

North Somerset Prevention and Early Intervention Strategy for Adults and Older People

Improving the health, wellbeing and independence of
adults in North Somerset

2015 - 2020

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1. Introduction

Background

“The Care Act will help to improve people’s independence and wellbeing. It makes clear that local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support.” (Care Act Factsheet no. 1 General responsibilities Department of Health, 2014)

There is an increasing emphasis from legislation and guidance on how statutory provision should support people to remain independent and avoid the need for services. This support can range from advice and guidance on healthy living to ensuring that those people in receipt of services are able to remain as independent as possible. The aim is to prevent needs for care and support from developing where possible. This approach has the dual benefits of enabling people to retain independence and autonomy over their care as well as ensuring public funds are spent economically and effectively.

The Better Care Fund is a Government initiative launched in 2013 to increase and enhance integration of Health and Social Care services. The aim is to improve people’s experience and the outcomes achieved with a more efficient use of resources overall. The fund creates a single pooled budget for health and social care in order that they can work more closely together.

In North Somerset the People and Communities Board (the Health and Wellbeing Board) has developed a “Prevention and Early Intervention Commitment”, which forms an overarching and comprehensive approach to prevention in the area. It is recognised that prevention occurs in many areas and the commitment ties together the prevention elements of numerous strategic initiatives led by the different elements of the Board. By “joining up” prevention across North Somerset it is felt that we will be able to achieve the vision of the Care Act and better meet the aspirations of the Better Care Fund in relation to integration.

This strategy forms part of the People and Communities Prevention Commitment and outlines the preventative work in place and in development for adults including older people. It is a joint strategy with North Somerset Council People and Communities Directorate (P&C), North Somerset Clinical Commissioning Group (NS CCG) and Public Health (PH) as key stakeholders.

The previous “Early Intervention and Prevention Strategy” was developed to cover the period 2011-15. This “refresh” reviews that document (appendix E) and develops a new action plan for the continued delivery of services for the period 2015-20 (Appendix A).

Definition

In the previous strategy the definition of prevention and early intervention was taken from “Making a strategic shift to prevention and early intervention” (Department of Health, 2008). Whilst this reference is an old one it continues to be relevant and the same three divisions are used in the 2014 Care Act. These definitions have therefore been updated for the new strategy and are described thus:

Primary Prevention / Promoting Wellbeing

For people who have no particular care needs or symptoms of illness. The focus is therefore on maintaining and promoting independence, good health and wellbeing.

Secondary prevention / Early intervention

For people at risk, to halt or slow down any deterioration and actively seek to improve their situation.

Tertiary prevention

This is aimed at minimising disability or deterioration from established health conditions or complex care needs. The focus here is on maximising people's functioning and independence.

Engagement

The Prevention and Early Intervention Strategy for Adults and Older People has been shared with several forums and engagement groups in order to inform its development. These include:

Senior Community Links Groups in all areas of North Somerset
The Older People's Champion Group
The Older People's Transformation Programme Board
The Health Integration Strategy Board
The Adult Joint Commissioning Group
The Carer's Strategy Implementation Group
Commissioning leads in the Clinical Commissioning Group (CCG)
Medicines Management in the CCG

It was also published for consultation as a draft in March 2015. The results of these consultation and engagement measures will be used to ensure that it reflects the priorities across the area. The full consultation results are added as Appendix H.

Governance

As described above this strategy forms part of the People and Communities Board (North Somerset's Health and Wellbeing Board) "Prevention and Early Intervention Commitment". It will be governed by the Older People's Transformation Programme Board and the Health Integration Strategy Board. These joint forums are made up of senior management from North Somerset Council People and Communities, Public Health and North Somerset Clinical Commissioning Group and have a remit to ensure that services for older people in North Somerset are comprehensive, integrated and cost effective.

The action plan for this strategy highlights priorities for adults in North Somerset. Those elements falling under the remit of this strategy will have actions and responsibilities indicated and where they are met by other strategies this will also be clearly stated along with where governance for those strategies reside.

Abbreviations

The following abbreviations are used in this strategy document, particularly within the action plans for brevity.

