Living Well and Ageing Well in Devon

Joint Commissioning Strategy for Prevention 2015–2018

NHS
South Devon and Torbay Clinical Commissioning Group

NHS
Northern, Eastern and Western Devon Clinical Commissioning Group

Teignbridge DISTRICT COUNCIL South Devon www.teignbridge.gov.uk

Mid Devon DISTRICT COUNCIL Where People Matter

East Devon www.eastdevon.gov.uk

Devon County Council

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Introduction

Devon's approach to prevention will follow the principles of starting well[1], living well and ageing well; and although this high-level strategy provides a focus on adults it recognises the importance of a healthy start. The approach supports Devon's Health and Wellbeing Strategy and will impact on **behavioural factors, health and care related factors** (including access) and **social circumstances** to make a difference.

Prevention covers a spectrum of activity ranging from wide-scale whole-population measures aimed at promoting health and wellbeing, to more targeted, individual interventions. Figure 1 describes primary, secondary and tertiary prevention.

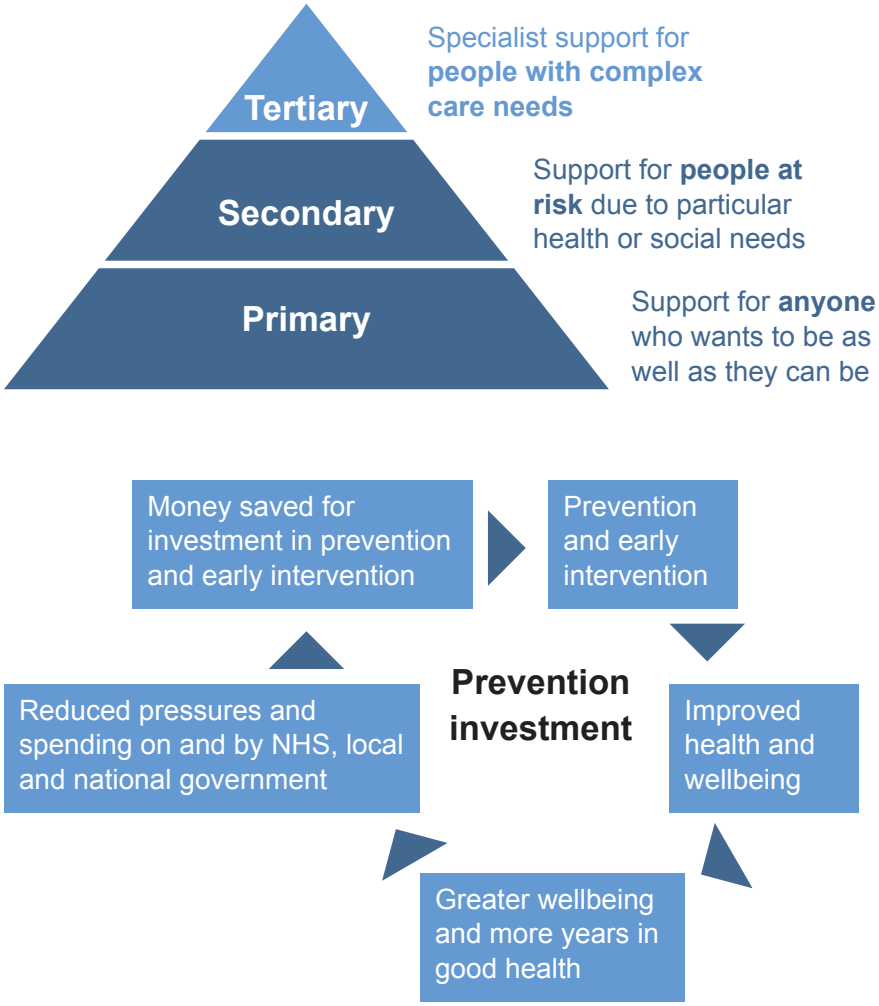
Getting serious about prevention[2]

Billions of pounds are being spent on addressing wholly avoidable illness and social need. With an ageing population and severe financial pressures we must fundamentally rethink how people, communities and commissioners can work together to prevent illness and disability and ensure everyone in Devon can enjoy the best possible health and wellbeing.

