



*Windsor, Ascot and Maidenhead
Clinical Commissioning Group*



*Bracknell and Ascot
Clinical Commissioning Group*



**Supporting people
in the Royal Borough of Windsor & Maidenhead
to maintain their health and independence**

**Our strategy for
prevention and enablement**

2014 - 2019

February 2014

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Foreword

We are pleased to welcome this document which is a crucial mechanism to support delivery of the Prevention and Early Intervention theme in our Joint Health and Wellbeing Strategy. It outlines how we will develop services to help local residents and patients stay well and independent for as long as possible.

We have already done a lot to invest in a range of preventative services to address these issues. There has been investment from Public Health in supporting residents to adopt healthy lifestyles through successful programmes addressing smoking cessation, health checks, diet and exercise, drug and alcohol use and take up of vaccinations.

There has also been sustained focus from Adult Social Care on preventing the need for health service interventions through reablement and supporting people in their own homes for longer through assistive technology. We have also invested in initiatives that address isolation, such as Carebank. Furthermore the local authority and CCG have recently jointly commissioned a Prevention service that is particularly focused on falls prevention.

However, we need to do more. We have significant challenges. It is estimated that more than 3% of the RBWM population will be over the age of 85 by 2020, a fact to be celebrated. But with increased age comes increased potential for reduced mobility, more health problems, isolation and loneliness - *unless* people are actively encouraged and supported to do things that help prevent these things occurring, and get good, early support if and when they do. That's what this strategy is all about.

The partnership approach to service delivery and transformational work that we articulate in the strategy, and have increased opportunities for with the Better Care Fund, will help achieve this and will mean that more people are helped to stay living in their own homes, more receive treatment without needing to go into hospital, and people feel better supported.

This strategy will not make a difference unless we all work together in a partnership for prevention. We hope that you will join us in working to make it happen.

Cllr David Coppinger
Chair of Health & Wellbeing Board
RBWM Lead Member

Dr Adrian Hayter
Chair of WAM CCG

Summary

1. Introduction

1.1 RBWM's Health and Wellbeing Strategy focuses on activity in three key areas, including **early intervention and prevention**, and this document – a specific prevention and enablement strategy – is key to its implementation. It details what Windsor, Ascot and Maidenhead Clinical Commissioning Group (WAM CCG) and RBWM Council, in partnership with Bracknell & Ascot Clinical Commissioning Group¹, will do to help local residents stay as well and independent as possible and to lead fulfilled lives. This will, in turn, reduce their need for support from health and social care services. *Successful* prevention and enablement will help the CCG and Council to manage cost pressures, freeing up money that can then be invested in essential services and support for other people. It will also improve people's health, their quality of life, the impact on their families, the borough's employment and economic profile. The potential benefits are wide-ranging and significant. The CCG and the Council are clear that it's not just about managing the budget but about "*...working together for improved outcomes for residents...*"

1.2 Our strategy focuses on 12 key areas, and is built on a commitment to working with individuals, families and local citizens to enhance their strengths, build resilience and create more inclusive, mutually-supportive communities in RBWM². Our strategy is to:

- Offer *early support* to people
- Deliver Public Health activities that have been proven to help people stay healthy and well, and that are targeted to people who most need that help
- Make enablement and prevention 'everyone's business'
- Ensure that prevention and enablement activities reach *all* adults
- Enable people to live in accommodation and access aids to daily living that support their independence, health and wellbeing
- Give people information, advice and support so they can help themselves to stay as healthy and well as possible
- Enable family carers to continue caring and stay well
- Ensure that networks of community support are built around people who are isolated
- Develop partnerships with community organisations and groups to deliver early intervention and prevention activities across the borough
- Have a comprehensive network of community-based intermediate care services that prevent people going into hospital, and support early discharge and recovery
- Make sure people get more 'joined up' health and care support, and staff work in a more unified way around individuals with significant health and care needs
- Ensure that people can access a full and diverse range of therapies

¹ WAM CCG commissions services for patients registered with three GP practices in Ascot that include residents of Bracknell local authority. People living in the Royal Borough may be registered with GP practices that are part of Bracknell and Ascot CCG. This strategy covers all these people.

² This is referred to as asset-based community development

1.3 The full strategy document explains why we are focusing on these twelve areas. It explores national evidence around 'prevention and enablement', what's already happening in the borough, and areas for improvement and development. It also describes the results that we are aiming to achieve for local residents, as well as for the Council and CCG.

2. Our priorities

2.1 Our immediate priorities are -

- To achieve a significant decrease in the number of people experiencing falls and fractures
- To consult on, agree and begin implementing a carers strategy
- To refresh the transitions strategy for young people with additional needs (SEN) to ensure that young people maximise their independence and health
- To decide how to develop the *whole network* of intermediate care services in the borough to achieve more comprehensive coverage and continuity of support
- To build prevention and enablement approaches into domiciliary care
- To create a workforce development programme to support an increased focus on prevention and enablement across services and sectors
- To schedule a strategic review of therapy services
- To review prevention and enablement in relation to people with mental health conditions and people with learning disabilities
- To build on early intervention activity with people who have dementia
- To develop a comprehensive, coordinated programme that supports self-care for people with Long Term Conditions

2.2 RBWM has a slightly higher than average population of children (9-19 years) and a slightly higher than average population of senior citizens, at 17.2%. It is estimated that 2.46% of the population are over the age of 85. By 2020 these figures are projected to rise to 18.22% and 3.01%. The borough's demographic profile means that transformational changes must be made now to meet the growth in numbers of people with long term conditions, increase in numbers of young people with learning disabilities 'in transition' to adult services, and growth in numbers with dementia. Cardiovascular disease, such as coronary heart disease, high blood pressure and stroke, is the major cause of premature death in the borough. Around 66% of people with chronic heart failure in the Borough have four or more long term conditions. In 2011/12 the proportion of people admitted to hospital following Accident and Emergency (A&E) attendances was significantly above the England average, at 24% against 20.8%. Increasing the focus on prevention and enablement is essential.

3. Working together for prevention

3.1 The strategy builds on the commitment to early intervention, prevention and enablement that is evident across health and social care organisations in the borough. There's a lot of good partnership work already happening that we can build on. Every element of the health and social care network will be contributing to the prevention agenda in some shape or form. It is absolutely part and parcel of what health and social care professionals do. It is also what third sector, voluntary and community services do, as well as families and carers –

in short, it is everybody's business.

- 3.2 There is a significant role for Public Health, community safety partnerships, library and leisure services, and planning and environmental services in creating the building blocks of early intervention, prevention and enablement. Enabling and supporting people to maintain their health and wellbeing requires a strategic commissioning partnership that goes beyond health, social care and statutory services. We believe that having a network of strong and vibrant community organisations and groups is essential to achieve this strategy, as part of RBWM's commitment to promoting Big Society initiatives.

4. Prevention at every opportunity

- 4.1 Our strategy targets preventative activities and support to people when they are:

- well, and coping independently
- beginning to get health problems, or beginning to struggle to cope independently
- needing regular, low level healthcare and/or care support
- needing intensive health and/or care supports
- having a health or care crisis

- 4.2 Preventative action is needed at all of these times to help people stay as well and independent as possible. *Enabling* approaches are at the heart of our strategy. We need to ensure that people engaged in delivering health and social care have the right knowledge and skills to make enablement a reality, supported by access to equipment, facilities and resources that help them to achieve it.

5. Commissioning principles

- 5.1 WAM CCG and RBWM have agreed a set of principles to underpin our joint commissioning for prevention. We will commission, and support the development of a network of preventative, enabling services and supports in the borough that will -

- Help people to help themselves, make informed choices and decisions about their own lives, and be in control of their health and care
- Be tailored to people's individual needs and preferences
- Value and support the contribution of carers
- Harness and strengthen the contribution of local people in local communities
- Have the confidence and support of our borough residents
- Give people *early* support
- Maximise safety and protect people from harm
- Be responsive and make things happen for people in a timely way
- Reach people, including those in marginalised groups or who are isolated
- Be delivered in ways that make best possible use of health and social care resources
- Be sustained if they are shown to be achieving positive prevention outcomes

6. Making it happen

- 6.1 We will ensure that this strategy is *actively* led by adopting a programme management approach to drive it forward. The work will be led by a joint post, funded through the Better Care Fund, who will be a member of our Integrated Commissioning Board, and will report on implementation of the strategy to the Health and Wellbeing Board. A Prevention Delivery Group will be established to oversee the prevention programme, and will produce an annual progress report for the Board. We will also commission an annual survey to

measure 'prevention' outcomes from the perspective of residents, as part of a wider survey of Health and Wellbeing.

7. Financing the strategy

- 7.1 The strategy will be financed over a period of years and is currently part of existing budget plans. The main funding mechanisms initially will be –
- funds allocated by the DH annually - 'social care transfer monies' - that includes identified monies for reablement and carers support
 - the Better Care Fund (pooled budget) from 2015
 - Investing To Save i.e. where it is clear that funding a prevention or early intervention initiative will deliver longer-term savings
 - health and social care Innovation Funds
 - applications for short-term, pump-priming grants
 - partnership funding with Public Health, children's services and other Council and health services
- 7.2 The annual growth forecast for RBWM's adult social care services takes into account changes in demand related to our population demographics. They demonstrate the financial challenge we are facing. For the coming three years, the period of this strategy, the forecast is for an additional spend of £400k per year on services for the over 65s and £350k per year for the under 65s. The DH has recognised that funding for CCGs has not reflected the substantial shifts in population and health needs which have taken place in recent years. WAM CCG will receive a funding increase matching inflation in the next two years (2014/15 and 2015/16). However, we anticipate that significant budgetary pressures will continue. This prevention and enablement strategy will have a positive impact by helping us to manage increasing demand and related spend.
- 7.3 It is clear from national research that some preventative activities have an established evidence base in relation to generating savings, whilst 'the jury is still out' on others. We are confident that the following will assist us to manage budgetary pressures whilst improving outcomes across the health and care system over the long term:
- Activities that help people to look after their health, keep active and avoid getting ill
 - Investment in community-wide, helping hand initiatives
 - Enablement and re-ablement programmes
 - Preventing falls and fractures
 - Improved planning for young people 'in transition'
 - Supporting people to stay in their own homes for longer, reducing dependence on residential and nursing care placements
 - Promoting health and wellbeing, and reducing social isolation.
- 7.4 Part of the remit of the Prevention Delivery Group will be to use Economic Appraisal methodology to consider the business case for specific prevention activities, assess the evidence about outcomes and financial impact, and make recommendations to the Joint Commissioning Board. This will help ensure that public money is invested in the most advantageous way.
- 7.5 Research cautions that realising savings from prevention activity is not always possible and that savings are unlikely to happen unless there is active *disinvestment* in some services, such as acute hospital services, to fund growth in community services. This is a requirement

of the DH Better Care Fund. To reduce needs we have to make an investment in prevention and enablement activities, which means spend in some areas will need to increase. We anticipate that there will need to be increased investment in:

- Neighbourhood services provided by the third sector
- Community health services, including intermediate care
- Aids and equipment, including telecare
- Disabled Facilities Grants
- Domiciliary care
- Supported Living placements
- Public health activities
- Therapy services

8. Just the start...

- 8.1 The full strategy is accompanied by an initial, three year action plan that will be built on with partner services and organisations. We will develop an implementation plan for each of the twelve key strategic areas. The overall action plan will be reviewed through the Health & Wellbeing Board, and updated annually.
- 8.2 Early intervention, prevention and enablement activities will not achieve an instant impact. It is therefore essential that we see this strategy as the start of a long-term process. We are committed to reviewing and updating it in 2017, in line with our Joint Strategic Needs Assessment.

Our strategy for prevention and enablement

Part 1 What we are aiming to do

A whole system approach is crucial to prevention. Many social care interventions produce reductions in the usage of health services; many health interventions can have an impact on reducing the use of social care services. Jointly planning and explicitly sharing the risks and benefits have the potential to produce the greatest improvement for all.

Department of Health 2009³

1. Introduction

- 1.1 This strategy is about what our organisations - Windsor, Ascot and Maidenhead Clinical Commissioning Group (WAM CCG) and RBWM Council - will do to help people maintain their health and independence and, by so doing, reduce their need for support from health and social care services. It focuses on early intervention, prevention and enablement activities.
- 1.2 Over the past fifteen years there has been increasing focus nationally on early intervention, prevention and enablement programmes in health and social care. The list of policies and governmental guidance stressing the need for a shift from reactive to preventative interventions is lengthy⁴. The role of health and social care services in promoting people's *wellbeing* has taken centre stage: the Government has created shared measures of wellbeing across both the NHS, Public Health and Adult Social Care Outcomes Frameworks, and the Care Bill 2013 is introducing legislation that creates a duty on local authorities to incorporate preventive practice and early intervention into care commissioning and planning, with a new general duty to promote wellbeing.
- 1.3 The strategy comes at a time when there are both opportunities and challenges for the CCG and the local authority in the Royal Borough. The CCG took over responsibility for health commissioning in April 2013. At the same time, the local authority took over Public Health responsibilities, and a new consumer champion 'Healthwatch' came into place. The CCG and Local Authority has agreed a Health and Wellbeing Strategy that sets a shared framework for local commissioning, overseen by our new Health and Wellbeing Board. Putting all of these changes into effect has been challenging, but it has presented an opportunity to build new partnerships and to do things differently. We aim to positively build on the progress we have made through this joint prevention and enablement strategy.
- 1.4 Our shared vision is for integrated commissioning of community-based health and care services that:
- are preventative and enabling: that support people to maximise their independence and health, thereby avoiding need for NHS and social care services
 - draw on the strength of our local communities and third sector in enhancing prevention, improving public health, and delivering wellbeing, as part of a whole system approach
 - are delivered in an integrated, seamless way, with simple, responsive, support services, and
 - focus on achieving the outcomes that people want and need, delivered in line with their preferences.

³ *Prevention for Older People Resource* DH 2009

⁴ For the purpose of brevity, this strategy does not include a list of relevant policies.

- 1.5 Our organisations, however, are facing significant budgetary challenges. The budgeted spend across Adult Social Care and the CCG in 2013/14 is circa £176.6million, including spend on Public Health activities. Government requires RBWM to achieve further savings on its net spend over the coming three years. The Adult Social Care net budget for 2013-14 is £32.3m, with an additional £3.2 million for Public Health activity. 4% savings are expected in 2014/15, 5.2% in 2015/16 and 5.3% in 2016/17. WAM CCG operates to a resource limit set by the Department of Health (DH) which creates a financial pressure to be managed. It has a net budget of £141.1m for 2013-14 after it has achieved the required surplus, and allocations of £146.4m for 2104-15 and £151.6m for 2015-16. We know that achieving savings and surplus targets, and managing the pressure on those health and care budgets will remain a challenge.
- 1.6 Given the above, this strategy is timely in setting out how we will improve outcomes for people. If prevention and enablement activities are successful local residents will stay independent and well for longer, and need less support from health and care services. Prevention and enablement means that everyone wins. This strategy:
- presents a model of early intervention, prevention and enablement to underpin the joint health and wellbeing strategy for the borough, with a particular focus on services for adults
 - considers early intervention, prevention and enablement outcomes from the perspective of people who may receive health and social care services, and their families, as well as health and social care commissioning organisations
 - outlines current prevention and enablement activity across health and social care services, including the third sector, and identifies gaps
 - considers the evidence base for focusing on particular development areas
 - identifies priorities, and considers how to ‘make things happen’.
- 1.7 Whilst this strategy focuses on adults we recognise that, for some, ‘early intervention’ to achieve prevention outcomes needs to start during childhood. We aim to build on this strategy in partnership with children’s services in line with the focus on early intervention in the new Children’s Bill.
- 1.8 This is a joint health and social care strategy, which will be supported by joint commissioning. It will help address health inequalities, achieve better health and care outcomes, increase efficiency in the delivery of health and social care, and help to address budgetary challenges. At its heart, it aims to help local people to stay as well and independent as possible, and to lead fulfilled lives.