In addition, any further abbreviations used will follow the convention of initially defining the abbreviation alongside the abbreviation in parentheses i.e. Prevention and Early Intervention (PEI), prior to further use.

- CCG:** Clinical commissioning group – the CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
- DoH:** Department of Health - the government department responsible for public health issues.
- I&A:** Information and Advice - usually relating to the strategy concerning this area
- JSNA:** Joint Strategic Needs Assessment – which provides local policy makers and commissioners with a profile of the health and wellbeing needs of the local population.
- LGA:** Local Government Association – a politically-led, cross-party organisation that works on behalf of councils with the aim to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems.
- NHS:** National Health Service - the four publicly funded health care systems in the countries of the United Kingdom.
- NSC:** North Somerset Council (NS – North Somerset)
- ONS:** Office of National Statistics – the executive office of the UK Statistics Authority, a non-ministerial department which reports directly to the UK Parliament.
- OT:** Occupational therapy - the assessment and treatment of physical and psychiatric conditions using specific activity to prevent disability and promote independent function in all aspects of daily life. Occupational Therapist – one who practices occupational therapy.
- PEI:** Prevention and early intervention
- SCL:** Senior Community Links – representative engagement groups who meet to discuss and consider the issues facing older people in each part of NS.
- TLAP:** Think Local Act Personal - a national partnership of more than 50 organisations committed to transforming health and care through personalisation and community-based support.

2. What do we want to do?

Vision:

“To improve the health, wellbeing and independence of adults in North Somerset”

It is felt that this vision reflects the principle of wellbeing as promoted by the Care Act as well as meeting the aspirations of the People and Communities Board Prevention Commitment.

How we will improve people’s experience – Aims of Strategy

Our aims are:

1. That by September 2015 people in North Somerset will have access to information and advice about social care services via a comprehensive website and face to face services.
2. To ensure that people can get the help and support they need at an early stage to reduce the likelihood of greater needs developing.
3. To ensure people can access the support they need to remain at home and in control.
4. To support people live well with long term conditions, managing their own care where possible and maintaining their health and independence.
5. To ensure people are not socially isolated unless they choose to be and do not become incapacitated by the impact of loneliness.
6. To ensure communities develop into supportive places to live.
7. To develop a coordinated approach to prevention across the community through the development of the Community Connect partnership and through the Prevention Statement.

The action plan for this strategy (appendix A) is designed to achieve the above aims and is organised around the three areas of prevention as highlighted in the definitions given in section 1.

Local Direction

This strategy sits under the framework of the People and Communities “Prevention and Early Intervention Strategy Commitment”. The vision for People and Communities is:

‘Sustainable, inclusive, safe healthy, prosperous communities thriving in a quality environment’.

The aim for the People and Communities Board Commitment on Prevention is equally relevant to this document:

The aim of early intervention and prevention policies and services in North Somerset is to provide people who may need to use care, community safety, fire and safety, health and housing services with the advice, information and support they need. This will enable people to keep as healthy, independent, and safe and secure as possible whilst reducing reliance on acute services. It will be achieved by supporting a proactive partnership approach towards prevention and early intervention across North Somerset and jointly prioritising initiatives to target resources effectively.

The People and Communities Prevention Commitment principles will also be adopted here:

- Partnership working for prevention wherever possible,
- Coordinating the approach to information and advice,

- Maximising independence (including planning ahead),
- Promoting self care,
- Reducing isolation,
- Developing community networks,
- Evaluating and prioritising together.

National Direction

Appendix B gives a detailed analysis of the current policy direction regarding prevention and early intervention for each of the partners involved in developing the strategy. The main statutory driver of change for prevention services currently is the 2014 Care Act which introduces the principle of “wellbeing” as central to all social care provisions in section 1. In addition it places an emphasis on the preventative agenda which is described as follows:

“The importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist. At every interaction with a person, a local authority should consider whether or how the person’s needs could be reduced or other needs could be delayed from arising. Effective interventions at the right time can stop needs from escalating, and help people maintain their independence for longer.” (DoH Care and Support Statutory Guidance issued under the Care Act 2014 page 3)

In order to ensure implementation of prevention the Act is explicit in the statutory duties of the local authority with regard to prevention and working in partnership with Health:

“Section 2 requires local authorities to ensure the provision of preventative services - that is services which help prevent or delay the development of care and support needs, or reduce care and support needs (including carer’s support needs).