This will involve four significant changes:

- Making prevention the main focus at important stages of life,
- Coordinating everything we do to promote good health and wellbeing and avoid/delay the need for health and care services,
- Enabling people and communities to build on their own capabilities,
- Moving investment from acute to preventive services in order to reduce costs in the long term.

Figure 1.
Prevention definitions[3]



[1] The Devon Early Help Strategy for Children and Families & Commissioning Strategy for Maternity Services 2014-2019
[2] NHS Five Year Forward Plan
[3] Care Act 2014

Our vision

To support local people to remain active, healthy and independent for as long as possible. We want to see local services focused on those who have the greatest need.

Our aim is to embed prevention as something that everyone sees as their responsibility and is considered at every opportunity along the course of their lives. People will be supported and encouraged to take personal responsibility for their own health and wellbeing and the wellbeing of others and in particular vulnerable and marginalised members of their community.

Our commitment

We are committed to:

- Supporting people to maintain a healthy and active mind and body
- Working with communities and partners to build community resilience
- Making it easier for people to access preventive services
- Encouraging and empowering people to take responsibility for their own health and wellbeing and that of their families, neighbours and local communities

We will do this by:

- Focusing on where the problems are greatest/areas of greatest need
- Making sure the health of the poorest improves fastest to close the health inequalities gap
- Focusing action at an earlier age (mid-life) to reduce future health problems and prepare for later life
- Supporting people to change their behaviour around diet, physical activity, smoking, alcohol misuse and mental health and emotional wellbeing
- Intervening early and take action when problems arise/on first diagnosis
- Focusing on the prevention and management of long-term conditions and supporting recovery
- Reducing poverty and fuel poverty
- Preventing social isolation and loneliness and overcoming barriers to inclusion
- Supporting people to access or return to employment, education and volunteering
- Preventing falls
- Reducing housing related health issues
- Preventing abuse, neglect or loss of dignity

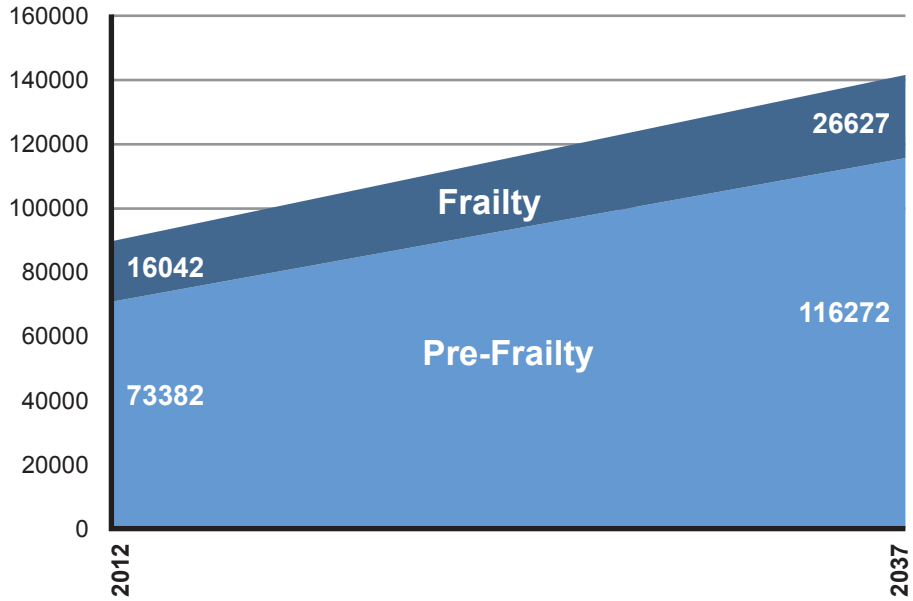
We will ensure that ‘every contact and every visit counts to maximise the opportunity for prevention and early intervention including promotion of advice, guidance and support services and will do this through training to identify opportunities to connect people to preventive services.