2. Background

2.1 Building on shared commitment and experience

- 2.1.1 WAM CCG and RBWM have a clear and shared commitment to developing services and supports that achieve prevention and enablement outcomes, demonstrated through the Joint Strategic Needs Assessment and our Health and Wellbeing strategy. Both centre

around six priorities suggested by the Marmot review⁵, all of which reflect a preventative and enabling ethos:

Giving every child the best start in life:

supporting parents and children in the early years

Enabling all children, young people and adults to maximise their capabilities and have control over their lives:

preventative services, early interventions and safeguarding support.

Creating Fair Employment and Good Work for All:

supporting employment and maximising opportunities.

Ensuring a healthy standard of living for all:

addressing the wider determinants of health such as environmental issues, poverty and lifestyles.

Creating and developing healthy and sustainable places and communities: accessing community services and housing, and dealing with crime.

Strengthening the role and impact of ill-health prevention:

prevention and treatment of major health problems and reducing health inequalities.

2.1.2 RBWM's Adult Social Care strategy specifically focuses on making a shift towards services that are "personal, sensitive to individual need and that *maintain independence* and dignity", and a "strategic reorientation towards *promoting health and well-being*, where possible *investing earlier to reduce ill health*."⁶ The CCG's strategic objectives include commissioning services which *promote recovery* from ill health or injury, which *prevent ill health and premature death*, and which provide our population with the greatest chances of living *full and independent lives*⁷. Both our organisations are seeking to achieve common objectives and a strategic shift towards prevention. Working in partnership, pooling resources and commissioning together to achieve that shared agenda not only makes sense but is essential.

2.1.3 Joint commissioning to achieve prevention and enablement is not new in Windsor & Maidenhead: a pooled budget and 'Section 75 agreement'⁸ is in place for a Short Term Support and Rehabilitation service, with enhanced intermediate care and end of life service, hosted by the local authority. Additional funding transfers under Section 256 of the NHS Act 2006 have taken place annually since 2011/12 to support a joint programme of work, and to address 'winter pressures' and 'carers support' since 2012/13. In 2012/13 we managed £1.693m jointly. We anticipate that this will increase to more than £8m in 2015/16 as a result of (a) additional allocation from Government to address requirements in the 2013 Care Bill, and (b) a share of the £3.8 billion 'Better Care Fund' from 2015/16: a single pooled budget for health and social care services to work more closely together in local areas. To access the Better Care Fund each locality has to develop a local plan by March 2014, which will need to set out how the pooled funding will be used. This presents a significant opportunity to build more preventative and enabling approaches to meet the health and care needs of our residents.

⁵ Fair Society, Healthy Lives - Marmot Review 2010

⁶ Making personalisation a reality: A strategy for adult care services 2008 – 2020 RBWM

⁷ WAM Commissioning Plan 2013-14

⁸ Partnership Arrangements under Section 75 of the NHS Act 2006 relating to the Joint Commissioning and delivery of Services In the Royal Borough of Windsor and Maidenhead

- 2.1.4 For 2013/14 we have, amongst other things, focused our joint budget on extending short term rehabilitation support (intermediate care), enhancing falls prevention and early intervention, extending telecare and telehealth provision, extending joint commissioning capacity, home care and nursing home placements to facilitate hospital discharge, improving quality in care homes, and improved community services for people with dementia.
- 2.1.5 The commitment to early intervention, prevention and enablement in the borough is also demonstrated through the breadth of third sector and voluntary organisations delivering community-based supports to residents, and speaking up about what local people need. Section 10 gives an overview. We believe that having a network of strong and vibrant community organisations and groups is essential to achieve early intervention and prevention. As well as delivering support to residents, local groups and organisations have an important role in shaping commissioning decisions and priorities. We need to take a system-wide view that recognises the interdependence of organisations across *all* sectors in achieving prevention goals.
- 2.1.6 This strategy recognises work that is already underway, and services that are already in place, and builds on them – but not without challenge. The strategy is informed by national best practice, research findings and evidence about what works, summarised in Part 2. A commitment to learning from experience and to evaluation is an important theme in this strategy, demonstrating that the actions we take really do enable people and achieve prevention outcomes.

2.2 Involvement and consultation

- 2.2.1 This strategy was developed with input from many people across the Royal borough and beyond, across statutory and third sector organisations, commissioning and provider organisations, advocacy and monitoring groups. Underpinning work took place in the autumn of 2012, leading to a report in December 2012 that contained a number of recommendations for joint commissioning and action⁹. We have already made a start on implementing some of the recommendations in order to address significant gaps in support, for example in relation to falls prevention.
- 2.2.2 Information was gathered through face-to-face meetings, use of a structured question format, thematic analysis of Board minutes¹⁰ and recent consultations, data searches and strategic planning documents such as the JSNA. There was also engagement with staff working across NHS East Berkshire as well as external consultancy organisations engaged with Adult Social Care services.
- 2.2.3 A consultation event in December 2012 was used to gather feedback on the outcomes framework in this strategy, from participants across agencies and services, third sector organisations, the Local Involvement Network (LINK, since replaced by Healthwatch), and local advocacy services.

⁹ Supporting people in the Royal Borough to maintain their health and independence: Joint commissioning for 'early intervention, prevention and enablement' 8th December 2012 A Cole Support2Improve

¹⁰ For example, the Older People's Partnership Board, Carers Partnership Board, Intermediate Care Board

- 2.2.4 An Equalities Impact Assessment has been completed for this strategy¹¹ but we will also need to assess the impact of specific initiatives in their own right as plans are implemented. We want to strengthen the resilience of local residents, so making sure that information and support actually reaches people is a key consideration. Identifying any barriers and addressing them in partnership with community leaders and groups will be essential to ensure that this strategy makes a difference to *all* those who can benefit, including people in marginalised groups.
- 2.2.5 An action plan forms part of this strategy. It covers three years and will be reviewed and refreshed annually. When the strategy is updated and renewed in 2017 a new action plan will be developed. We are committed to involving stakeholders, across sectors and organisations, in reviewing the plans and agreeing how they should be taken forward.

3. Defining early intervention, prevention and enablement

'It means encouraging everyone to have healthy, active and fulfilling lifestyles; supporting people when a care need first arises to stop the problem escalating
(Department of Health 2008a; 2010).

3.1 Three levels of prevention

"*Making a strategic shift to prevention and early intervention*" (Department of Health, 2008) identifies three levels for prevention activities –

- **Primary prevention** – universal services that are aimed at people who have no particular social care needs or symptoms of illness, but including those who may be at risk of developing them i.e. focusing on maintaining and promoting independence, good health and wellbeing through, for example -
 - providing universal access to good quality information
 - supporting safer neighbourhoods
 - building housing to 'lifetime homes' standards
 - promoting healthy and active lifestyles
 - combating ageism
- **Secondary prevention** – services that aim to halt or slow down deterioration for people who have some social care need or illness i.e. intervening in the early stages to improve a person's situation through, for example -
 - screening services to identify individuals at risk
 - preventative advice and support
 - enablement support
 - targeted healthy living advice and activities
 - promoting self-management
- **Tertiary prevention** - services that are aimed at minimising the impact of established health conditions or complex social care needs i.e. providing effective support to people to maximise their functioning and independence through, for example -
 - rehabilitation
 - specialist support related to long term conditions

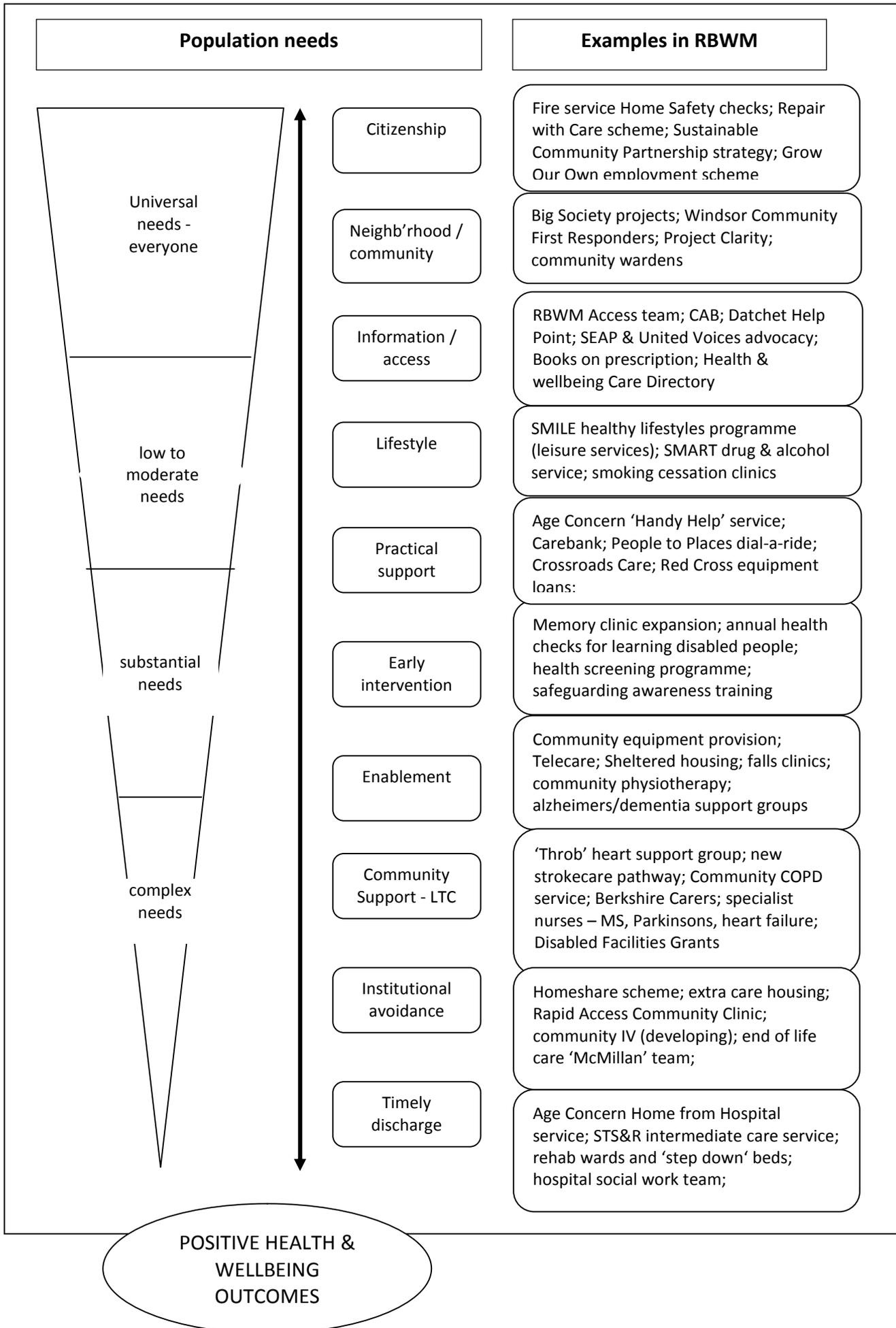
¹¹ EIAs help public authorities meet their equality duties and identify active steps they can take to promote equality. Carrying out an EIA involves systematically assessing the likely (or actual) effects of policies on people in respect of disability, gender and racial equality, and wider equality areas.

- joint case management where a person has complex needs

- 3.2 An "inverted triangle of care" has been used to demonstrate the range of support necessary to meet needs, from the general population through to people with complex care needs – see Figure 1 overleaf. It highlights the importance of actions by citizens themselves, neighbourhoods and communities, and access to good information in preventing or delaying onset of needs that require health and/or social care interventions. Examples of some relevant services and supports in RBWM are mapped onto the diagram.
- 3.3 Our strategy is built on a commitment to working with individuals, families and local citizens to support their strengths, build resilience and create more inclusive, mutually-supportive communities in RBWM. The diagram illustrates the breadth of challenge for strategic commissioning - with local areas needing an infrastructure of active community groups, third sector organisations, charities and businesses. Early intervention, prevention and enablement is not just about statutory services... it requires a strategic shift that includes building up the range of local, community based support and services.
- 3.4 The idea of individuals taking responsibility for maximising their own health and well-being is central, and the NHS constitution¹² stresses the responsibilities of patients and public. Social care and the NHS have increasingly focused on putting the person at the centre of their own health and care, but that does not resolve statutory agencies of their responsibilities. Rather, it implies that the focus of commissioning needs to change, with greater focus on provision of information, education, advice and support, choices, assistive equipment, self-assessment, self-monitoring and decision support tools. As an integral part of our strategy we need to do more to promote and enhance people's resilience, to support people to help themselves and to fulfil their potential.
- 3.5 There is a significant role for Public Health, community safety partnerships, planning and environmental services in creating the building blocks of early intervention, prevention and enablement. Enabling and supporting people to maintain their health and wellbeing requires a strategic commissioning partnership that goes beyond health and social care. Locally the Health and Wellbeing Board brings together WAM CCG, Bracknell & Ascot CCG, elected Councillors, Senior Managers for Adult and Children's social care services, and the Director of Public Health. To achieve a significant shift to early intervention, prevention and enablement, and to progress this strategy, a wider partnership will be needed.

¹²

Figure 1 Inverted Triangle of Care DH 2008



4. Our framework for prevention

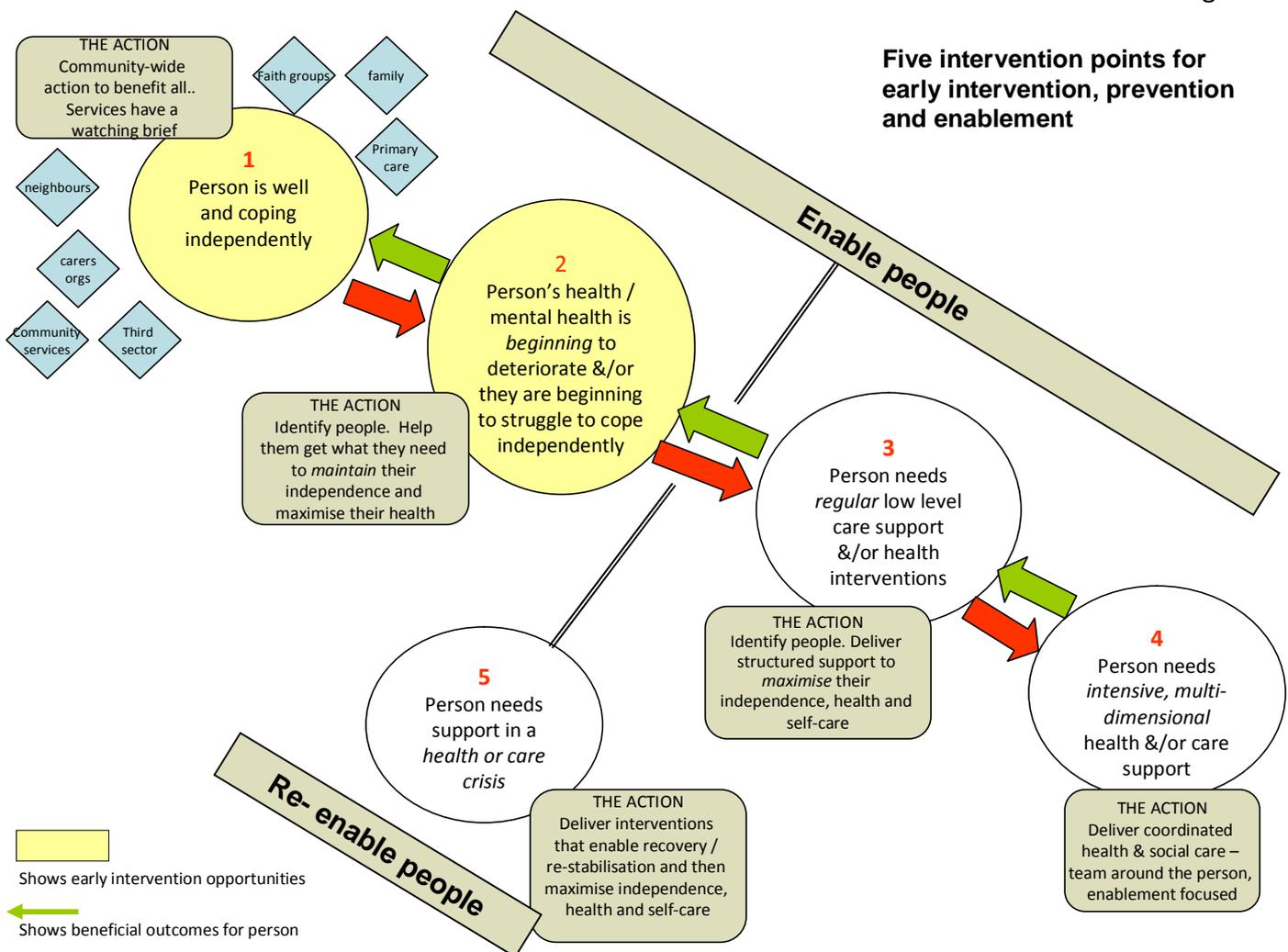
4.1 Intervention points

4.1.1 Our framework for early intervention, prevention and enablement focuses on **five key intervention points**. Our strategy is to achieve preventative action at each of these points in a person's life:

- When a person is well and coping independently
- When a person's health / mental health is beginning to deteriorate, or they are beginning to struggle to cope independently
- When a person needs regular, low level healthcare interventions and/or care support
- When a person needs intensive, multi-dimensional health and/or care supports
- When a person needs support in a health or care crisis

Figure 2 presents a simplistic overview.