This duty builds upon existing requirements to provide certain preventive services (e.g. under Schedule 20 to the NHS Act 2006) and supports other duties, such as those to undertake joint strategic needs assessments. This expands current legal requirements, to reflect best practice in relation to local approaches to preventing and delaying needs.”

“This section [3] establishes a duty on local authorities to carry out their care and support functions with the aim of integrating services with those provided by the NHS or other health-related services (for example, housing).” (LGA Care Act Clause Analysis, http://www.local.gov.uk/care-support-reform/-/journal_content/56/10180/5761381/ARTICLE, last accessed February 2015)

Investment in Prevention is also a core part of the NHS Five Year Forward View. The Forward View was published in October 2014 and was developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. It sets out the vision for the future of the NHS; why change is needed, what that change might look like and how this change can be achieved.

3. Who is the strategy for?

A needs analysis of adults and older people in North Somerset is included as appendix D. In addition this section attempts to highlight the importance of each stage of prevention for particular groups.

Primary Prevention:

This area targets people who have no particular care needs or symptoms of illness and therefore the whole population are potential customers. Having said that there are particular factors which influence the development of good or poor health.

Deprivation

There are links between poverty and poor health as well as reduced life expectancy as are summarised by the findings of the Marmot review in 2010:

- People living in the poorest neighbourhoods in England will on average die seven years earlier than people living in the richest neighbourhoods
- People living in poorer areas not only die sooner, but spend more of their lives with disability - an average total difference of 17 years
- The Review highlights the social gradient of health inequalities - put simply, the lower one's social and economic status, the poorer one's health is likely to be
- Health inequalities arise from a complex interaction of many factors - housing, income, education, social isolation, disability - all of which are strongly affected by one's economic and social status
- Health inequalities are largely preventable. Not only is there a strong social justice case for addressing health inequalities, there is also a pressing economic case. It is estimated that the annual cost of health inequalities is between £36 billion to £40 billion through lost taxes, welfare payments and costs to the NHS
- Action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home and community

(from summary of Marmot Review 2010 on http://www.local.gov.uk/health/-/journal_content/56/10180/3510094/ARTICLE last accessed April 2015)

In North Somerset there is evidence of a correlation between health and deprivation, with figures showing that males in the most advantaged areas can expect to live 19.3 years longer in 'Good' health than those in the least advantaged areas as measured by the slope index of inequality (SII). For females this was 20.1 years¹. Specifically in North Somerset, life expectancy is 9.8 years lower for men and 6.6 years lower for women in the most deprived areas than in the least deprived areas².

1. ONS: Inequality in Healthy Life Expectancy at Birth by National Deciles of Area Deprivation: England, 2009-11 | 14 March 2014

2. Public Health England: Public Health Profile for North Somerset, August 2014

Diet, smoking, and exercise

North Somerset faces many challenges in the indicators concerned with health improvement. Although levels of smoking are lower than the national average and have declined over time, an estimated 16.3% of adults smoke in North Somerset and each year 300 people die from smoking related illness. Smoking remains the single biggest risk factor for premature death and disability.

There has been little change in the levels of obesity, with 24% of 4–5 year olds and 29% of 10–11 year olds either overweight or obese. Hospital admissions for deliberate self-harm and alcohol have risen over recent years. Uptake of the health checks programme has been low compared to the national average. Even in areas where North Somerset performs well compared to the national average, e.g. breastfeeding, considerable differences between communities persist. (From NS Public Health Strategy 2012-15)

Mental Health

Foresight Mental Capital and Wellbeing Project concludes that:

“An individual’s mental capital and mental wellbeing crucially affect their path through life. Moreover, they are vitally important for the healthy functioning of families, communities and society. Together, they fundamentally affect behaviour, social cohesion, social inclusion and our prosperity. A key conclusion of the Project is that mental capital and mental wellbeing are intimately linked: measures to address one will often affect the other. This argues for them to be considered together when developing policies and designing interventions.” (Foresight Mental Capital and Wellbeing Project (2008). Final Project report – Executive summary. The Government Office for Science, London P10.)

