

The Roads Asset Management Plans are a good example of long-term strategic documents which focus on prevention/intervening at the correct time (covering footways, roads, bridges, street lighting etc.) to maintain the roads networks. The learning from the development of the RAMPS has been shared across all 32 Local Authorities – including a platform for collaboration and benchmarking. Support to develop similar approach to other thematic areas would be welcome.
7. What lessons can we learn from other countries in delivering a preventative approach?

There are important lessons to be learned from countries such as Scandinavia, the Netherlands and Australia. However, within the UK the approach adopted by cities such as Nottingham and Sheffield also requires further consideration by CPPs. Much of the literature on “prevention” focuses on early years interventions, which contribute to cross-cutting beneficial outcomes across a range of policy areas. The Scandic model, which requires a totally different approach to resourcing, is interesting however it may not be suitable within our existing culture.

8. What are the implications for the provision of public services if the decisive shift to prevention does not take place?

Public bodies will be faced with addressing growing need with limited resources. Within this context there may be a tendency to focus increasingly scarce resources on meeting statutory obligations and consequently resource allocation on prevention may become more challenging. The cycle of negative outcomes will continue unchecked, resulting in an increased need for acute/reactive service provision.

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