Health and care needs in Devon

Devon has a population of around 760,000 people and has an older population profile than nationally, particularly in those aged 50-70 years reflecting significant in-ward migration in this age group, and those aged 85 years and over, reflecting an ageing population and longer life expectancy. This profile impacts on health and social care use.

Over a third of the population are estimated to have one long-term condition (36.68%), around a seventh are likely to have two or more conditions (14.37%), and around one in 170 people are likely to have five or more long-term conditions. This reveals that with increasing age some individuals may have increasing comorbidities. When deprivation is considered a different pattern emerges. Individuals living in the most deprived areas are typically around 10 to 15 years ahead in terms of the state of their health and this is even wider for certain age groups. The JSNA (2015) describes the health related risk factors in detail.[4]

Frailty and Pre-Frailty Projections, Devon, 2012 to 2037. We know that the numbers of frail and pre-frail individuals in Devon will increase significantly in the coming years and action is needed to support such individuals and prevent frailty, disability and illness in later life. The risk of an accidental fall increases rapidly with age, and higher levels are evident in people living alone, people with existing medical conditions, and people living in more deprived areas. Most falls occur within the home. There were 3,259 emergency hospital admissions due to falls in 2012-13 in Devon for people aged 65 and over. However, the rate in Devon is the second lowest in the South West and the second lowest in Devon's local authority group. Age standardised admission rates have remained consistently higher in the most deprived deprivation quintile. Whilst the gap narrowed in 2012-13, the rate in the most deprived areas was still 47% higher than the least deprived areas.



Around 14,080 people living in Devon are estimated to have dementia in 2015, representing 1.84% of the population, which is set to rise to 25,227 by 2035, when it will affect around 2.97% of the population. Districts with an older age profile such as East Devon have a higher percentage of the population living with dementia. The biggest shifts over the next 20 years will be in the 90 and over age group. Due to higher living costs and lower average household incomes, fuel poverty in Devon is higher than similar local authorities nationally, and particularly affects older age groups. The provision of unpaid care also has a major impact on older people, with those who are caring for 50 or more hours per week likely to experience more rapid deterioration in their own health as they get older.

[4] http://www.devonhealthandwellbeing.org.uk/jsna/

Our achievements so far

The Devon Prevention Strategy 'Promoting Independence and Wellbeing for Adults' 2011-13 identified an approach to prevention and had a focus on older age; more recently the Devon Integration Plan (I-plan) set out an integration plan for health, wellbeing and care in Devon. The integrated system of wellbeing focussed at an individual, family and community level. Mapping of prevention activity has commenced and identified areas where we currently commission prevention services. We have considered demand for services and developed an approach to understanding community resilience this will allow us to further refine the community based model and approach for prevention which may vary from one area to another.

To support the work an evidence review of preventive interventions has been undertaken to consider clinical and behavioural interventions, and social and community interventions to support the development of the strategy. The evidence review and earlier Commissioning for Prevention Paper (DCC 2014) demonstrating the importance of developing a **mid-life** approach to prevention.[5]

There is already a good range of preventive provision available across Devon and it is important to recognise some of the progress that has been made so far as outlined in the examples below. A local approach may be needed and in Newton Abbot a frailty hub with 'well-being' co-ordinators has been developed and in Exeter the Integrated Care Exeter programme is developing a local integrated model of care, in Budleigh Salterton a 'Health and Wellbeing Hub' has been developed.