An estimated 20,600 people aged 18-64 were affected by common mental health conditions in North Somerset in 2011. (NS JSNA Adult Mental Health chapter 2012)

One aspect of promoting good mental health is considering the impact of social isolation. Recent research from The English Longitudinal Study of Ageing indicates that this has more detrimental effects than loneliness:

“The study found that both social isolation and loneliness were associated with increased risk of death. However, if demographic factors and initial health were taken into account, loneliness was no longer significantly associated with risk of death. There was still a significant link between social isolation and risk of death, however, after these other factors and even loneliness had been taken into account.

This suggests that factors other than loneliness – such as having no-one to check on a person’s health – may contribute to increased risk of death.

(From <http://www.nhs.uk/news/2013/03march/pages/social-isolation-increases-death-risk-in-older-people.aspx> Last accessed April 2015)

The Campaign to End Loneliness however cites other research identifying the impact of that condition:

Loneliness and physical health

- The effect of loneliness and isolation on mortality exceeds the impact of well-known risk factors such as obesity, and has a similar influence as cigarette smoking (Holt-Lunstad, 2010)
- Loneliness increases the risk of high blood pressure (Hawkley et al, 2010)
- Lonely individuals are also at higher risk of the onset of disability (Lund et al, 2010)
- **Loneliness and mental health**
- Loneliness puts individuals at greater risk of cognitive decline (James et al, 2011)
- One study concludes lonely people have a 64% increased chance of developing clinical dementia (Holwerda et al, 2012)

- Lonely individuals are more prone to depression (Cacioppo et al, 2006) (Green et al, 1992)
- Loneliness and low social interaction are predictive of suicide in older age (O'Connell et al, 2004)

(From: Campaign to End Loneliness: <http://www.campaigntoendloneliness.org/threat-to-health/>
Last accessed April 2015)

Secondary Prevention:

This area targets people at risk of losing independence through poor health or increasing frailty, to halt or slow down any deterioration and actively seek to improve their situation. Whilst there are many factors which might place an individual at risk some are more likely to have an impact than others.

Age

The ageing population has an impact on health and social care services since there is a long established correlation between age and health and care needs. The King's Fund suggests that:

- the annual costs of health and social care are significantly greater for older people
- the number of elective and non-elective hospital admissions for older people has increased more rapidly than the growth in absolute numbers
- current projections suggest that a high proportion of older people in the future will be living on their own and are therefore likely to require formal care
- the number of older people with care needs is expected to rise by more than 60 per cent in the next 20 years.

(King's Fund web pages "Ageing Population" <http://www.kingsfund.org.uk/time-to-think-differently/trends/demography/ageing-population> last accessed 10/02/2015)

Long term conditions

The King's Fund also describes the links between long term conditions and the take up of health and social care services:

People with long-term conditions account for around 50 per cent of GP appointments, 64 per cent of outpatient appointments and 70 per cent of hospital bed days (Department of Health 2012a). Around 70 per cent of total health and care expenditure in England is attributed to people with long-term conditions (Department of Health 2012a). (Transforming the delivery of Health and Social Care – The Case for Fundamental Change, King's Fund 2012 p.9)

According to one projection model, the number of people aged 65 and over in England with care needs, such as difficulty in washing and dressing, will grow from approximately 2.5 million in 2010 to 4.1 million in 2030, an increase of 61 per cent (Wittenberg et al 2011).). (Transforming the delivery of Health and Social Care – The Case for Fundamental Change, King's Fund 2012 p.9)

It can be seen then that the population has a large proportion of people at risk of developing health or care needs. Older people are a key population at risk as are those with long term conditions. In order to reduce the impact of this increasing population targeted secondary prevention can support people to meet their own needs, develop their own resilience and stay independent for longer. A large number of interventions in this strategy's action plan are therefore aimed towards older people and those with long term conditions.