Figure 2



- 4.1.2 Ideally, early intervention and prevention activity will reduce the likelihood of emergencies occurring, but it will not eliminate them. The way our health and care services respond to people following a crisis – commonly an emergency hospital admission (e.g. following a heart attack or an accident), a health crisis (e.g. an acute re-emergence of a mental health condition), or a sudden breakdown or threat to their care at home (e.g. their carer becomes ill or the care provider ceases trading) – will impact significantly on their longer-term health and independence, and their need for ongoing health and social care input. *Re-enabling* people is central to our strategy for preventing dependence.
- 4.1.3 Figure 2 demonstrates that *enabling* approaches need to be at the heart of our prevention strategy and run right across the health and care system. We need to ensure that people engaged in delivering health and social care have the right knowledge and skills to make enablement a reality, supported by access to equipment, facilities and resources that help them to achieve it.

4.2 Principles to underpin our joint commissioning for prevention

- 4.2.1 National policy supports *joint* commissioning of early intervention, prevention and enablement activity where there are shared benefits to commissioning organisations. WAM CCG and RBWM have agreed a set of principles which fit with the thrust of national policy and guidance to underpin our joint commissioning for prevention:

We will commission, and support the development of a network of preventative, enabling services and supports in the borough that will -

- Help people to help themselves, make informed choices and decisions about their own lives, and be in control of their health and care
- Be tailored to people’s individual needs and preferences
- Value and support the contribution of carers
- Harness and strengthen the contribution of local people in local communities
- Have the confidence and support of our borough residents
- Give people *early* support
- Maximise safety and protect people from harm
- Be responsive and make things happen for people in a timely way
- Reach people, including those in marginalised groups or who are isolated
- Be delivered in ways that make best possible use of health and social care resources
- Be sustained if they are shown to be achieving positive prevention outcomes

4.3 Outcomes and Indicators

- 4.3.1 The list of policies and governmental guidance stressing early intervention, prevention and enablement is lengthy. The national imperative is clearly linked to the UK’s demographics - people are living longer, with increasing health and support requirements and associated costs. Preventing the onset of ill health and reducing dependency on public sector services helps to manage the national budget.

4.3.2 At our local level, *successful* early intervention, prevention and enablement will help the CCG and Council to manage cost pressures, freeing up money that can then be invested in essential services and support for other people. It will also improve people's health, their quality of life, the impact on their families, the borough's employment and economic profile. The potential benefits are wide-ranging and significant. The CCG and the Council are clear that it's not just about managing the budget but about "*...working together for improved outcomes for residents...*"¹³

4.3.3 We recognise that early intervention and prevention activities will not achieve an instant impact on CCG and local authority budgets. As the Association of Chief Executives of Voluntary Organisations (ACEVO) point out¹⁴:

"Investment in prevention requires a long-term approach to improving outcomes and saving money. The benefits of integrated, preventative care take time to manifest themselves and even longer to produce any financial savings through improved health outcomes and reduced demand for treatment".

It is therefore essential that we see this strategy as the start of a long-term process and commit to reviewing and renewing it in early 2017.

4.3.4 Both the NHS outcomes framework and the Adult Social Care Outcomes Framework¹⁵ include indicators and improvement areas related to early intervention, prevention and enablement. The Department of Health is working to align the frameworks across Adult Social Care, the NHS and public health "*to better support the integration of care*". There is clear cross-over in relation to the early intervention, prevention and enablement agenda, and these areas are particularly important to consider for joint commissioning. However, as pointed out in the NHS Outcomes Framework, whilst it is important to encourage collaboration "*it is important that different organisations are correctly held to account for what improvements they are able to deliver*".

4.3.5 The national outcomes help to focus commissioning and organisational action, but they are not exclusive and do not necessarily reflect local area profiles and differences. The Adult Social Care Outcomes Framework makes it clear that "*it will be for councils to set their own local priorities, driven by both the framework and by their local Joint Strategic Needs Assessments and joint health and wellbeing strategies.*" In relation to early intervention, prevention and enablement the CCG and RBWM need *specific*, shared outcomes to drive their commissioning and monitoring activity.

4.3.6 CCG and Adult Social Care services' prevention priorities may not necessarily be the same as those of local residents. Research in the West Midlands¹⁶ has shown, for example, that older people's view of what constitutes prevention is different to the views of statutory services. During 2012, organisations representing older people and family carers in RBWM were asked a small number of specific questions about prevention, including two designed to identify the outcomes people want. The main themes that emerged were about –

preventing...

¹³ RBWM Health and Wellbeing Strategy

¹⁴ The prevention revolution: transforming health and social care ACEVO 2013

¹⁵ Transparency in outcomes: a framework for quality in adult social care DH March 2012

¹⁶ University of Birmingham

- deterioration of health
- falls
- isolation
- admissions to hospital
- adverse impact on carers

...and enabling

- good health and well-being
- safe mobility
- independence
- people to take responsibility for their own health and wellbeing
- people to stay at home, safely

4.3.7 As commissioners, WAM CCG and RBWM have wider organisational outcomes that we expect early intervention, prevention and enablement activities to contribute to:

- Maximising the health, wellbeing and satisfaction of local residents
- Meeting needs identified in our Joint Strategic Needs Assessment
- Achieving strategic priorities in our joint Health and Wellbeing Strategy
- Achieving efficiencies and related savings targets
- Supporting the development of our communities and a vibrant third sector
- Managing increasing demand on health and care services

4.3.8 Figure 3 shows our outcomes framework for early intervention, prevention and enablement in the Royal borough, incorporating health and social care national indicators *and* the perspective of local residents. The draft outcomes were presented to participants at a local consultation event in December 2012, and were subsequently refined.

4.3.9 The framework is *inclusive* in that it does not specify particular groups of people or people with specific conditions – the outcomes apply to all adult residents of the borough who need help with their health and/or independent living.

4.3.10 The ‘measures of success’ in the last column will be used as the basis for developing Key Performance Indicators (KPIs) so that we can monitor, assess and report our progress in achieving these prevention and enablement outcomes.

Figure 3 Outcomes framework for early intervention, prevention and enablement activities in RBWM

Early intervention, prevention and enablement aims	Outcome for residents	Outcome / implications for CCG & Local Authority	Measures of success
<p>1. prevent health deteriorating</p> <p>2. enable health and wellbeing</p>	<p>People stay well and premature death is avoided</p> <p>People’s need for care and support is delayed and reduced : they have been able to cope for longer</p>	<p>Reduced demand on all health services and for care support</p> <p>Reduced demand for care support</p> <p>Increased Public Health activities – health promotion</p> <p>Increased focus on early intervention</p>	<p>National measures –</p> <p>Potential years of life lost from causes considered amenable to healthcare;</p> <p>Life expectancy at 75 in males and females</p> <p>Average age when person first receives a care package increases</p>
<p>3. enable people to stay at home, safely</p> <p>4. prevent falls and related injuries</p> <p>5. enable safe mobility</p>	<p>People stay mobile and get around safely</p> <p>People do not fall</p> <p>People stay living safely in their home</p>	<p>Reduced attendances at falls clinics and A&E. Reduced hospital admissions for falls-related injuries, and demand for intermediate care</p> <p>Increased demand for exercise opportunities, Physiotherapy and OT, aids and equipment</p> <p>Increased demand for sensory services</p> <p>Increased Public Health activities – information and awareness campaigns</p> <p>Increased provision of assistive technology, adaptations and accessible housing</p> <p>Increased use of community transport</p> <p>Increased demand for repairs and adaptations to public spaces</p>	<p>Reduction in number of people:</p> <ul style="list-style-type: none"> - attending falls clinics - attending A&E for falls-related injuries - admitted to hospital for falls-related injuries <p>People report feeling safe in their home</p> <p>People reporting recovery to full mobility after surgery or fracture</p>

<p>6. prevent isolation</p> <p>7. prevent health inequalities</p> <p>8. enable people to have better lives, and to lead an ordinary life</p>	<p>People do not feel isolated or lonely</p> <p>People with long-term health conditions, and people who need care and support feel they have a good quality of life</p> <p>People get employment, maintain a family and social life and contribute to community life</p>	<p>Reduced GP attendances for depression</p> <p>Reduced demand on all health services</p> <p>Reduced referrals to mental health (wellbeing) and IAPT services</p> <p>Increased referrals to third sector services</p> <p>Meets equalities agenda / requirements</p>	<p>People report that they do not feel so isolated or lonely</p> <p>People satisfied with the quality of their life</p> <p>People report they are happy with their employment status</p> <p>Increase in :</p> <ul style="list-style-type: none"> - No. of people in employment, including people with support needs and mental health conditions - No. of people using third sector groups and services
<p>9. prevent avoidable admissions</p> <p>10. prevent inappropriate admissions or appointments</p>	<p>People do not go into hospital or care settings when they could be helped at home</p> <p>People get help from the service most appropriate for their needs</p>	<p>Reduction in attendances at A&E, unplanned hospital admissions and care home admissions</p> <p>Increased demand on district nursing, community clinics and community health services, 24 hrs</p> <p>Increased demand for:</p> <ul style="list-style-type: none"> - intermediate care service - urgent and 24 hr support packages - assistive technology - accessible &/or adapted housing <p>Home care / domiciliary support staff deliver low level healthcare tasks</p>	<p>Reductions in:</p> <ul style="list-style-type: none"> - No. entering care homes - No. unplanned hospital admissions <p>Increases in:</p> <ul style="list-style-type: none"> - No. receiving community support - No. of accessible units of social housing - No. using community Rapid Access Clinic - No. needing intermediate care service emergency response
<p>11. prevent adverse impact on carers</p>	<p>Carers stay healthy and well</p>	<p>Reduced GP attendances, and hospital admissions for stress and exhaustion-related illnesses</p>	<p>No. of carers reporting they are receiving support for stress or exhaustion</p> <p>No. of GP registered carers admitted to</p>

		<p>Reduced demand for care support for the people carers look after</p> <p>Increased spend on breaks and support for carers</p>	hospital
12. enable independence	People are able to do things for themselves	<p>Reduced demand on community health services</p> <p>Reduced demand for care support</p> <p>Increased demand for assistive technology, aids and adaptations</p>	Increase in average age at which people are referred for support
<p>13. enable people to take responsibility for their own health and wellbeing</p> <p>14. enable choice and control, and decision-making about own health and support, including when in crisis and at end of life</p>	<p>People</p> <ul style="list-style-type: none"> - look after their health and wellbeing - know what help they can get, and who to contact when they need it. - manage their own care and support as much as they want, and are in control of what, how and when support is delivered - plan ahead and have the freedom to manage risks the way that they wish. 	<p>Reduction in inappropriate GP attendances</p> <p>Reduced demand on community health services, and reduced demand for care support</p> <p>Increased role for community pharmacists</p> <p>Personal health budgets are implemented</p> <p>Professionals face less ethical dilemmas</p> <p>Increased demand for support with planning</p> <p>Increased Public Health activities, and visits to on-line RBWM directory</p> <p>Increased demand for assistive technology</p> <p>Increase demand for flexible home support and Personal Assistants</p>	<p>No. of people using telehealth monitoring</p> <p>No. of people participating in SMILE activities</p> <p>Uptake of annual health checks and (flu) vaccinations</p> <p>No. of website hits</p> <p>No of people with an advance directive</p> <p>No of carers with an emergency plan</p> <p>No. of information / access related complaints</p> <p>No. of people with Personal Health Budgets</p> <p>People report satisfaction with <i>when</i> they receive support</p>
15. enable people to cope without long-term support:	People recover from episodes of ill health or injury and regain their	Increased demand on community health services, rehabilitative services and	Average no. of hours of support in long-term care packages

<p>re-able people</p> <p>16. prevent deterioration and dependence</p>	<p>independence; They are less dependent on long-term intensive support services</p>	<p>intermediate care services</p> <p>Improved preparation for discharge from acute settings</p> <p>Reduced long-term, high level care /support packages</p> <p>Improved, enablement focused home support market</p>	<p>No. of people going from hospital to long-term care</p> <p>No. of people going <i>back in</i> to hospital</p> <p>People satisfied with their level of recovery</p> <p>People report that home support staff enable them (not do for)</p> <p>No. of intermediate care packages where people regain full independence</p>
<p>17. prevent avoidable harm</p>	<p>People do not suffer from avoidable harm, disease or injuries, including adverse side effects from medication. They are physically safe and feel secure. People are free from physical and emotional abuse, harassment, neglect and self-harm</p> <p>People and their carers are satisfied with the quality of care and support services.</p>	<p>Reduced demand on all health services, and for care support</p> <p>Increased role for community pharmacists</p> <p>Confidence that people's healthcare and support needs are being met</p> <p>Reduction in safeguarding investigations</p> <p>Increased Public Health and community safety activities</p>	<p>Reduction in:</p> <p>No. of safeguarding alerts for older / disabled people that result in investigation</p> <p>No. of instances of infection and falls, in hospitals and care homes</p> <p>No. attending falls clinics and/or A&E for falls</p> <p>People reporting feeling unsafe in their home or community</p> <p>People's level of satisfaction increases</p>

5. Our strategy, priorities and action plan for 2014 - 2017

We are committed to working together to make best possible use of the public resources available to us in order to help local residents achieve positive health and wellbeing outcomes. Our strategy for prevention and enablement is to:

5.1 Offer *early support* to people

This means we need to:

- start preventative work with children, young people and their families
- achieve early identification, treatment and support for medical conditions
- build a network of services to support people when they begin to struggle / get ill

5.2 Deliver Public Health activities that have been proven to help people stay healthy and well, and that are targeted to people who most need that help

This means we need to:

- be clear about the evidence-based for activities
- target specific groups and check that Public Health activities are reaching them
- monitor and evaluate the results / outcomes

5.3 Embed a culture of enablement and prevention across health and care services in the borough, making it 'everyone's business'

This means we need to:

- develop people's knowledge and skills around prevention and enablement
- build prevention and enablement into all service specifications
- deliberately work to keep prevention and enablement in the spotlight

5.4 Ensure that early intervention, prevention and enablement activities reach all adults across our local communities, and are adapted to people's individual circumstances and needs

This means we need to:

- Think 'all means all': prevention and enablement in all settings and with all patients/clients
- do more for people in the rural areas of the borough, and in areas of deprivation
- listen to consumer and advocacy groups so we get it right for people

5.5 Enable people to live in accommodation and access aids to daily living that facilitate their independence, health and wellbeing

This means we need to:

- deliberately plan and develop appropriate accommodation
- help people understand the potential benefits of assistive technology, and access it
- make sure people get helpful aids, equipment and home adaptations speedily

5.6 Equip people with information, advice and support so that they can maximise their own health and wellbeing, and help themselves

This means we need to:

- have excellent, accessible information available for people
- develop staff skills to embed 'healthcare self-management' approaches
- make sure people have access to support when they need it

5.7 Enable family carers to continue caring and maintain their own health and wellbeing by broadening the supports available to them

This means we need to:

- develop and implement a local carers strategy
- continue to commission a range of carers support services
- listen to carers about what support they need and how they want it delivered

5.8 Ensure that networks of local community support are deliberately built around individuals who are isolated

This means we need to:

- commission services to do it
- ask community groups and services to identify and target support to isolated people
- take a neighbourhood approach

5.9 Develop work with community organisations and groups to deliver early intervention and prevention activities across the borough

This means we need to:

- support the third sector to grow
- consider with the third sector how we all work together to achieve prevention
- welcome innovative prevention ideas that come from the third sector

5.10 Commission a comprehensive community-based network of intermediate care services to prevent hospital admissions & support early discharge and recovery

This means we need to:

- decide what services are needed in the network
- consult with residents,
- and then make it happen

5.11 Make sure people get more 'joined up' health and care support, and staff work in a more unified way around individuals with significant health and care needs

This means we need to:

- build on work that's already happened to develop integrated primary care services
- develop 'joined-up' care plans for individuals that address both their health *and* care needs
- develop domiciliary care services with staff that deliver care support and some healthcare

5.12 Ensure that people can access a full and diverse range of enabling therapies

This means we need to:

- undertake a strategic review of therapy services and decide how they need to develop
- develop more schemes so that people can choose and arrange their own therapy
- ensure therapy services are making adjustments to delivery so that anyone in need can use them

5.13 Our immediate priorities are -

- To achieve a significant decrease in the number of people experiencing falls and fractures
- To agree and begin implementing a carers strategy
- To refresh the transitions strategy for young people with additional needs (SEN) to ensure that young people are enabled to maximise their independence and health
- To decide how to develop the *whole network* of intermediate care services in the borough in order to achieve more comprehensive coverage and continuity of support
- To build prevention and enablement approaches into domiciliary care
- To create a workforce development programme to support an increased focus on prevention and enablement across services and sectors
- To schedule a strategic review of therapy services
- To review prevention and enablement in relation to people with mental health conditions and people with learning disabilities
- To build on early intervention activity with people who have dementia
- To develop a comprehensive, coordinated programme that supports self-care for people with Long Term Conditions

6. Implementation and governance

- 6.1 WAM CCG and RBWM are predominantly commissioning organisations. We need to work collaboratively with a wide range of services in order to deliver this strategy.
- 6.2 Prevention relies upon service providers doing things differently. Commissioning can direct what needs to be achieved (the outcomes), and provide a framework for delivery (delivery principles) but providers have to manage the changes. A cooperative developmental partnership with opportunities for providers to influence what's commissioned is desirable – and there is a good foundation in the borough. We will build on that foundation to develop more ways that providers' across the system can contribute their ideas and proposals for early intervention, enablement and prevention. We want to stimulate innovation and the shift of focus that's needed – but as commissioners we also need to maintain a borough-wide oversight.
- 6.3 Key issues with any developments in the current financial climate are achievability and sustainability. Health and social care organisations in the

borough have pared down, and capacity to lead developments is stretched. A number of 'prevention' oriented initiatives in the past have foundered because of short-term funding, including a falls prevention programme. Finding ways of commissioning for longevity and value is essential given that the financial impact of 'prevention' initiatives may take time to show. This will not be easy but we understand the importance and are committed to trying to achieve it.

- 6.4 We will ensure that this strategy is *actively* led, across health and social care by adopting a programme management approach to drive it forward. The work will be led by a joint post, funded through the Better Care Fund, who will be a member of our Integrated Commissioning Board, and will report on implementation of the strategy to the Health and Wellbeing Board. A joint Prevention Delivery Group will be established to oversee the prevention programme, and will produce an annual workplan and progress report for the Board. This report will be a public document.
- 6.5 The importance of user / patient involvement in governance and monitoring is well-documented, and demonstrated through local Partnership Boards and Healthwatch. Their involvement in the governance and monitoring of this prevention strategy is crucial. It is envisaged that Healthwatch and Partnership Board leads would be represented on the Prevention Delivery group. We will also commission an annual survey to measure 'prevention' outcomes from the perspective of residents (as part of a wider survey of Health and Wellbeing)
- 6.6 To create a culture where prevention and enablement is 'everybody's business' we want to open up the opportunity for providers to bring proposals / business cases for new prevention-focused developments to the Prevention Delivery group. The Delivery group will then advise on funding routes, identify potential duplication, and champion some new developments.
- 6.7 We are keen to build a 'prevention and enablement challenge' into all new health and care developments, and into contract monitoring, and will explore mechanisms to achieve it during the first year of this strategy.
- 6.8 Embedding the prevention ethos across services, and demonstrating that positive outcomes have been achieved, will not be easy. But, we're not alone in trying to make it happen: neighbouring local authorities and CCGs are working on the same agenda. Sharing ideas and experiences can benefit us all. To that end we will aim to develop a 'prevention and enablement ideas collective' across Berkshire to help maintain our focus and energy over time.

7. Financing the strategy

- 7.1 This strategy will be financed over a period of years. Recognising, and in keeping with our separate responsibilities, activities that are entirely about preventative healthcare will be funded through the CCG; activities that are entirely about preventative social care will be funded through RBWM. However, we anticipate that many of the activities in this strategy will need to be funded jointly because

they support people to stay healthy, well and independent, and there will be gains to both health and care services in the longer-term. Prevention and enablement to enhance people's health and wellbeing is 'a good fit' with our new, pooled 'Better Care Fund'.

- 7.2 The main funding mechanisms initially will be –
- funds allocated by the DH annually - 'social care transfer monies'¹⁷ - that includes identified monies for reablement and carers support
 - the Better Care Fund (pooled budget) from 2015
 - Investing To Save i.e. where it is clear that funding a prevention or early intervention initiative will deliver longer-term savings
 - 'winter pressures monies' allocated by the DH to meet growth in demand
 - health and social care Innovation Funds
 - applications for short-term, pump-priming grants
 - partnership funding with Public Health, children's services and other health and Council services.
- 7.3 Invest to Save prevention initiatives will be integrated into RBWM's social care transformation programme and WAM CCG's Quality Innovation Productivity and Performance (QIPP) programmes. This will ensure that progress is regularly reported and monitored.
- 7.4 In the introduction to this strategy we acknowledged that our organisations need to achieve savings / surplus in order to manage increasing demand for health and care. Health services are free at the point of need, but it is important to note that the relative affluence of the RBWM population is a determining factor in the funding allocation received from government. Before the NHS changes in April 2013, Berkshire East PCT was the 9th lowest funded PCT in the country. The plain truth is that we have to work together across health and social care to make our funds go further to meet need, and this strategy can help us to achieve that.
- 7.5 Investing in prevention in order to realise savings is not straightforward though: we are mindful that, nationally, modelling financial impact and demonstrating potential savings from prevention activities is proving a significant challenge. However, there is widespread acceptance that preventative approaches that include early intervention and enablement do have an impact on use of health and social care services - thereby creating savings. As an example, an economic analysis of early intervention and prevention activities in mental health¹⁸ found that -
- many interventions were outstandingly good value for money.
 - a number of interventions were self-financing over time. However, the scope for 'quick wins', i.e very short payback periods was relatively limited.
 - many interventions had a broad range of pay-offs, both within the public sector and more widely, such as through better educational performance, improved

¹⁷ Transfers under Section 256 of the NHS Act 2006

¹⁸ Martin Knapp, David McDaid and Michael Parsonage (editors) Personal Social Services Research Unit, London School of Economics and Political Science April 2011

employment /earnings and reduced crime. In some cases the pay-offs are spread over many years.

- many interventions are very low cost. A small shift in the balance of expenditure from treatment to prevention/promotion should generate efficiency gains.
- programme design and implementation are key. The most cost-effective action when refining a programme may be to increase take-up among high-risk groups or to improve completion rates, rather than to broaden coverage.
- selecting interventions that have been *shown* to be effective is crucial.

The economic analyses showed that, over and above gains in health and quality of life, the interventions also generated very significant economic benefits including savings in public expenditure.

7.6 It is clear from national research that some preventative activities have a sound evidence base in relation to generating savings, whilst ‘the jury is still out’ on others. We are confident that the following will assist us to manage budgetary pressures across the health and care system over the long term:

- Activities that help people to look after their health and avoid getting ill
- Investment in community-wide, helping hand initiatives
- Enablement and re-ablement programmes
- Preventing falls and fractures
- Improved planning for young people 'in transition'
- Supporting people to stay in their own homes for longer, reducing dependence on residential and nursing care placements.

7.7 The annual growth forecast for RBWM’s adult social care services takes into account changes in demand related to our population demographics. They demonstrate the financial challenge we are facing. For the coming three years the forecast is for an additional spend of £400k per year on services for the over 65s and £350k per year for the under 65s. The DH has recognised that funding for CCGs has not reflected the substantial shifts in population and health needs which have taken place in recent years. WAM CCG will receive a funding increase matching inflation in the next two years (2014/15 and 2015/16). However, we anticipate that significant budgetary pressures will continue. This prevention and enablement strategy will have a positive impact by helping us to manage the costs of increasing demand in the following areas:

	2013/14 anticipated spend (gross)
Nursing and residential care for older and disabled people	c £9.9 m
Domiciliary care (including re-ablement)	c £5.6 m
Residential care and supported living for people with learning disabilities	c £11.9 m
Mental health services & placements (health & social care)	c £14.7 m
All Acute Hospital services	c £78.2m

- 7.8 We have already set savings targets for some of these activities, but need to carefully monitor and evaluate the outcomes actually achieved. Avoidance of dependence through improved transition planning with young people is expected to deliver financial savings within 3 years of £200k, but significantly greater savings are forecast in subsequent years; reducing dependence on residential and nursing care placements is expected to deliver financial savings of £335k per year within 3 years; preventing falls and fractures is expected to deliver savings of £646k per year based on a 20% reduction in hip fractures.
- 7.9 Research evidence is still not totally conclusive about the impact of telecare and telehealth technologies in reducing costs across the health and care system. However, we are progressing developments in these areas based on the weight of evidence from practice, accepting that rigorous evaluation will be needed to establish their outcomes in relation to prevention and enablement, and the cost-benefits. We are taking a cautious ‘monitored implementation’ approach, but are expecting increased use of telecare devices to improve outcomes and safety for residents whilst reducing costs to social care by an estimated £220k per year within 3 years. When combined with an increase in use of telehealth for people with COPD, heart failure and diabetes projected **gross** savings are in the range of 798k to c£1.004m per year across health and social care.
- 7.10 However, research¹⁹²⁰ also cautions that realising savings from prevention activity is not always possible. The national POPP projects found that gains cannot be fully realised *“unless cashable savings can be released and re-invested... 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”*. Research concludes that there is insufficient evidence, as yet, about cost savings from treating people in community settings rather than hospital settings, and that savings are unlikely to happen unless there is active *disinvestment* in hospital services, or not investing in growing hospital services if disinvestment is not possible or appropriate.
- 7.11 Roemer’s law states that a ‘hospital bed built is a hospital bed filled’ (Ginsburg and Koretz, 1983). In other words, if hospital avoidance interventions are successful, the financial gains may be undermined by hospitals admitting lower-risk individuals. And, it is difficult to close whole wards or units to release savings. It’s a risk that we are mindful of. Transfer of funds from the acute hospital sector into the community health and care sector may be difficult to achieve with the pressures on hospital services, but it is an avenue that we will need to explore to fully implement this strategy. Making that shift is a *requirement* of the DH Better Care Fund.

¹⁹ The national evaluation of the POPP projects 2009

²⁰ International Evidence about Interventions to Reduce Unplanned Hospital Use Doone Winnard, Wing Cheuk Chan, February 2012

7.12 To reduce needs we have to make an investment in prevention and enablement activities, which means that spend in some areas will need to increase. More will need to be spent on:

Neighbourhood services provided by the third sector
Community health services, including intermediate care
Aids and equipment, including telecare
Disabled Facilities Grants
Domiciliary care
Supported Living placements
Public health activities
Therapy services

7.13 JT Cohen et al (2008) caution that there needs to be “careful analysis of the costs and benefits of specific interventions, rather than broad generalisations”. To that end, part of the remit of the Prevention Delivery Group will be to consider the business case for specific prevention activities, review the evidence re outcomes and financial impact, and make recommendations to the Integrated Commissioning Board. Economic Appraisal methodology (as set out by HM Treasury) will be used.

7.14 Investment in leadership, training and development activities, community development work, and work with the third sector will be essential. So too will investment in evaluation in order to establish whether activity is achieving the prevention and enablement outcomes desired. When developing individual business cases for different elements of the strategy we will ensure that leadership, training, evaluation and all essential ‘support’ is built in to the costings.

7.15 We will use resource incentives to help services make the shift to prevention and enablement. We will also -

- use the contracts we have with providers to ask them to ‘add value’ to our funding²¹ and to develop initiatives that support delivery of this prevention and enablement strategy²²
- consider developing arms-length, staff-run social enterprises that can develop a trading arm for their services (for example, therapy services that people who have financial means or a Personal Health Budget can directly purchase)
- actively pursue funding through government initiatives that ‘call for proposals’ during the life of the strategy (e.g. the care and support housing fund, providing £200 m capital funding over five years from 2013/14).

²¹ for example, adding value by using their community links to engage local citizens, neighbours, volunteers in service delivery; working in partnership and sharing costs with other services; third sector services using their capacity to apply for match funding from grant making organisations

²² For example, through the CQUIN payment framework which enables commissioners to reward excellence by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals.

8. Our initial action plan

- 8.1 The action plan that follows will be built on with partner services and organisations to achieve an implementation plan, timelines and officer leads for each of the strategic areas. Implementation leads will report progress to the Prevention Delivery group. The action plan will be monitored by the Health and Wellbeing Board.
- 8.2 We will host a prevention and enablement workshop in the first half of 2014 to engage with partners *across sectors* to achieve this, including patient and user representative groups. This will be built on through annual events.