[5] A Rapid Review of Evidence for Prevention for Mid and Later Life

Examples of Primary Prevention

Primary: Lifestyle services

Just under 40,000 NHS Health Checks have been delivered in the Devon County area for 40-74 year olds since 2013 providing an opportunity identify health issues and make lifestyle change. Weight management services have been commissioned to support the programme alongside stop smoking and alcohol services.

Primary: Community Impact Support Scheme

The Community Impact Support Scheme (CISS) will provide support to social enterprises that have innovative proposals to promote independence and self-reliance in communities. Support from the CISS will comprise one-off grants, typically ranging from £10,000 to £50,000, together with access to business support to help applicants develop ideas, business plans and financial forecasts. Support through the scheme will make small enterprises more attractive to a range of other investment opportunities and help ensure their long term sustainability.

A particular focus will be approaches designed to improve long term prospects for people that are unemployed or heavily benefit-dependent, thereby addressing disadvantage that is known to manifest itself in poor health over time.

Examples of Secondary Prevention

Secondary: Self Care

In South Devon and Torbay, we have commissioned a supported self-care service, known as Live Well, Feel Better. Clients are provided with a self-care coach who will provide 5 hours of support depending on the specific needs of the individual including face to face, telephone and group support, managed by the patient themselves or their Self-care Coach on their behalf. The service aims to work with 200 clients per year.

Secondary: Single point of co-ordination

Devon County Council has an established care management model, which has been running since 2008. Plans are in place to enhance this model, to ensure co-ordination of all contacts to Adult social Care and Health. This service plays a significant role in supporting individuals with the assessment of their needs and in providing information and advice about local preventative services and initiatives that help to prevent or delay their need for social care services.

Secondary: Dementia Support

Dementia Support is available throughout Devon in the form of an established network of community led resources, an example of this is memory cafes run by volunteer groups. Individuals with higher stage dementia are support by their communities, preventing or delaying the need for adult social care services

Secondary: Connected Communities Pilot

This pilot preventative scheme in Southern Devon provides a 'navigation and connecting' role to individuals who have identified outcomes that prevention services in the community could meet; thus preventing those needs from escalating and delaying the impact on their overall health and wellbeing. The service supports people through provision of information and advice, helping people to build on their strengths and assets, supporting people to link with services and facilities within the local community. If required, people can access small levels of 'seed funding' to enable their outcomes to be fully met (average funding per individual of £64 during first year of pilot). The pilot has a secondary benefit of identifying the types of prevention needs people may have and enables the voluntary sector and communities themselves to develop local responses to these without the need for more costly formal commissioning of services. The pilot is due to be evaluated as part of the better care fund, and if anticipated outcomes are met, could be rolled out across the whole of Devon.

Examples of Tertiary Prevention

Tertiary: Extra Care Housing

Extra care housing aims to bridge the gap between residential care and people living independently in their own home. It helps to provide individuals with more options about how they receive their care whilst promoting independence and delaying the need for residential care.

Tertiary: Intermediate Care

Intermediate care was introduced in the Southern Devon area in 2011, funded by Section 256 money. Funding was allocated for co-ordinators, physiotherapists, occupational therapists and generic support workers. The service supports around 3% of the over 65 population.

Tertiary: Social Care Reablement (SCR)

What is Social Care Reablement?
Social Care Reablement is a Social Care service. The service supports people to regain confidence, learn or relearn the skills necessary to undertake daily living activities such as washing and dressing, preparing and cooking meals or getting out and about in the community.

When could individuals use this Service?
If an individual has recently been admitted to hospital, has had a period of illness or injury and are concerned about managing at home, they may be eligible for this service for which there is no charge.