Tertiary Prevention: this focuses on helping people manage complicated, long-term health problems such as diabetes, heart disease, cancer and chronic musculoskeletal pain. The goals

include preventing further physical deterioration and maximizing quality of life. There are some areas worth particular consideration.

Long Term Conditions

People with long term conditions will require services of one form or another. Tertiary prevention is about ensuring that people with a health condition are supported to stay as well and as independent as possible for as long as possible. There are multiple interventions which can enhance quality of life and prolong an individual's capacity to self-care. These interventions are provided alongside mainstream services from health and social care. They are not therefore covered in the action plan for this strategy as they sit within other strategic directives but they are mapped to some extent in the attached table to identify issues (appendix G). The impact of these interventions is not inconsiderable however, as the group of people in this category represent the majority of social care and health spend.

Services commissioned by NSC indicate 1228 people are in receipt of care packages at home, 1250 number of people in residential or nursing beds (as at January 2015). Estimates vary as to the percentage of care which is privately funded but It is worth noting that statutory figures only represent part of the population.

Multiple Morbidities

A study in Kent showed that long term conditions were often multiple and, when multiple, had more of an impact on use of services than age. The conclusions of their four year study of the whole population of Kent were that:

- “Multimorbidity is strongly related to age
- Multimorbidity is more common than single morbidity
- People with more physical morbidities are also more likely to have a mental health morbidity
- Total health and social care costs are strongly related to risk score and multimorbidity
- Multimorbidity appears to be more strongly related than age to total health and social care costs
- Acute non-elective costs contribute most to the increased cost for people with multimorbidity”

(Web ref:

http://www.nhs.uk/media/2514788/population_level_commissioning_for_the_future.pdf

Last accessed April 2015).

4. What services are there?

There are numerous services provided for adults across North Somerset that have a prevention element and they are offered by a range of organisations.

Primary prevention for people with no care needs or symptoms of illness:

At the primary prevention stage there are a vast amount of services and facilities that could be considered to contribute towards primary prevention for the general population. These include mainstream facilities not obviously associated with prevention such as shops and libraries and more recognisable prevention facilities such as health and leisure facilities. In truth almost anything could be considered in the context of prevention at this level but another way of looking at this is to consider what is not available that could contribute to ill health or failure to thrive. For example a consideration of the geography of the county reveals that those living in the more rural areas have less access to facilities urban areas can take for granted such as public transport and internet access. Facilitating equal access could ensure that people are able to get the services they need thus supporting their independence for longer. Many provisions at this level if not part of a “general offer” are offered by Public Health to stimulate the public to consider and enhance their own wellbeing. Many services offered by the voluntary sector are also instrumental in ensuring people are supported in their independence including those focusing on information and advice.

Examples of possible interventions in this category are:

Advice; information; emotional support; practical help; exercise opportunities; classes; holiday opportunities; leisure activities; education; diet; help to stop smoking; housing; oral health; immunisation; health screening.

Interventions commissioned or provided by health and social care in North Somerset include (this is not a comprehensive list):

North Somerset online directory; Community Connect; Advice North Somerset; community transport; staying steady service; books on prescription; health walks; seasonal flu vaccination programme; Senior Community Links; extra care housing; supporting people services;

Secondary prevention for people at risk, to halt or slow down any deterioration and actively seek to improve their situation:

Provision for secondary prevention is also made up of a range of services from a number of areas but since this stage is focused on people who are at risk of developing a support or care need the services are more recognisable as providing a prevention focus. The needs of people at this stage are not necessarily considered to be “eligible” for social care support or expected to be provided for under statute as a “duty” but it is recognised that targeted provision at this stage can reduce the need for provision at a higher level later on.

A lot of services available at this stage are provided by the voluntary sector either as a result of statutory investment in prevention or as a separate response to an identified need. It is an important strand of this strategy to encourage working with the voluntary sector on developing provisions which can offer people the advice and support they need to remain independent.