**Achieving Prevention and Enablement in RBWM
Our Initial Action Plan 2014 - 2017**

Strategic theme	Immediate priority	Actions 2014 - 15	Actions 2015 - 16	Actions 2016-17
<p>Offer <i>early support to people</i></p>	<p>To refresh the transitions strategy for young people with additional needs (SEN) in partnership with children's services, to ensure they are enabled to maximise their independence and health</p> <p>To build on early intervention activity with people who have dementia</p>	<p>Support <i>Keep Safe and Stay Well</i> service to bed in</p> <p>Plan action in partnership with children's services to reduce the number of residential school placements made before a young person is 16.</p> <p>Support GPs and integrated primary care services to use their risk-stratification tool as an aid to early intervention and prevention</p>	<p>Evaluation of <i>Keep Safe and Stay Well</i> service. Decide on extension of service.</p> <p>Develop a <i>joint</i> Autistic Spectrum Conditions plan with Children's services to ensure a <i>whole life</i> approach</p>	<p>Develop early intervention plan in partnership with third sector</p>
<p>Ensure our Public Health programme focuses on activities that are proven to make a difference in preventing ill health, addressing health inequalities and promoting wellbeing</p>	<p>To develop an action plan to reduce health inequalities for people with mental health problems</p>	<p>Agree monitoring to ensure that PH activities are 'inclusive' in design and approach.</p> <p>Develop osteoporosis strategy.</p> <p>Develop programme to deliver strengthening exercise to people at home.</p> <p>Secure health activist for dementia, to roll out Ageing Well seminars to all GP practices</p>	<p>Extend existing 'exercise on prescription' scheme / make it more consistent across borough.</p>	<p>Evaluate annual health checks programme (all groups)</p>
<p>Embed a culture of enablement and prevention across health and care services in the borough, making it 'everyone's business'</p>	<p>To create a workforce development programme to support an increased focus on prevention and enablement across services and sectors</p>	<p>Evaluate care home development programme and medication review service for residents, and decide on roll-out to more care homes and spread to Sheltered Housing tenants.</p>	<p>Adjust all service specifications and monitoring to include a specific focus on enablement, and specific outcomes</p> <p>Evaluate and renew workforce</p>	<p>Make innovation funding available for early intervention, prevention and enablement projects</p>

		<p>Re-commission homecare services to secure domiciliary staff with knowledge and skills to work in an enabling way with people with complex needs, including advanced dementia.</p> <p>Develop a prevention and enablement ideas collective</p>	development programme	
<p>Ensure that early intervention, prevention and enablement activities reach all adults across our local communities, and are adapted to people's individual circumstances and needs</p>	To review prevention and enablement activities in relation to people with mental health conditions	<p>Review prevention and enablement activities in relation to people with learning disabilities</p> <p>Secure <i>joint</i> health and social care commissioning lead for people with dementia</p> <p>Review accessibility of service information leaflets</p>	<p>Evaluate outcomes from the <i>Transforming Care</i> Action Plan for people with learning disabilities</p> <p>Commission work to address isolation of people with visual impairments</p> <p>Evaluate current dementia initiatives, and sustain if achieving positive outcomes</p>	Develop 'next steps' plan for early intervention and enablement of people with dementia
<p>Enable people to live in accommodation and access aids to daily living that facilitate their independence, health and wellbeing</p>		<p>Develop contingency plan to prevent older people having to move if care provider stops trading</p> <p>Produce Supported Accommodation strategy for older people and people with learning disabilities, incorporating extra care housing</p> <p>Review the pathway to aids and equipment to ensure timely provision</p> <p>Progress telecare and telehealth growth plan</p>	<p>Develop an <i>accessible housing and environment</i> plan for the borough with Environment and Planning services</p> <p>Analyse potential benefits / drawbacks of introducing a register of accessible housing</p> <p>Review Disabled Facilities Grants process to ensure timely response</p>	Evaluation of telecare and telehealth initiatives and decision re further roll-out
<p>Equip people with information, advice and</p>	To achieve a significant decrease in the number of	Implement falls prevention strategy	Develop specific info and awareness programme focusing	Evaluation and renewal of falls prevention strategy

support so that they can maximise their own health and wellbeing, and help themselves	people experiencing falls and related fractures Trial a self-management of health programme, targeting the most significant long-term conditions.		on preventing Type 2 diabetes	
Enable family carers to continue caring and maintain their own health and wellbeing by broadening the supports available to them	To consult on and agree a carers strategy	...and begin implementing it Extend capacity for carers workers to link into GP surgeries and hospitals Commission support to deliver advance planning / development of emergency support plans for people living with elderly carers		Review and refresh the Carers Strategy
Ensure that networks of local community support are deliberately built around individuals who are isolated		Develop plan with sheltered housing schemes to offer opportunities to other, local elderly people to create new social networks and combat isolation.	Commission capacity to achieve wraparound, natural supports for larger numbers of people, targeting people with dementia. Develop a circles project for people with visual impairments	Review progress and refresh plans
Develop community organisations and groups to deliver early intervention and prevention activities across the borough		Bring together third sector forum to develop an early intervention, prevention and enablement' plan Host discussion forum with people with mental health issues to identify development agenda	Implement third sector plan Implement mental health development agenda Review volunteering in the borough	Refresh plan with third sector forum
Commission a comprehensive community-based network of	To decide how to develop the <i>whole network</i> of intermediate care services	Commission work to track where older and disabled people enter hospital from, and where they go	Extend the Home Treatment team for people with dementia / older people with mental	Review of health and care supports available at weekends and overnight

<p>intermediate care services to prevent hospital admissions & support early discharge and recovery</p>	<p>in the borough in order to achieve more comprehensive coverage and continuity of support</p>	<p>after discharge</p> <p>Cost-benefit analysis of the STS&R service and decisions re further development</p> <p>Consultation with residents re intermediate care services and agree a development plan</p> <p>Commission <i>integrated</i> health and social care discharge planning service</p>	<p>health issues</p> <p>Commission <i>integrated</i> health and social care rehabilitation support for each community in-patient unit</p> <p>Review use of the Rapid Access Community Clinic</p> <p>Evaluate outcomes of Early Supported Discharge for stroke patients</p>	
<p>Make sure people get more ‘joined up’ health and care support, and staff work in a more unified way around individuals with significant health and care needs</p>	<p>To build prevention and enablement approaches into domiciliary care</p>	<p>Modelling and decision re an enablement period for <i>all</i> people referred to Adult Social Care i.e. at the front end, before assessment.</p> <p>Piloting of domiciliary care with workers acting as ‘eyes and ears’ for health, and delivering basic healthcare maintenance tasks linked to a person’s <i>integrated</i> health and care support plan.</p> <p>Commission work to join up health and social care hospital admission and discharge pathways</p>	<p>Commission work to join up health and social care pathways <i>across the system</i></p>	<p>Review of integrated working for prevention</p>
<p>Ensure that people can access a full and diverse range of enabling therapies</p>	<p>To schedule a strategic review of therapy services</p>	<p>Improve access to psychology support for people with ASC</p> <p>Review access to physiotherapy provision across settings</p> <p>Develop ‘whole system’ commissioning plan focused on helping people maintain their mobility</p>	<p>Review communication support</p> <p>Personal Health Budget pilot focused on access to therapies</p> <p>Implement recommendations from physiotherapy review</p>	<p>Review Access to Psychological Therapies</p>

<p>Implementation, planning and governance</p>	<p>To develop Prevention Delivery group and identify operational lead for the Prevention programme</p> <p>Prepare the Prevention Delivery group in Economic Appraisal methodology</p>	<p>Develop wider strategic partnership to progress the strategy</p> <p>First annual survey to measure 'prevention' outcomes from the perspective of residents</p> <p>First annual progress report on prevention and enablement</p> <p>Develop detailed proposals and costed business cases for each priority area</p>	<p>Second annual survey to measure 'prevention' outcomes from the perspective of residents</p> <p>Annual progress report on prevention and enablement</p> <p>Review economic gains from prevention initiatives</p>	<p>Third annual survey to measure 'prevention' outcomes from the perspective of residents</p> <p>Annual progress report on prevention and enablement</p> <p>Review and renew this strategy in early 2017, and develop joint prevention strategy in partnership with children's services</p>
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9. Evidence about what works

9.1 In 2008 the Department of Health²³ judged the following interventions as key to making a strategic shift towards early intervention, prevention and enablement:

- Age proofing mainstream services i.e. ensuring they are 'fit' for older people
- Having a range of wellbeing services
- Providing information for all
- Case finding i.e. identifying people who may be at risk
- Case co-ordination / service navigation
- Having a managed pathway for those not eligible for ongoing social care
- Building capacity in local neighbourhoods
- Providing re-ablement support
- Joint health and social care community support for people with long term conditions / complex needs
- Providing support to care homes
- Crisis response services / out of hours services
- Telecare and assistive technology
- Extra Care housing, and housing-related support
- A falls prevention programme
- Support for carers

It is important to consider how effective these interventions are in achieving the outcomes listed in Section 4 of this report, particularly where they involve significant reconfiguration of services or commissioning of new supports / services. Put simply, do the potential benefits outweigh the costs?

9.2 The evidence base on the outcomes of early intervention, prevention and enablement activities is relatively new and, as yet, research findings are largely *indicative* rather than conclusive. There is a significant challenge for researchers and evaluators in establishing a causal link between preventative activities and outcomes. This challenge needs to be carefully considered when implementing a strategy for the Royal borough, and reinforces the need to evaluate the outcomes of local initiatives and to take an action learning approach.

9.3 Some of the key findings from national research are highlighted briefly below, with their implications for local services.

9.4 Action for the whole population

9.4.1 Communities living in areas of deprivation have greater healthcare needs²⁴. However, the Marmot review suggested that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently, and that actions must be universal, but with a

²³ Making a strategic shift to prevention and early intervention: A guide DH October 2008

²⁴ Fair Society, Healthy Lives The 'Marmot review' DH 2010

scale and intensity proportionate to the level of disadvantage (“proportionate universalism”). A review of progress in 2012 showed that “inequalities in life expectancy persist between communities with different levels of deprivation...”. This is backed up by recent research into the use of NHS Direct across England²⁵. Older people from deprived areas made more calls than people in affluent areas. The implication is that some targeting of interventions to particular geographical areas may be beneficial as part of a multi-pronged strategy for the Royal borough as a whole.

- 9.4.2 Focusing on improved opportunities and support for the whole population of older people and not just the small percentage with complex health and social care needs can bring significant benefits. Practical help (e.g. small housing repairs, gardening, limited assistive technology and shopping) and exercise programmes increase people’s health-related quality of life. The national Partnerships for Older People Programme (POPP) evaluation demonstrated that such interventions led to a 12% increase in people’s health-related quality of life. The implication is that *early* provision of practical assistance and easy access to exercise programmes can help people to maintain their health and wellbeing for longer²⁶.
- 9.4.3 Social isolation, depression, and housing issues have been found to be underlying conditions influencing progression to care²⁷. But research has also indicated that a significant proportion of people going in to care homes are admitted directly from hospital. Health and social characteristics intertwine, but there may also be issues about the rehabilitative pathway. The implication is that interventions aimed at preventing care home admission need to address *both* health and social characteristics, and provision of rehabilitative support in order to be successful. Clarity about whether there is a similar link between hospital discharge and care home admissions in RBWM is needed in order to intervene effectively.
- 9.4.4 There is national debate on the value of health screening for some specific diseases, and on the effectiveness of smoking cessation programmes and flu vaccinations. This suggests that information and choice are essential so that people can make up their own minds, until unequivocal evidence *against* their effectiveness can be established.
- 9.4.5 The important role that communities and local people play in achieving prevention is clear and well-documented. Supporting communities to help each other, through volunteers, neighbourhood initiatives, peer support, and more, is where an effective prevention strategy needs to start. Positive outcomes have been demonstrated through a rich diversity of projects, such as the development of Community Health Champions, Community Places of Safety, mentoring schemes, Alcoholics Anonymous, Community First Responders ... Engaging the strength and contribution of local citizens gets results. The POPP projects in the third sector demonstrated the value of engaging older people to find other older people at risk of ill health or crisis. Nationally, Social Work Practice Pilots are demonstrating the value of linking with community organisations to connect

²⁵ ‘The association of geographical location and neighbourhood deprivation with older people’s use of NHS Direct – a population based study’, Wen-Chin Hsu, Dr P Bath, S Large S Williams, 10 October 2012

²⁶ Partnerships for Older People Project (POPP) 2007-2009

²⁷ Institute for Public Care and Oxfordshire County Council

people to peer-support networks and befriending schemes when they might otherwise be at risk of isolation²⁸.

- 9.4.6 The POPP projects evaluation also demonstrated that interventions which address the whole population of older people and not just the small percentage with complex health and social care needs, can reduce emergency hospital admissions and result in savings. For every £1 spent on the POPP services, there was an average £1.20 additional benefit in savings on emergency hospital stays.

9.5 Enabling self-responsibility and self-management

- 9.5.1 Supporting people to manage their own healthcare has been found to improve health and quality of life, increase satisfaction and have a significant impact on use of services²⁹. But, it requires *long-term behaviour change*, and initial training programmes for clinicians and people with long-term conditions need to be followed up with ongoing support. Self-management support cannot be an 'add-on' but needs to be embedded within care pathways and commissioning contracts³⁰. Given that 30% of the population living with a long term condition account for 70% of health spending, increasing peoples' control and wellbeing through self management may be a cost effective way of working. However, the implication is that any self-management programme in the Royal borough would need to be long-term and designed to *sustain* self-management over time.

- 9.5.2 The Commission on Funding of Care and Support (2011) identified **extra care housing** (see Glossary) as providing a means by which people might exercise greater control over their lives by planning ahead and moving to more suitable housing before developing significant care and support needs. Evidence³¹ has shown that it can provide better outcomes and be a cost-effective alternative to residential care. When matched with a group of equivalent people moving into residential care, costs were the same or lower, but the research cautions that: 'Without attracting a wide range of residents, including those with few or no care and support needs as well as those with higher levels of need, extra care housing may become more like residential care and lose its distinctiveness'. The implication is that, if more extra care housing is developed in RBWM as a means of enabling people to maintain independence, the model and style of development needs to be carefully considered to sustain interest and viability over time.

- 9.5.3 There is a robust economic case that low-cost interventions in primary care offer good value for money in reducing alcohol-related harm. Services should consider targeted approaches (e.g. focusing on young males), screening people only when they change GP rather than at next consultation, or using practice nurses rather than GPs to provide the screening and/or follow-up advice.

9.6 Early intervention with people in marginalised groups

- 9.6.1 The benefits of early intervention for **people with dementia** are well evidenced. It can slow disease progression, improve quality of life and have a positive impact on the lives

²⁸ Reported in Caring for our future: reforming care and support White Paper DH July 2012

²⁹ www.dh.gov.uk/selfcare and www.kingsfund.org.uk Reported that visits to the GP can reduce by up to 69% ; outpatient visits can reduce by up to 76%; A&E attendances can reduce by up to 54% ; hospital admissions and number of days in hospital may be halved; use of medicines and compliance is improved; days off work can be reduced by up to 50%

³⁰ King's Fund 2010 Purdy et al

³¹ Improving housing with care choices for older people PSSRU / Housing LIN Netten et al 2009

of family carers. Taking a person-centred ‘recovery focused’ approach and ensuring access to rehabilitation and therapy services is predicted to reduce stays in hospital, enabling better outcomes for people for less cost. Improved community support services reduce the financial impact of dementia on hospitals by helping avoid crisis admissions.

9.6.2 Use of adult social care services among **people with learning disabilities** is predicted by the presence of additional physical, emotional and behavioural needs. Interventions that address these early in their development can reduce the need for adult social care and/or health supports in the future.³² Evidence points to a number of potentially effective preventative approaches which include annual health checks, early intervention with people who show development of behavioural difficulties, additional support to families / improving the health of carers, and increasing the opportunities for people to follow a healthy lifestyle. People with learning disabilities who present behaviours that challenge services (some of whom may also have Autistic Spectrum Disorder) are known to be especially at risk of being placed in high-cost residential services or hospital-based units at a distance from family and friends. The implication is that local areas need a comprehensive plan to achieve specialised, skilled support and accommodation locally to prevent residential and / or out of area placements.

9.6.3 The RNIB³³ points out that prevention is particularly relevant to **blind and partially sighted people**, given their greater than average propensity to experience depression and to suffer injuries through falls. Blind and partially sighted people are more likely to live alone than the general population and are more vulnerable to isolation. With early support more could lead independent lives: *“[some] people just need equipment and someone to teach them right at the beginning, just to get them going, not somebody coming in all the time, like somebody who needs bathing and dressing”*

9.6.4 Recent research suggests that the number of people living with either Type 1 or Type 2 diabetes will rise from around 3.8 million today to 6.25 million in 2035. Consequently, the direct cost to the NHS of treating diabetes in the UK is projected to rise from £9.8 billion to £16.9 billion over the next 25 years. Ultimately this would mean the NHS spending 17% of its entire budget on the treatment of diabetes alone, rising from 10% today. NICE guidance on preventing type 2 diabetes highlights particular communities that are at risk – South Asian, African Caribbean, Black African, people of Chinese descent, and people in lower socioeconomic groups³⁴ - indicating that targeting of diabetes prevention initiatives may be beneficial.

9.7 Keeping people well: reducing unplanned hospital admissions

9.7.1 A summary of the international evidence³⁵ suggests

- a need for *multiple, evidence-based strategies*, not just small scale projects
- the greatest opportunity is in *proactive management of those with long term conditions*, especially with multiple conditions.