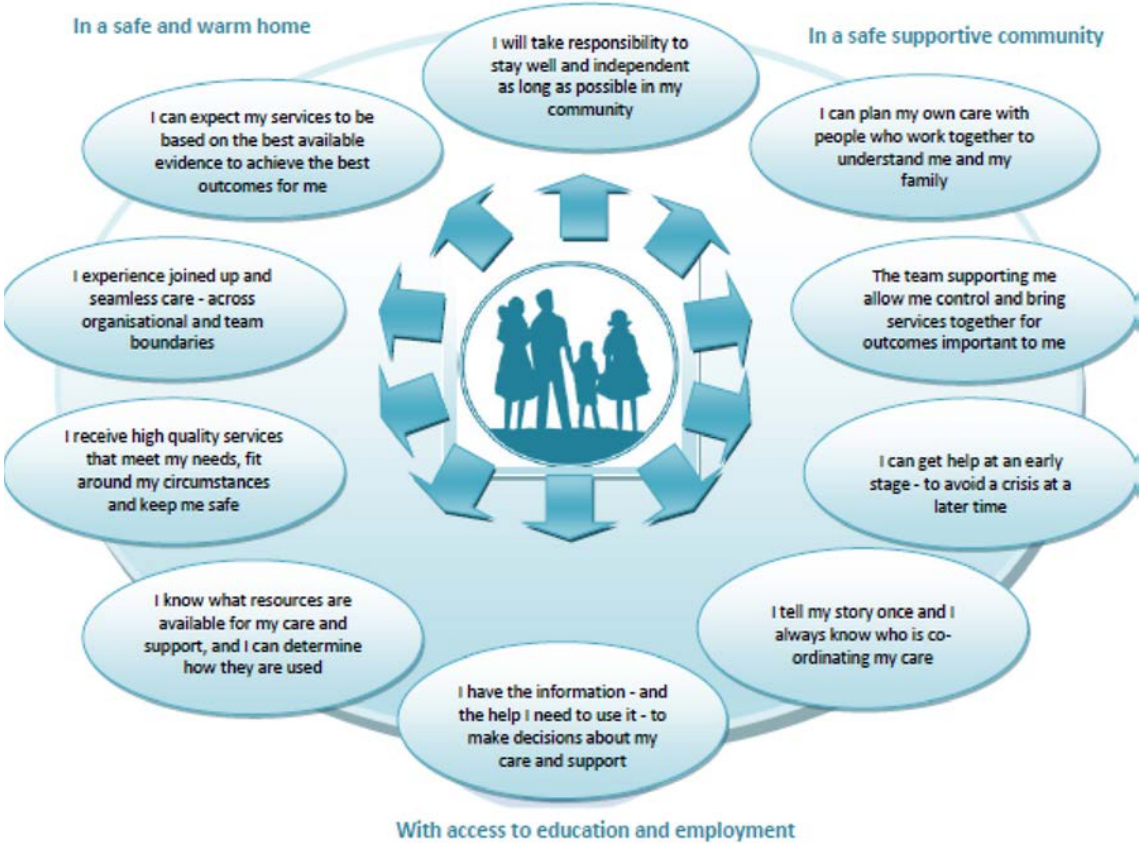
What happens when people have Social Care Reablement?
When the service starts, a Reablement Team Leader will ask what it is individuals want to be able to do for themselves (these will be their 'goals') and they will agree with them how they can be supported to do these things independently. The 'goals' will be reviewed regularly with the individual and the amount of visits and support given will be adjusted as people gain in confidence. The Service is often no longer needed after about 4 weeks, although it can continue for a maximum of 6 weeks.

How does someone ask for Social Care Reablement?
If someone feels they would benefit from a period of this type of support, they can contact (or ask someone to do this on their behalf) Care Direct on **0345 1551 007**

Outcomes for individuals

Devon County Council and NEW Devon Clinical Commissioning Group and South Devon and Torbay Clinical Commissioning Group have developed Joint Commissioning Principles in its integration plan 'The Journey to 'I' an integration plan for Devon'. The I plan sets out a series of 'I Statements' (right) which the joint prevention approach needs to fulfil. The plan specifies action at an individual, family and community level as should any approach to prevention.[6]

[6] Journey to 'I' integration plan



What still needs to be done?