Other services at this stage are prescribed as a duty under social care legislation and are therefore provided or commissioned services by the local or health authority. For the purposes of this strategy it is important that statutory services at this stage have an emphasis on “re-ablement” so that people are not encouraged to become dependant on services at the expense of their own

resilience.

Examples of possible interventions in this category are:

Specific education; relearning skills; maintaining skills; practical support; floating support; social interaction; equipment; home check; shopping; cleaning; meals; gardening; dog walking; activities; childcare; financial advice; transport; social opportunities; medical advice; medical prompts; dressings; routine prompts.

Interventions commissioned or provided by health and social care in North Somerset include (this is not a comprehensive list):

Community Connect; carers' support services including at GP surgeries; equipment and demonstration centre; "Vials of Life"; Carelink; Community Care Advisors: Care Navigators; sensory impairment service; digital news and events for visually impaired; social isolation action plan; dementia friendly communities; support to stop smoking; slimming on referral; Positive Steps for adults and carers; extra care housing; community based care and support; homelessness team; warm homes initiative; assistive technology; community geriatrician and specialist older peoples team; dementia support services; day services; floating support; community wards; Check and Connect checklist; Direct Payments; meals service; Integrated Community Equipment Service; trusted assessor service; Just Checking: Home from Hospital; Rapid Response Team; Falls Clinic; Parkinson's clinic; Response 24, Primary Care.

Tertiary prevention - aimed at minimising disability or deterioration from established health conditions or complex care needs. The focus here is on maximising people's functioning and independence:

At this stage people are likely not only to be eligible for social care services but are also likely to be in receipt of a care package or health service. There are numerous services provided at this stage the majority of which are commissioned or provided by the statutory sector. The aim of strategy with regard to services at this stage is to minimise the impact of disability and to reduce deterioration. It is important therefore that providers have a clear understanding of prevention in this context and do not assume that once a care or support package is in place that there is no prevention to be undertaken.

Examples of possible interventions in this category are:

Personal care; day opportunities; outpatient attendance; medical consultations; clinic attendance; counselling; group support; 1:1 care or support; 2:1 care or support; alcohol and drug rehabilitation services; HIV support; consultant lead care; end of life care.

Interventions commissioned or provided by health and social care in North Somerset include (this is not a comprehensive list):

Domiciliary care services; nursing care services; residential care homes; nursing homes; residential care homes support team; personal budgets; enablement and enablement plus; reablement and reablement plus; primary care; specialised medical services; hospital and hospice care.

4. How much does it cost?

This strategy is developed at a time when Britain faces some of the most stringent cuts to budgets for health and social care ever. There are more restrictions on public spending alongside an increasing elderly population and a rise in long term conditions such as dementia which make balancing the public purse whilst meeting statutory obligations in social care a constant challenge. Financial austerity is one reason why a preventative approach that leads to efficient targeting of resources is crucial.

The aims of this strategy are to keep people well and reduce demand on public resources but there are no additional resources with which to focus on prevention. Appendix E attempts to map the current commitment of resources from each of the partners in preventative initiatives at the current time.

When it comes to resources for prevention the picture is wider than the resource envelope of the local authority or CCG. Whilst there are obligations on each to consider prevention and to support independence it is also recognised that prevention starts with the individual and their resources to invest in their own wellbeing is varied.

Individual resources:

A large proportion of primary prevention measures are so generic that they are the responsibility of the individual to provide for themselves. Whilst there is a statutory role in ensuring the availability and accessibility of services for all it is down to an individual to look after themselves in the first instance. However, whilst an individual has a responsibility to consider their own health and wellbeing there are differences in levels of individual resource which can affect their ability to do so. It is therefore recognised that resources need to be targeted more specifically on those areas where there is less individual financial resilience. As identified above there is a link between poverty and poor health so that these areas are more likely to experience higher risks to independence.

Funded resources:

Public Health has a budget of £7.6m in NS for 2014/15. The Public Health Strategy 2013-15 sets out how this will be allocated between various public health agendas including, drug misuse, sexual health and children's health.