³² Emerson Hatton and Robertson School for Social Care research 2011

³³ RNIB submission to DH Review of FACS eligibility criteria 2009

³⁴ Preventing Type 2 diabetes NICE Guidance PH38 July 2012

³⁵ International evidence about Interventions to Reduce Unplanned Hospital Use Doone Winnard, Wing Cheuk Chan, February 2012

- cost effective interventions such as statins and blood pressure management prevent hospitalisations and mortality
- for the elderly and those with complications from long term conditions (especially congestive heart failure and chronic obstructive pulmonary disease) care in the community may be an effective alternative to hospital treatment *especially if it is based on an integrated approach*
- patients appear to express greater satisfaction with care in their home/ community at least for less serious conditions
- people from *lower socio-economic groups* are at higher risk of avoidable emergency admissions
- outcomes depend on the *quality of service* rather than where it is provided.
- community-based services typically treat less severe and less complex cases, and may only be offered to patients who already have carer support at home

The research overview also concludes that there is insufficient evidence about cost savings from treating people in community settings rather than hospital settings, and that savings are unlikely to happen unless there is active *disinvestment* in hospital services (or not investing in growing hospital services if disinvestment is not possible or appropriate).

9.7.2 An evaluation of eight of the POPP Projects³⁶ found that some interventions were associated with *increases* in hospital use – a finding also observed in other hospital avoidance initiatives. The process of case finding identifies new problems which result in individuals being referred into the healthcare system. In short, more contact between individuals and healthcare professionals may result in more hospital activity, possibly increasing the quality of care without reducing costs in the short term.

9.7.3 The King's Fund³⁷ also suggests that the following needs to be considered:

- being clear about which admissions are potentially avoidable and which interventions are likely to be effective;
- higher continuity of care with a GP is associated with lower risk of admission;
- hospital at home produces similar outcomes to inpatient care, at a similar cost;
- case management in the community and in hospital is not effective in reducing generic admissions. Assertive case management is beneficial for patients with mental health problems;
- acute assessment units may reduce avoidable admissions, but the overall impact on number of admissions should be considered;
- early review by a senior clinician in the emergency department is effective. GPs working in the emergency department are probably effective in reducing admissions, but may not be cost-effective;
- developing a personalised healthcare programme for people seen in medical outpatients and frequently admitted can reduce re-admissions;
- structured discharge planning is effective in reducing future re-admissions.

9.8 Integrated working

³⁶ An evaluation of the impact of community-based interventions on hospital use. A case study of eight Partnership for Older People Projects (POPP) Nuffield Trust 2011 Steventon et al

³⁷ Avoiding hospital admissions What does the research evidence say? S Purdy Dec 2010 The King's Fund

- 9.8.1 There is some agreement that integrated working across primary and secondary healthcare, and across health and social care can help to achieve a shift towards prevention³⁸. However, the national evaluation of the DH Integrated Care Pilots found no evidence of a reduction in emergency hospital admissions and no significant impact on secondary care costs, but changes to the delivery of care had led to improvements in staff experience and organisational culture. They hypothesise that, *over a longer time period*, integrated working may bring about improvements in outcomes relating to patient care and longer-term cost savings.
- 9.8.2 The pilot sites implemented a range of different models of integrated working. There is consensus that there is no one ‘best’ model, but that focusing care around the person and targeting it well is what matters. The research found that it requires *significant investment in developing skills and capacity in primary and community care*. They support the creation of federations of general practices so that they are in a position to assume contracts to carry out much more extensive, 24/7 co-ordination of care, along with ensuring the provision of a range of intensive community-based services³⁹.
- 9.8.3 Integrated working needs to be accompanied by coordinated, person-centred care planning that focuses on people most at risk of hospital admission or a care crisis in order to achieve positive prevention outcomes. The implication of the research is that integrated working needs to be implemented with a strong focus on developing staff skills for risk identification and person-centred care coordination, and that big gains should not be expected too soon. However, an example of ‘anticipatory care’ focused on people aged 75+ in a large GP practice, costing £31,000 a year, is thought to have achieved cost savings to the practice whilst achieving comprehensive geriatric assessment, pro-active management, re-ablement and shared decision making⁴⁰. A highly targeted approach may be beneficial.
- 9.8.4 Research into the overlap between users of health and social care⁴¹ found that fourteen percent of older people received local authority-funded social care in one year, 59% accessed NHS hospital care and 10% accessed both types of service. Most people using social care also used a hospital service (71%). This was a higher proportion than for people who did not use social care services (57%). However, residents of care homes had fewer admissions to hospital, fewer Accident and Emergency attendances and fewer outpatient visits than people receiving high intensity home care. This suggests that domiciliary / home care services may be able to do more to recognise the healthcare needs of people living at home, and to help ensure they are addressed.

9.9 Enablement /re-ablement

- 9.9.1 A study of social care re-ablement programmes⁴² found that during the initial re-ablement period the cost exceeded that of conventional homecare. However, excluding the costs of the re-ablement intervention itself, the costs of social care services used by

³⁸ Purdy et al King’s Fund 2010; Preventative social care: is it cost effective? King’s Fund Natasha Curry 2006

³⁹ Integrated care for patients and populations: Improving outcomes by working together N Goodwin, J Smith, A Davies, C Perry, R Rosen, A Dixon, J Dixon, C Ham Nuffield Trust & The King’s Fund 2012

⁴⁰ Anticipatory Care: Stay Well 75+ D Beales 2012

⁴¹ Overlap of hospital use and social care in older people in England M Bardsley et al

⁴² Care Services Efficiency Drive research

people in the re-ablement group were 60 percent less than those for people with conventional homecare services. Studies also show that the benefits of re-ablement for many people last up to and beyond 24 months. No significant difference was found in the total cost of health services used by re-ablement and comparison groups.

9.9.2 Significant cost avoidance savings have been found for those social care services that have embedded enablement / re-ablement services into their operating models. If care is required at the end of the re-ablement period people have also been found to be more receptive to the concept of managing a personal budget.⁴³

9.10 Hospital discharge, re-ablement and rehabilitation

9.10.1 Age UK⁴⁴ points out that a hospital admission can occur when an older person has reached breaking point because of a combination of circumstances. Simply fixing the main medical problem does not put the older person back in a position to cope. The implication is that when a person has had a hospital admission they need a holistic discharge plan and associated action that addresses *all* the challenges they are facing.

9.10.2 A 'whole systems' approach is important, recognising the interdependency between organisations delivering health and care supports. The NHS Emergency Care Intensive Support Team has made a number of recommendations for successful hospital discharge of frail older people i.e. those with complex support needs⁴⁵. Their recommendations include:

- preventing admissions in the first place, by using 'frailty' indicators and screening to trigger a comprehensive geriatric assessment and care planning, with emergency pathways and access to multidisciplinary teams for treatment and therapies at home
- assertively managing the health and care needs of people with dementia to keep them out of hospital
- early, 'front-end' assessment on admission to hospital, with community services available 7 days a week to 'pull' people out of hospital
- electronic access to information about people across health and social care to expedite care planning
- regular review of people having a prolonged stay in hospital (including community hospitals), to agree action for the person and identify trends, involving hospital and community health staff, and social care
- early involvement of community staff (health and social care) in planning with the hospital for a person's discharge, ideally implementing a plan that was developed with the person before they were admitted
- simple and rapid processes for referral, initiation and funding of care packages
- promoting cultural change and improvements to hospital-based care for people with dementia
- developing programmes to reduce risk of admission from care homes and enhance staff competencies
- gathering patient and carer feedback, and auditing discharges and re-admissions to learn and share what needs to be improved.

⁴³ Putting People First Operating Models: learning from the early adopters ADASS 2009

⁴⁴ Age UK Right Care First Time: Services supporting safe hospital discharge and preventing hospital admission and readmission 2012

⁴⁵ Effective Approaches in Urgent and Emergency Care: Whole system priorities for the discharge of frail older people from hospital care NHS Interim Management & Support October 2012

9.10.3 For people who have had a stroke there is national consensus that an intensive re-ablement period through 'Early Supported Discharge' has positive outcomes for patients⁴⁶. Access to therapy services as part of the re-ablement team is crucial: physiotherapy, occupational therapy, and speech and communication therapy. Having therapy services that are available seven days a week improves equity of access, which has consequent impact on outcomes for people.

9.11 Carer support

9.11.1 It is well documented that carers can experience a negative impact on their health as a consequence of their caring role, and that this can be prevented or resolved through practical interventions - from assistive equipment provision to providing an opportunity for a break from caring. Those not receiving a break have been found far more likely to suffer from mental health problems: 36% compared to 17% of those getting a break. Supporting carers to continue in the caring role alleviates demand for statutory provision. The Care Bill in May 2013 made it a *duty* for local authorities to provide an assessment of a carers needs.

9.11.2 There is also national recognition of the value of advance planning with carers and their loved ones to minimise admissions to care in a crisis, for example if the carer becomes unwell or dies. Such 'contingency' or 'emergency' plans are particularly recommended in situations where a carer provides a substantial amount of care on a regular basis.

9.12 Assistive technology

9.12.1 A 2007 review⁴⁷ of the role of **assistive technology** in helping disabled people gain greater control over their social environment considered devices to aid mobility and physical access, devices to aid communication, devices to enhance environmental control and devices to enhance safety. They recommended that commissioners and practitioners:

- try to engage with as many information and provider sources as possible
- explore joint funding, joint commissioning and follow up
- are culturally and age sensitive in identifying likely needs; generational expectations and willingness to adopt complex digital technology is changing
- avoid 'over-technologising' a solution to environmental needs; where possible use the simplest technology that fulfils the purpose of the intervention
- involve specialist equipment services where needs are complex and where users welcome them
- listen to disabled people who often have a very good idea of the best assistive technology to adopt
- look at the seamlessness and equal distribution of services across their area.

9.12.2 The evidence on **telehealth**, like the intervention itself, is almost developing daily! The Whole System Demonstrator programme showed that people receiving telehealth-assisted care had just 0.14 fewer emergency admissions in the one year follow up period, and there was no significant impact on hospital costs. However, mortality at 12

⁴⁶ Mind The Gap NHS Improvement Agency 2011

⁴⁷ RIPfA (Research In Practice for Adults)

months was lower for intervention patients and length of hospital stay was shorter.⁴⁸ Commissioners and providers are cautioned not to jump uncritically at solutions but to “try telehealth soberly as part of a wider set of changes and evaluate as you go”⁴⁹. There have been consistent messages from telehealth programmes around the UK about the need to view it as one element of a wider system to improve care. Without progress on the other elements of the system telehealth may not achieve the outcomes anticipated and desired. Other high quality research *suggests* that telehealth care may be most effective / achieve positive outcomes when targeted to people who -

- have pulmonary or cardiac disorders
- live in areas of socio-economic deprivation

9.12.3 The evidence on the benefits of **telecare** as a tool for prevention and enablement is also mixed. The Whole System Demonstrator programme evaluated use of telecare equipment over a 12 month period, and found that it had no significant impact on duration of care, admissions to care homes, admissions to hospitals, length of hospital stay or GP contacts, compared with a control group receiving usual care over the same period. The authors concluded that telecare may have an effect over *a longer term* and that the benefits may not be to reduce costs, but to reduce people’s anxiety and enable a quicker response to potential crises. However, evaluation of a large-scale telecare initiative in North Yorkshire claimed a 38% reduction in care costs, with the council saving more than £1m in the first year of the programme. In Essex, for every £1 spent on telecare, £3.82 is reported to have been saved on traditional care. There is widespread acceptance amongst social care practitioners with experience of telecare in use that it can bring increased independence, choice and control for individuals and their carers. The implication is that local development needs to be subject to rigorous cost-benefit analysis.

9.13 Starting young

9.13.1 The national Transition Support Programme identified the importance of enabling interventions for young people with additional needs aged 14-25. A number of factors are acknowledged as key to achieving a good transition and a good start to adulthood - improving transition planning for young people, starting at school, aligned with better access to supported employment schemes, personalised support and ‘ordinary’ opportunities, personal budgets, better planning for healthcare in adulthood, and better partnership with families. The Children and Families Bill (2013) requires staff to work together across agencies to create Education, Health and Care plans with young people aged 14+ and their families. Getting all of these things right can increase young people’s independence, enable them to fulfil their potential and lead fulfilling lives, and divert some young people away from needing social care support.

10. The current picture in RBWM

10.1 Demographics

10.1.1 RBWM is a diverse place, with strong community and a vibrant cultural mix. There are many benefits to this mix: different experiences, skills, cultures and approaches to life.

⁴⁸ Effect of telehealth on use of secondary care and mortality: findings from the Whole System Demonstrator cluster randomised trial BMJ 21st June 2012 Steventon et al

⁴⁹ J Dixon et al Evaluation of the Whole System Demonstrator

However, it is important to acknowledge the difficulties that this can mask. We know, for example, that some groups of people feel excluded from community life, that there are huge differences in economic well-being within the Borough, and that the number of people over the age of 85 with health and care needs is growing significantly. Addressing these factors is a challenge.

10.1.2 146,500 people were estimated to live in RBWM in 2012. The 2011 Census showed that the population had increased by 8.2% since 2001, against a national increase of 7%. RBWM has a slightly higher than average population of children (9-19 years) and a slightly higher than average population of senior citizens, at 17.2%. It is estimated that 2.46% of the population are over the age of 85. By 2020 these figures are projected to rise to 18.22% and 3.01%. In 2011 there were estimated to be c3,500 people aged 65+ with a long-term health condition, c8,500 people aged 65+ living alone, c2000 people with dementia, c14,400 people with common mental disorders, c486 adults with learning disabilities, c2,450 carers – the list goes on. The number of older people in the Borough who are predicted to have had a fall is higher than across the South East and England. It is also estimated that approximately 1,076 people in the borough have dementia, set to rise to 3,045 by 2030, a significant increase. All of these individuals and groups, and the many others not listed, can potentially benefit from early intervention, prevention and enablement activities.

10.1.3 The leading causes of death in RBWM are circulatory diseases and cancer. Cardiovascular disease, such as coronary heart disease, high blood pressure and stroke, is the major cause of premature death. Around 66% of people with chronic heart failure in the Borough have four or more long term conditions.⁵⁰ In 2011/12 the proportion of people admitted to hospital following Accident and Emergency (A&E) attendances was significantly above the England average, at 24% against 20.8%. Planned admission rates in Urology and Orthopaedics are higher than the regional and England average.

10.1.4 Our demographic profile means that transformational changes must be made now to meet the growth in numbers of people with long term conditions, increase in numbers of young people with learning disabilities ‘in transition’ to adult services, and growth in numbers with dementia. Increasing the focus on prevention and enablement is an important part of that transformational change.

10.1.5 Every element of the health and social care network in the Royal borough will be contributing to the prevention agenda in some shape or form. It is absolutely part and parcel of what health and social care professionals do. It is also what third sector, voluntary and community services do, as well as families and carers – in short, it is everybody’s business.

10.2 What local people have said

10.2.1 Four key themes emerged when local people were asked what health and social care services should be **enabling older people and disabled people to do**. They were to:

- * take some responsibility for own health and well-being
- * know where to go for information
- * develop IT skills for social engagement and to use telecare
- * stay as mobile and independent as possible

⁵⁰

JSNA, 2011

10.2.2 People identified a number of services that are **really helpful**: the leisure services SMILE programme (see below), Occupational Therapy, Physiotherapy, sensory support services for hearing and vision, and services across the voluntary sector.

They also identified a number of actions that could lead to improved outcomes:

- * Integrating health and social care services
- * A "one-stop-shop" for information
- * A regular health MOT with a GP
- * Regular reviews of medication
- * More emphasis on improving / maintaining mobility
- * Audits of people's daily living environment to prevent falls (where risk is suspected)
- * Easy access to aids / equipment for daily living to promote independence
- * Easier access to support for carers
- * Accessible information on relevant aspects of health and social care

There was a clear and strong emphasis on *easy access* to advice and support, embedded in communities, with people able to refer themselves, and available regardless of a person's ability to pay. It should 'reach in' to people who are hard to reach and do not use services, and go into people's homes.