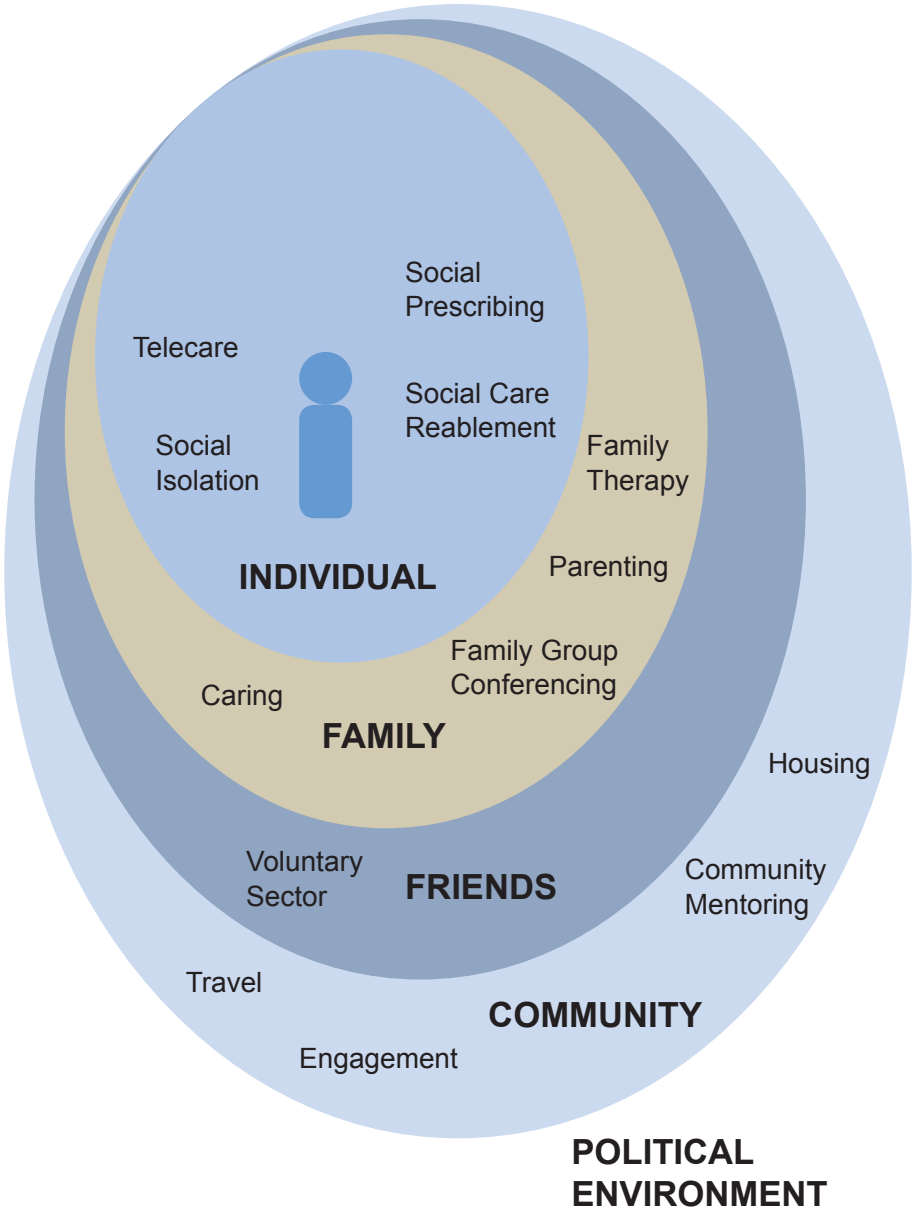
There is already a good range of preventive provision available across Devon, however there is work to do to improve equity and extend the availability of certain provision but a more targeted approach may be needed in more disadvantaged communities and with certain groups. We also know we need to have a clear information and advice strategy so people know what is available and where to go.