NSC has a net budget of £151.2m set for 2015/16 of which £61.7m is set for adult social care, which represents almost 41% of total budget. Of this over £7m is allocated for prevention based services.

Of these identified resources within Health and Social Care budgets it should be acknowledged that most are already committed to existing initiatives and provision (see appendix E summary of resource allocation for prevention in North Somerset) which means that there is little or no flexibility for developing new projects. As a result it is not an easy undertaking to divert resources for any new initiatives. This means that if a need is identified for new provision resources can only be identified by redirecting from those projects deemed to be less successful or effective. For this reason it is necessary to ensure that all commissioned provisions are monitored for effectiveness.

6. What is missing?

This section considers what areas of prevention work in each of the three categories are in need of further development. The areas have been identified as a result of engagement with key stakeholders in the development of the strategy. As identified above, there are limited resources available to provide any new services so that each identified gap needs to be considered in terms of resources required to address and priority for re-allocation of resources freed up by demand reductions elsewhere.

Some areas will come under the responsibility of this strategy whilst others will be picked up in other work streams. A detailed list of gap areas and proposed provisions as well as where the responsibility for each lies is included as appendix G. In summary those identified in each preventative area are:

Primary

Aim 1 - Information and advice

- Carers have a varied understanding of benefits and sometimes need assistance in managing these on behalf of the cared for; there is a particular concern regarding how to cope with loss of income if the cared for person moves out.
- Not everyone has internet access or wants to get information in a digital format; there is therefore a need for access to information which is not IT based
- The Care Act 2014 introduces “care caps” and other changes to funding arrangements. There is a need for advice and guidance on navigating the care system once these changes come into place.
- There is a need for increased awareness around fair trading issues and scams which are proliferating currently.
- People want to know how to access low level services such as gardening or dog walking.

Aim 2 - Early intervention

- Accurate statistics on need and projected need would assist future housing planning to ensure that it will be appropriate for the people who will be needing it.
- Projections of population change would facilitate better health and care planning for the future.
- Early identification of carers support needs to reduce the risk of carer breakdown or ill health.

Aim 3 - Independence

- Support for carers to work or return to work.

Aim 4 - Self care

- Promote awareness of self-care options to support people to be independent.

Aim 5 - Isolation

- Social isolation can contribute to poor health so measures to address this could prevent deterioration.

Aim 6 Community

- There are geographical inequalities in provision of resources and opportunities across the area.

Aim 7 - Partnership

- There are multiple prevention initiatives across several organisations, a coordinated approach is required across the community.
- Commissioning of services should always consider what prevention can or will be delivered within any provision.

Secondary

Aim 1 – Information and advice

- Advice and support around finances for carers is necessary as carers are not always able to take up respite opportunities due to financial restriction or difficulties.
- Carers would often benefit from access to specific information around the condition they are dealing with, particularly around the time of diagnosis to enable them to better plan and organise their circumstances.
- The Care Act 2014 places a new duty on local authorities to provide access to independent advocacy to those who would otherwise have difficulty in being involved in care and support planning and have no appropriate person who can support their involvement.
- The Children and Families Act 2014 requires awareness of services for disabled children to be raised by the provision of a “Local Offer” in all local authorities which makes clear what is available locally.
- There is a need to improve signposting to prevention services from hospital.
- There is a need to improve carers understanding of their role
- Pharmacists can be used to diagnose and treat minor ailments; there is a need to raise awareness and uptake of these services.
- There is a need to raise awareness about best use of antibiotics

Aim 2 - Early intervention

- People with poor mental health find there is insufficient support at times for them at times of crisis, more support at this time might avoid some admissions.
- There is a need to ensure good transitions from children’s to adult’s services, early planning can improve later independence in adulthood.
- There is a need to improve access to equipment so that it is in place in a timely manner. This will support people and their carers to remain independent for longer and may avert crises.
- There is a need for timely intervention in complex cases to prevent deterioration.
- Addressing psychological or emotional abuse at an early stage can avert mental health difficulties in later life.
- There is a need for appropriate affordable accommodation for older people in North Somerset.
- There is insufficient dietary support services for people with obesity.
- Early intervention in dementia can prolong the time a person with the condition remains independent.
- There is a need to provide podiatry advice for people with low risk of complications to ensure good foot care, this in turn can prevent falls.
- There is a need to identify people at risk and work with them at an early stage to avoid their developing care needs.