10.2.3 Since receiving recommendations for action in the 'prevention report', December 2012, the CCG and RBWM have initiated work in a number of areas to address gaps and make a head start with implementing this prevention strategy. We make no apologies for 'putting the cart before the horse' and acting before the strategy has been published – it fits with our desire to achieve a bias to action, as indicated in our joint principles on page 18.

10.3 Prevention through the Public Health programme

10.3.1 Since April 2013 the local authority has taken over responsibility for the Public Health programme for the borough and an action plan is currently being developed. The public health function includes responsibilities for:

- Smoking cessation programmes and tobacco control
- Drug and Alcohol misuse services
- Public health services for children aged 5-19 (e.g. Healthy Child Programme) and the National Childhood Measurement Programme
- Nutrition initiatives and obesity, including lifestyle and weight management solutions
- Physical activity
- NHS health check assessments
- Public mental health services
- Public dental health services
- Accidental injury prevention
- Population level interventions to reduce and prevent birth defects
- Behavioural and lifestyle changes to prevent cancer
- Local initiatives on workplace health
- Immunisation and screening programmes
- Sexual health services
- Reducing excess seasonal mortality
- Reduction of environmental risks to health and a role in health protection incidents, outbreaks and emergencies

- Promotion of community safety, violence prevention and responses
- Addressing social exclusion

It is essential that the Public Health action plan and this prevention strategy are coherent with each other – the two are inextricably linked. Many Public Health activities are about *primary* prevention: about actions that people can take when they are well and coping independently in order to help them stay that way (the first of our 5 key intervention points – see page 17). RBWM’s Public Health team is fully committed to supporting delivery of this prevention strategy.

10.3.2 The biggest causes of premature death in the borough are heart disease and stroke, liver disease and cancer (source: Public Health England). A number of the programmes listed above can have a positive impact on helping to prevent these diseases e.g. physical activity, smoking cessation, alcohol misuse, lifestyle and weight management. It is important that these programmes reach people who may be affected by health inequalities, for example people with mental health problems, people with learning disabilities, people with dementia, people whose first language is not English, and people living in areas of deprivation. We will monitor to ensure that they are ‘inclusive’ in design and approach.

10.3.3 Annual health checks and screening programmes enable GPs to intervene early to prevent development of disease and to treat illness in the early stages, but without help and encouragement many people do not take them up. In 2010/11, for example, less than half of people with learning disabilities registered with GPs in the borough received an annual health check⁵¹. That situation is likely to be mirrored amongst adults who are struggling to cope but not receiving support, amongst people with mental health problems and amongst people who have difficulties with mobility. Encouraging and supporting people to take up annual health checks is an important preventative measure and one where the borough’s third sector and voluntary services have an important role to play. We will work in partnership with those services to make sure that local residents benefit from the NHS health checks and screening programmes.

10.3.4 Linked to this, the Public Health team will be building on the Berkshire ‘health activist’ programme in RBWM. Health activists are individuals who work to improve people’s knowledge about particular conditions, and to help people get the information they need to take control of their health and healthcare. They are local health champions. It is about reaching, empowering and enabling people using a multitude of means – social media, writing, rallies, campaigns... It puts into effect the belief that, in the words of a Berkshire health activist: *“There are NO hard to reach communities. It is how you go about trying to reach them, and having the will to do so”*. Our first priority will be to secure a health activist for dementia in order to roll out Ageing Well seminars for patients with dementia and their carers, covering all GP practices in the area.

10.3.5 As part of our joint action plan for falls prevention and to minimise the impact of falls we are committed to developing and implementing a specific osteoporosis strategy. This will be taken forward by the Public Health team and CCG, working in partnership. They will also be working to extend the existing ‘exercise on prescription’ scheme and to make it a more consistent offer to residents across the borough. We believe that more

⁵¹ IHAL report 2012 for RBWM see www.ihal.org.uk

elderly and disabled residents could benefit from strengthening exercise if it could be delivered in their own homes: we will explore ways that this could be achieved.

10.3.6 We are concerned that there may be particular issues for people with mental health problems in the borough and that more could be done to provide early support and enable mental wellness. Mental disorder affects more than 1 in 4 of the population at any one time and costs the English economy an estimated £105 billion a year. Mental *wellbeing* is associated with a wide range of improved outcomes in health, education and employment, as well as reduced crime and antisocial behaviour. The Government⁵² is introducing a new duty on local Health and Wellbeing Boards to reduce health inequalities in their area, including in mental health. It is also making reducing mental health problems a priority for Public Health England. Although there are a healthy number of third sector and voluntary organisations in the borough few specialise in supporting people with mental health problems. The CCG has funded Depression Alliance to work with people to develop their social networks, and we will be implementing a suicide prevention strategy with local CCG partners in 2014, but we need to do more. RBWM's Public Health service will look specifically at these issues in 2014/15 and develop a local action plan.

10.4 Early intervention

'We must place renewed emphasis on keeping people as independent as possible, for as long as they feel able, not least by providing earlier support. People need to feel help is there as soon as problems occur...'

Rt Hon Andrew Lansley MP, Secretary of State for Health, speech on 'The Principles of Social Care Reform', July 2010

10.4.1 Services with a particularly strong focus on early intervention are largely universal services such as GPs and primary care, Citizen's Advice Bureaux and other advice giving services⁵³, and voluntary or third sector services. In RBWM these include:

- The SMILE programme, delivering exercise groups, tailored sessions for people with specific health conditions, and health checks in older people's day services.⁵⁴ It is a local model of excellence.
- Services organised by Age Concern such as 'Handy Help', home visiting and befriending.
- The WRVS Carebank scheme, an innovative approach linking volunteers to people who need tasks undertaken, with the volunteer receiving a credit to use in a variety of ways. The scheme is being funded via the local authority and the WRVS.
- Support groups and activities run by Alzheimer's Dementia Support and the Alzheimer's Society.
- The Places of Safety scheme which provides people with learning disabilities places of refuge in community settings such as shops, if they feel at risk.

⁵² Making mental health services more effective and accessible DH March 2013

⁵³ Although not directly involved in 'advice giving' local libraries are making a significant contribution by providing access to information across the full week, including sundays

⁵⁴ SMILE is a charity funded through the local authority, the Older Persons Partnership Board, Macmillan Cancer rehab, Heatherwood and Wexham Park Cardiac Rehabilitation service and through a GP referral 'prescription' programme.

- 10.4.2 A strong and active voluntary / third sector, with their reach into local communities, is absolutely the front line of successful prevention. Evidence about health inequalities supports the need for that 'reaching in' to marginalised and disadvantaged groups. A key question is how to both sustain and grow the level of activity so that more people are 'picked up' early and provided with low level, preventative support that helps them to cope and stay well for longer. At the end of 2012 the Royal borough did not have a service that 'seeks people out' through community networks, gives advice and helps them get what they need to stay independent and well – a holistic, enabling approach that focuses on the full spectrum of what an individual may need to sustain them.
- 10.4.3 In addition, there was no falls prevention service in the borough, though preventing falls is recognised as a key priority in the JSNA and Health and Wellbeing Strategy. In the three years Sept 2009 – Aug 2012, Heatherwood and Wexham Park Hospital Trust indicates that more than 4000 people from RBWM attended A&E as a result of falls. This does not include people who simply visited their GP and/or the falls clinics. The NHS Confederation indicates that a falls prevention strategy could reduce falls by 15 to 30 per cent, having a significant impact on the health and social care economy. Falls prevention is about taking action at two levels: a) through information and advice for groups at risk and their carers, and b) by identifying individuals who *have* fallen and working with them to minimise the risks that they face. It requires a range of skills, access to aids and equipment, including telecare, and links across health, social care and independent sector services: not necessarily the province of a single profession.
- 10.4.1 We have taken action to plug both of these gaps by jointly commissioning a new service, *Keep Safe and Stay Well*, which became operational in January 2014. The service will deliver falls prevention and response activities, and will also seek to build circles of support around people who are isolated. It is initially being funded through a two year contract which will be extended for a third year if the service demonstrates results, before a decision is made about further contract renewal. The service will take a coordinating role on behalf of the CCG and RBWM in relation to falls prevention and response, and our new, cross-agency falls prevention strategy and action plan.
- 10.4.2 Early identification and intervention for people with dementia can have a positive impact on preventing / delaying dependency. We have been piloting a screening initiative with three local GP practices, and dementia screening and support is now being taken up by our integrated primary care teams. We have also been working with neighbouring CCG and local authorities on a number of projects that will enhance self-help, awareness and support, including a programme of dementia awareness in the community, integrating with the Safe Places scheme. We are monitoring the impact of these initiatives and aim to build on them if positive results are demonstrated. We know that we need to do more to support people and will explore how we can work with local third sector services to develop circles of natural community support around people with dementia and their carers.
- 10.4.3 Identifying carers and intervening early to support them is an essential element in a prevention strategy, recognising the economic benefits that carers have on the health and social care system. The consequences of not providing adequate support are well documented, for both carers and cared for. There are numerous organisations providing support to carers across the borough, and additional money has been allocated by Government to boost provision over the coming two years. This will enable

significant steps forward. Amongst other things, carers will have money allocated directly to them to spend in the way they choose to secure the breaks they need. However, there are some additional considerations –

- Carers need to be sought out and offered support. There is currently no carers service in the borough that specifically links into GP surgeries and hospitals as an important route to identifying (and registering) carers. The level of carers assessments is also reported to be low.
- There are particular prevention issues in relation to people with support needs who have a carer who is elderly. Advance planning to ensure there is an emergency plan that can be activated if the carer is incapacitated or dies can prevent sudden crises and emergency care placements.
- Services that enable carers to have a break focus largely on the provision of replacement support for their loved one – either at home or at a group /centre. Older carers and carers experiencing stress may need *active* encouragement to have regular breaks, and hands-on support to decide the kind of breaks that will most help them, and to make the arrangements. A ‘support planning’ model that helps carers to access more regular breaks, specifically designed to rejuvenate, including in the evenings and at weekends, may be needed.

Developments need to be driven, and there is now a specific carers lead in adult social care services. A specific Carers strategy will be consulted on and agreed by April 2014, across health and social care.

10.4.4 In the region of 1200 older people live in Sheltered Housing across the borough and there are c1400 care home beds. It is essential that there is reach *in* to these settings to give tenants/residents and staff information and opportunities that enable people to stay as well and independent as possible. Information and advice is key to self-help; training is key to early identification and prevention (falls awareness, hydration, helpful exercise, etc): a comprehensive programme to support early intervention and prevention, developed with Sheltered Housing and care home providers, could reap dividends. There is also potential for these settings to offer opportunities to other, local elderly people to create new social networks and combat isolation. During 2013 we commenced a joint programme of work that initially focuses on improving prevention in a pilot group of care homes. We will roll-out to more care homes and spread to Sheltered Housing from 2014.

10.4.5 An appropriate, accessible home is crucial for people with mobility issues. The borough does not maintain a centralised record of level access, adapted social housing so that peoples’ needs can be matched to accommodation that becomes available. Whilst registers of adapted housing have recognised issues, there may also be benefits that should be explored. Linked to this, we are concerned that the process for residents to access Disabled Facilities Grants so that their property can be adapted to meet their needs may need to be faster if it is achieve prevention and enablement outcomes. We will look into these areas in more depth during the lifetime of this strategy.

10.4.6 New Shared Lives and Home Share services have been commissioned for older people and will be operational in 2014. We have also begun work to develop a Supported Accommodation strategy for older people and people with learning disabilities, identifying what’s needed and how we will develop it within the borough over the

coming three years. Prevention is about looking to the long-term future as well. Planning *all* new build housing and community facilities so that they are accessible and usable by people as they age is an important consideration – improving our area for everyone. We will work with RBWM’s Environment and Planning services to develop an *accessible housing and environment* plan for the borough, as part of our public sector equalities duties.

10.5 Enablement / Re-ablement

10.5.1 Enabling and re-abling approaches aim to maximise people’s abilities and their independence. They aim to reduce the level of ongoing support that a person requires. An important question is the extent to which ‘enablement’ is embedded in, and driving *all* health and social care interventions along a person’s journey of care in the borough. The indications are that there are significant issues and gaps.

10.5.2 Participants at the December 2012 consultation event pointed out that RBWM and the CCG need to take a long-term view. Ensuring that prevention activities start from a young age, promoting healthy living in schools and clubs for young people, will potentially reap benefits in the future. As one person pointed out “*Prevention is an 80 year project!*” This strategy focuses on adults, but also considers what can be done to enable young people at the point of ‘transition’ of support to adult services – intervening early to maximise independence and wellbeing. But, we need to go further, and our intention is to develop a *unified* prevention strategy with children’s health and care services by 2017, when this strategy is due to be refreshed. This development will be led through the Health and Wellbeing Board.

10.5.3 We have been working closely with RBWM’s children’s services since 2011 to improve transition planning and enablement for young people with additional needs / Special Educational Needs, following a review by the National Development Team for Inclusion. There are now two additional Supported Employment specialists, one for young people at Manor Green school and one working with people who have Autistic Spectrum Conditions. A programme with a local Further Education provider was agreed as a local alternative to an out of county residential college placement. Whilst this has had an impact in neighbouring local authorities on reducing the number of learners placed with Independent Specialist colleges, the number placed by RBWM remains stubbornly high. This is partly as a consequence of the number of residential school placements made before a young person is 16. We will work in partnership with children’s services during 2014/15 to address this issue when refreshing the transitions strategy and action plan.

10.5.4 With the introduction of self-directed support and Individual Budgets in Adult Social Care (‘personalisation’), local authorities introduced new assessment and care planning pathways. In most cases these have included a period of short-term support to ‘enable’ or ‘re-able’ a person before assessment. In RBWM the Short-Term Support and Rehabilitation service takes referrals from health and social care services, providing people with a period of intensive re-ablement in their own homes for up to six weeks. It also provides 2 hour rapid response, night-time support and end of life care, focusing on avoidance of hospital admissions and facilitating hospital discharge. The service includes physiotherapists, rehabilitation assistants, social work staff and a stroke coordinator. It is funded jointly by RBWM and WAM CCG. Since it was set up demand

for the service has grown significantly. Referrals have risen from 794 in 2009/10 to 1597 in 2012/13. The service is free of charge to recipients.

10.5.5 In the two years 2010 - 2012, on average 58% of people referred⁵⁵ were able to cope independently at the end of the intervention. The service is clearly re-abling and enabling people. However, there remains a lack of clarity about how the service should develop. The prevention report in December 2012 recommended –

- a cost-benefit analysis to help forecast and manage future resource requirements;
- developing a locality focus by having staff based in other areas of the borough;
- protecting the service from ad hoc developments and changes through a clear set of outcomes and core delivery principles built into its specification.

We are currently considering how to develop the *whole network* of intermediate care services in the borough to achieve more comprehensive coverage and continuity of support. Our aim is to have services that deliver appropriate treatment and care in community settings, avoiding the need for people to go into hospital, as well as supporting people to recover their health and independence after illness or incapacity.

10.5.6 The report also recommended that the service could expand to offer a period of enablement to *all* people referred to Adult Social Care i.e. at the front end, before assessment. Evidence indicates that this approach has potential to delay people's need for long-term care packages, achieves positive outcomes for recipients and reduces long-term costs for Adult Social Care. We need to model potential demand, forecast potential financial gains and benchmark against similar services to inform our decisions.

10.5.7 The sharp drop-off in support at the end of STS&R involvement has been raised as an issue by stakeholders across services. This has been echoed in relation to Early Supported Discharge for people who have had a stroke. This suggests that more attention needs to be given to planning exit strategies and 'bridging' support via voluntary groups and community resources. Personal circles of support can help prevent a person 'bouncing back' to services at an early date. Our new Keep Safe and Stay Well service will begin to develop this approach, but we will need to build greater capacity to achieve wraparound, natural supports for larger numbers of people.