Social and community support offer in Devon

The evidence review has considered social and community interventions and has framed these at an individual, family and community level and the delivery plans need to develop this approach further. The mapping work identified some specific areas for further development where the offer is not clear:

- Engaging with the local third sector to support older people (and other vulnerable groups) to continue living as independently as possible in their local community
- Ensuring that we have the quality of housing we need to enable people to live independently in the community or providing a safe, warm and well maintained home which is appropriate to their needs
- Helping to build self-supporting and resilient communities which can deal with many challenges that would otherwise become the responsibility of statutory sector partners. Building this “social capital” by working with communities and voluntary and community sector partners needs to be an inherent part of our approach to prevention.
- Navigating and signposting people to prevention services which enable them to connect with their local community, as well as accessing the services they require.

Appendix 1 outlines the emerging pathway for prevention.



Next steps

Proposed approach for prevention

Both nationally and locally, the recent focus has been on the integration of health and social care and on prevention. The Care Act has introduced a wider duty to consider physical, mental and emotional wellbeing of individuals needing care and a duty to provide preventive services to prevent reduce and delay needs. The Better Care Fund allows further pooling of health and social care funding and the ability to integrate services further. The aim is for an upstream shift to preventive action to reduce health inequalities and reduce premature disability, morbidity and mortality and for preventive work streams align and form a cohesive whole.

To impact on prevention, programmes need to support successful ageing from middle age onwards rather than simply aiming to support elderly people to prevent worsening of chronic conditions. Successful ageing enables people to have the knowledge to develop the behaviours and acquire the skills as they grow older to avoid the development of disease and stay active and positively healthy and socially engaged for as long as possible. This update to the Prevention Strategy shifts the focus to a mid-life approach to support living and ageing well to prevent and reduce avoidable illness, disability and isolation and to act early to limit the consequences of ill health and support recovery and independence. The new approach considers prevention across health and social care and through communities.

We will develop a plan for implementing our commitments which will also include the priority actions listed below:

- We want to make sure people are fully involved in the development of the strategy as well as the commissioning and provision of services as this is crucial to the effective implementation of the strategy
- We will continue to analyse the type and frequency of demand on our adult social care services so that we can target our preventative interventions to divert demand away from social care
- We will continue to map the current preventative services and interventions commissioned or delivered by Social Care Commissioning, Public Health and Services for Communities and include Health in order to
    1. Evaluate the effectiveness of current preventative interventions (and so understand which interventions we should continue to invest in)
    2. Ensure that we are not duplicating effort and funding
    3. Identify any gaps in provision
    4. Develop a co-ordinated approach to joint commissioning of preventative services
- We will continue to develop our understanding of how self reliant communities in Devon are and develop a plan
- We will develop a high-level outcome reporting framework to help ensure that this strategy is a success
- We will ensure that the strategy aligns with the Carers Prevention and the Information and Advice strategies
- We will learn from each other, best practice to develop innovative solutions and learning
- We will undertake further analysis to understand current investment and opportunities for different spend around prevention

Reporting progress

How will we know our approach to prevention is working?

- People know what to do to maintain health and independence in older age and take action at an early age
- People can easily and reliably access health and wellbeing information and advice and be signposted and supported to access a choice of preventive support services and community resources
- People are well informed about options available to them when faced with potential risks and support needs
- More people are accessing a preventative service as an alternative to a Personal Budget or alongside their personal budget
- More people have been supported to maintain their independence
- More people have been supported to maintain or become involved in a range of community activities
- More people are helped to avoid a crisis that could lead to unnecessary admissions to hospital or into longer term care, through joined up early intervention.
- We will have narrowed the health inequalities gap

We will measure success through high level outcome reporting and evaluation of programmes implemented to deliver the approach.

Appendix 1:

Emerging Pathways for prevention
How people will access the prevention offer