Aim 3 - Independence

- There can be prevention of carer breakdown if it is ensured that there is an adequate care package in place for the "cared for" person.
- Another measure to prevent carer breakdown and avoiding residential placements is ensuring

that adequate respite is available for carers.

- More employment support for people with learning disabilities is needed.
- There is a need for more supported living for people with learning disabilities.
- There is a need for a short breaks service.
- There is a need for more telecare and telehealth support to stay at home.
- There is a need for support for people to return home after a stay in a Bristol hospital.

Aim 4 - Self care

- There is a need to ensure the correct medication goes into hospital with patients to avoid any confusion or instances of incorrect medication being given.
- There is a need for support around the self-management of long term conditions to enable people to remain at home.

Aim 6 Community

- There are geographical inequalities of service delivery across the county.
- Supporting people to die in the place of their choice can avoid mental health concerns in those they leave behind.

Aim 7 - Partnership

- There is a need to recognise the complex dynamics and needs within families so that services can work in a joined up way to meet the needs (including preventative) of all concerned rather than focussing purely on one individual.

Tertiary

Aim 1 - Info and advice

- There is a need for specialist health advice for older people
- There is a need for specialist advice and support around dementia

Aim 3 - Independence

- Community care services are available to support people to remain at home but there is a need to manage the market and ensure the capacity and breadth of provision is adequate.
- Support to live independently in one's own home under supported living arrangements continues to be a need for people with learning disabilities.
- Support to remain at home and remain independent through periods of poor mental health is required through supported accommodation provision.

Aim 4 - Self care

- There is a need for rehabilitation after drug and alcohol use/addiction to support people to regain or retain independence.
- There is a need for support for people with HIV to maintain their independence.

7. What do we need to do next

Summary of what is needed from the action plan (Appendix A)

Primary Prevention

- A programme of media campaigns to promote awareness of self-care.
- A plan to support people at risk of social isolation and to promote support and activities available.
- A coordinated approach to develop the Community Connect partnership to ensure a coordinated and efficient use of community resources.

Secondary Prevention

- To make extra care housing and shared lives accessible to people with early stage dementia.
- To develop extra care housing for self-funders or those with few care needs.
- To consider and develop OT service for carers to give advice and information on aids and adaptations.
- To consider and develop podiatry advice and guidance for people with low risk of complications.
- To improve identification and management of risk factors for in primary care - Community Care Advisers posts and linking with Community Connect
- To further develop telecare and telehealth services to support carers in their role.
- To ensure consistency of response from the “Home from hospital” initiative when working with North Somerset residents in Bristol hospitals
- To support people with a long term condition to self-care, maintaining their health and wellbeing and reducing reliance on statutory interventions.
- Support the development of 'compassionate communities' to enable people to die well and, if possible, at home.
- To develop a unified approach to technological solutions promoting those that support people to live well with long term conditions.

Tertiary Prevention

Tertiary prevention measures sit predominantly in mainstream services provided by social care and health. Where people are receiving mainstream services there is a focus on maintaining and developing independence wherever possible and reducing dependence on statutory services if appropriate.

These services are generally governed by statutory mechanisms and therefore do not appear in this “Prevention Action Plan” but are identified within the gap analysis document (appendix G).

The action plan identifies the projects which will be taken forward under this strategy; who is responsible for each; where the governance sits; and what resources have been identified.

Monitoring the effectiveness of this action plan

Progress against this strategy will be assessed through the on-going development and monitoring of the local action plan. The focus of the action plan may shift over time as actions are implemented and the context changes.

The action plan will primarily be governed by the Joint Commissioning Board but will also have oversight from the People and Communities Board and will regularly report to the Older People's Champion Group.

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