10.5.8 The Home Treatment team for people with dementia / older people with mental health issues also operates using a short-term re-ablement model and has both health and social care staff. With the projected growth in numbers of people with dementia it will be important to grow this team but also to make sure that it can access domiciliary support delivered by staff with knowledge and skills to work in an enabling way with people with more advanced dementia. This is an issue that we will address through the Council's re-commissioning of homecare services in 2014/15. We have been successful in gaining significant external funding to improve local services and supports for people with dementia, which includes a project to improve the environment of hospitals and care homes so that they are more enabling for people.

10.5.9 We are very conscious that some people have numerous health and care staff visiting them during the course of a week, each with a distinct focus on carrying out 'health' tasks or 'care' tasks. Doing things differently may be more helpful, enabling and preventative for people. We are therefore piloting an approach to domiciliary care that

⁵⁵excluding those referred via the Adult Social Care Access & Advice team

has care workers acting as ‘eyes and ears’ for health, and delivering basic healthcare maintenance tasks to ensure that people’s full support needs are met. People will have an *integrated* health and care support plan that focuses on the outcomes they personally want to achieve. This work will feed into the re-commissioning of domiciliary care services: it is essential that the 4000 hours of domiciliary support funded each week for older people achieves maximum benefits in terms of enablement and enhanced independence.

10.5.10 Enabling people to maintain their mobility is fundamental to quality of life and health, and also impacts on their ability to care for themselves. In 2011 it was estimated that there were 9587 adults with mobility problems in the borough “such that they cannot manage a daily task”. Locally, older people have expressed concern about access to physiotherapy for rehabilitation after a surgical procedure or fall, and about access to mobility support for people who are developing visual impairments: 550 people aged 50+ were registered blind or partially sighted as at March 2011. The key word is *access*. People over 80, and those living in our rural areas, experience difficulties in getting to hospital-based physiotherapy services or organised exercise groups. Whilst the STS&R service and the Early Supported Discharge service for people who have had a stroke both include physiotherapists for short-term rehabilitation, and community physiotherapy is available through BHFT and GPs, in light of demographics there is a need to review and potentially increase provision that enables people to regain and/or maintain their mobility. This means developing a ‘whole system’ approach, recognising that staff in different roles and teams can make a contribution as well as physiotherapists.

10.5.11 Being able to communicate effectively can make a significant difference to individuals in getting the support they need, and also in enabling staff to deliver health and care support in ways that are ‘right’ for the person. Good communication is fundamental to achieving quality of life and care, and to preventing isolation. In addition, our health and care services need to be able to communicate well with people who have a diverse range of needs and literacy skills. Speech and communication therapy, easy-read accessible information, use of communication passports are all examples of interventions that enable independence. We are committed to reviewing this area during the lifetime of this strategy to identify local examples of excellence that can be shared and built on, as well as areas for development.

10.5.12 Telecare equipment is currently available to people through a number of routes in the borough, including the STS&R service, Adult Social Care teams, sheltered housing, and through direct purchase. Community alarms are the devices most commonly used. Efforts to develop a more expansive offer now need to be pushed forward to achieve the positive, prevention outcomes that telecare can deliver. To that end, during 2013 Adult Social Care services appointed a telecare project manager. However, it is important that telecare is not seen as just a ‘social care’ provision because of the numbers of people who have significant personal savings and will organise their own care rather than approach the local authority. To achieve prevention people need to be able to organise telecare directly if they do not wish to go through statutory services.

10.5.13 Monitoring vital health signs via telehealth is also underdeveloped in the borough. An *integrated* approach to expansion of telehealth and telecare is now being progressed, focused around GP practices. Tele*health* monitoring is initially focusing on people with

COPD, heart failure, and diabetes. Telecare provision will be inclusive so that it reaches anyone who could benefit, including people with dementia, mental health problems and people with learning disabilities. Implementation and outcomes will be closely monitored and evaluated to inform future commissioning decisions and ensure benefits outweigh costs.

- 10.5.14 Provision of aids and equipment are essential to prevent falls, enable mobility, and keep people as independent as possible. Identifying that there may be a piece of equipment that could help a person is the starting point, which means all community health and social care staff being 'equipment aware', including staff in care homes and domiciliary care services. But it is also important that the route to accessing equipment is as straightforward as it can be to avoid delays in getting equipment to people who need it. We are beginning work to simplify the pathway to aids and equipment to ensure that it gets to people quickly.
- 10.5.15 The issue of *how* to embed knowledge about all aspects of enablement – successful approaches with people who have different needs, equipment options, services that can help, etc – is a challenging one. Building cultures where staff take responsibility and do simple things to enable people has the potential to reduce demand on health and care services. ACEVO calls for services to embed a 'presumption of prevention' at all stages in care pathways, where *"each interaction with a (health) professional should be seen as an opportunity to examine the underlying factors influencing health and wellbeing..."* We need to create an enabling, preventative culture through specific development and training opportunities for the health and care workforce in the borough. We also need to ensure that service specifications and monitoring include a specific focus on enablement, and specific outcomes, so that the message spreads.
- 10.5.16 There is much more that could be done in RBWM to promote and support people with 'self-management' of their health. There is not yet a comprehensive, coordinated programme locally to develop and support people to help themselves by educating them about their condition, symptoms, what helps, etc. A small number of courses have been offered, but have achieved poor take-up. The national evidence suggests that local programmes can help achieve prevention outcomes but that a *sustained and embedded* approach is needed. Practices nurse and specialist nurses have an important role to play, but so too could Health Activists. Our aim is to trial a programme to promote and support self-management during 2014/15, targeting some of the most significant long-term conditions.
- 10.5.17 Personal health budgets are being implemented across the NHS Berks cluster⁵⁶ for patients who receive Continuing Healthcare funding, and we anticipate benefits in terms of patient choice and more flexible services. Personal health budgets present an opportunity to enable people and their carers to take control and address some of the gaps they currently experience, such as accessing physiotherapy input. We believe that expanding personal health budgets so that people can make choices about, and manage their own healthcare will contribute to prevention and we will consider rolling the scheme out to more people once we have learnt from the initial implementation.

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2012/13 operating plan

10.5.18 The borough has a specific team to support people with Autistic Spectrum Conditions, funded by the Council. The team works with people who have particular relationship and communication challenges, and is very much 'preventative' in nature. However, people's access to psychology support is limited. Mental health services are required by law to make 'reasonable adjustments' to provide enabling, preventative therapies to people with ASD and/or learning disabilities, in accordance with Equality Duties and national policy, and we need to ensure that this requirement is met.

10.5.19 There are c 50 people with learning disabilities and /or Autistic Spectrum Conditions in high cost residential placements. A strong commissioning lead is needed to prevent future placements and ensure there is appropriately skilled local support and accommodation for people whose behaviour can presents challenges. The Council has a new commissioner focused on people with learning disabilities and people with Autistic Spectrum Conditions who will work closely with the NHS Commissioning Support Unit to improve our joint commissioning in this area. Our local ASC action plan currently focuses on adults. We now need to work to develop a *joint* plan with Children's services to ensure a *whole life* approach that achieves early intervention and prevention.

10.6 Coordinated, preventative care across services

10.6.1 There are numerous handover points in a person's journey through primary care, community health and social care services, and acute services – and there are inevitably gaps and issues. The government's ambition⁵⁷ is for everyone who uses health, care and support to experience joined-up services that meet their needs and goals. The draft Care and Support Bill sets out a duty on the local authority to promote the integration of services, along similar lines to the duty on the local NHS enacted in 2012. In prevention terms, the evidence is clear that there are more likely to be gains by focusing integrated working around people who require high levels of health and care support. BHFT has begun to integrate community health services with, and around clusters of GP practices, delivering care coordination for people with complex health and care needs. Social work staff are involved, to a limited extent as yet, but this is a positive development that we will be building as one part of our strategy.

10.6.2 A risk stratification tool is used by the integrated primary care services to identify people with the most complex needs who will benefit from coordinated care planning. The tool enables patients with specific risk factors to be identified and presents an opportunity to deliver early, preventative supports to people. We will be working with GPs and the integrated primary care services to begin using the tool as an aid to achieve earlier intervention and prevention.

10.6.3 More integrated pathways of care *across* health and social care will help ensure that people receive the support they need at the time they need it, preventing later crises. The development of integrated pathways needs to involve both health and social care staff from the outset, recognising the interplay and interdependency of the two parts of the system. This will need deliberate leadership. Our local health and social care

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Caring for our future: reforming care and support White Paper DH July 2012

services are rapidly developing 'pathways' within their own services, but we now need to join them up.

10.6.4 We are concerned that there is a particular issue about the rate of safeguarding alerts in relation to neglect, 'predominantly of older people' in the borough. However, the Winterbourne View enquiry (2012) into abuse of people with learning disabilities highlights that vigilance is needed around *all* people in residential or institutional settings, whether long or short term. Preventing abuse and neglect is the responsibility of every agency. We have started a joint programme of work in care homes and a cross Berkshire action plan is being developed in response to the Winterbourne View enquiry, as required by Government. We will closely monitor the outcomes and expect to see a reduction in safeguarding alerts, number of placements in Assessment and Treatment units, and number of Mental Health Act detention orders used with people who have learning disabilities and/or Autistic Spectrum Conditions. We will also develop a contingency plan to prevent older people having to move if a care home provider ceases trading because of the adverse impact it can have on health and wellbeing.

10.6.5 In 10.5.3 above we have outlined the work underway to maximise the abilities and independence of young people with additional needs through improved transition planning, accommodation, employment and support. A smaller cohort of young people present with very complex, multiple needs and require continuing health and/or care supports into adulthood. Getting transition planning right for this group of young people, and for their families/carers, is essential to maximise their health and wellbeing. We want this group of young people to experience the same opportunities as any other young person in the borough, and to receive the support they need to lead fulfilled, ordinary lives. We will review progress on achieving that aim when refreshing the transition strategy / action plan with children's health and care services.

10.7 Support in a crisis

10.7.1 Heatherwood & Wexham Park Trust reports that almost 7700 people over the age of 80 attended A&E in the three years Sept 2009 – Aug 2012. From Apr – Sept 2012, c135 people used community beds, most over the age of 65. The STS&R service received 363 referrals in 2011/12 to facilitate hospital discharge. The pathway from home to hospital and back should focus on maximising a person's health and independence, preventing deterioration and dependency. There are significant issues in the current process:

- Concerns that insufficient people are using the Rapid Access Community Clinic thereby preventing a visit to A&E, and that it is sited too far away from A&E to pick up people who do not need an A&E response. Visiting A&E can result in an unnecessary in-patient stay. We need to address this issue.
- Once a person has been admitted to a ward, particularly an older person, there are concerns that they do not receive the stimulation or support they need to maintain their independence. There is unnecessary deterioration. This was stressed strongly during consultation in 2012: *"don't wait for a person to decline in hospital and then for rehabilitation to start in the home. Work on what can be done in the ward"*. This could be prevented by planning for rehabilitation and discharge home *from admission*, and better access to rehabilitation 'step down' beds with an appropriate level of therapeutic, enablement support to facilitate a move back home. This does not need to be in a hospital setting.

- 10.7.2 More detailed exploration is needed about the onward destinations that older and disabled people take after an in-patient stay, and why. There is some indication from the data that high numbers of older people are entering care settings directly from hospital, after an emergency, but the data is not reliable enough to form a firm conclusion. If this is the case, we need to understand why people are making those decisions in order to put services and supports into place that help them feel confident about returning home.
- 10.7.3 Currently there are a number of separate teams potentially involved when a person is being discharged from hospital – the hospital discharge team, the hospital social work team, a Community Liaison team, the STS&R service. For people with learning disabilities there is also the learning disability liaison nurse, a post that has made a significant difference to people’s experience of hospital care. A similar post has now been created at Wexham Park Hospital for people with dementia. We need to develop a more *integrated* approach to discharge, with acute and community staff, health and social care working together to a common pathway, possibly as a single ‘virtual’ team.
- 10.7.4 Support for people who experience a crisis at night or over a weekend is provided by the cross-Berks out of hours social work service and GP service, the STS&R service, the Ambulance service and District nurses. Out of hours support is essential to prevent unnecessary hospital admissions and emergency care placements, and emerged as a theme in ‘Shaping The Future’ consultation events. We need to more clearly establish what people need and want when an emergency occurs ‘out of hours’, and consider what local third sector services can contribute, and then develop a more comprehensive network of support.

Glossary of Terms

Assistive technology

An umbrella term for any device or system that allows an individual to perform a task they would otherwise be unable to do, or increase the ease and safety with which the task can be performed (e.g. monitoring equipment and devices such as medication dispensers, falls detectors and bed occupancy sensors). Royal Commission on Long-Term Care (1999). Also see telecare and telehealth below.

Better Care Fund

The Better Care Fund is providing £3.8 billion to local areas to integrate health and care services around the needs of residents / patients, so that people can stay at home more and be in hospital less. Local areas are required to complete and submit plans to the DH on how they will use their portion of the fund. National conditions set out the things that each plan must consider, such as 7-day services and steps to improve data sharing. £1 billion of the fund is linked to achieving improved outcomes for local people to ensure the money is being spent in the right way.

Enablement

Enablement is about supporting people in ways that help them build on their abilities to achieve greater independence. It means using approaches and interventions that help people to do more themselves.

Extra care housing

Laing and Buisson (2010) suggest that extra care housing can be recognised by a combination of characteristics:

- It is primarily for older people;
- The accommodation is (almost always) self-contained;
- Personal care can be delivered flexibly, usually by staff based on the premises;
- Support staff are available on the premises for 24 hours a day;
- Domestic care is available;
- Communal facilities and services are available
- Meals are usually available, and charged for when taken;
- It aims to be a home for life, and to allow people to age in place; and
- It is owner-occupied or offers security of tenure if rented.

Ideas collective

A community of people who come together to share ideas and thinking in order to unlock creativity and produce new ways forward

Intermediate care

A range of services aimed at helping people stay at home instead of going into hospital, or that help people get home after a hospital stay. Intermediate care aims to provide “care closer to home”. Intermediate care is delivered by teams of professionals that may include nurses, therapists, care assistants and others. Care can be provided for a few days, or several weeks.

Services include:

- Reablement (provided at home or within a care home or community hospital setting)
- Virtual wards, or hospital at home services
- Rapid response community teams
- Enhanced supported discharge.

Long term conditions (LTC)

A health problem that can't be cured but that can be controlled by medication or other therapies. In England, more than 15 million people have a long term condition. Examples of long term conditions include high blood pressure, depression, dementia and arthritis.

Care of people with long term conditions accounts for 70% of the money spent on health and social care in England (DH 2013)

Networks or Circles of community support

Circles of Support help those who are excluded or isolated, who live with physical disability, learning difficulties, mental health issues or disadvantage. The members of the Circle may include family, friends and other community members. People are involved because they care enough about the person to give their time and energy to help them overcome obstacles and increase their options.

Pathways of care

Also known as clinical pathways, care pathways, critical pathways, integrated care pathways, or care maps: one of the main tools used to standardise care processes and manage quality. Makes it clear who should do what, and when. Their use has been shown to reduce variability in clinical practice and improves outcomes

Reablement

Usually a time-limited period of support (in RBWM up to 6 weeks) given to people who have lost some of their usual functioning through ill health, injury or crisis. It is part of 'intermediate care' that is jointly funded by health and social care and free to recipients. It focuses on enabling people to *regain* their skills and confidence. There are different models, but what all reablement services have in common is an ethos of working to achieve goals set by the person and reablement team together, with the overall aim of maximising independence, choice and quality of life, and reducing the person's need for support in the future. In RBWM the Short-Term Support and Rehabilitation service provides reablement support to people in their own homes.

Telecare

'a combination of alarms, sensors and other equipment to help people live independently'. (Department of Health 2009)

Telehealth

a service that 'uses equipment to monitor people's health in their own home... monitoring vital signs such as blood pressure, blood oxygen levels or weight' (Department of Health 2009).

Third sector

i.e. not the public sector or private sector. The third sector encompasses organizations that are not for profit and non-governmental – sometimes referred to as the voluntary sector or community sector.