Agenda Item No: 8

ADULT SOCIAL CARE – STRENGTHENING PREVENTION

To:	**Cabinet**
Date:	**12 June 2012**
From:	**Service Director: Adult Social Care**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**This report proposes the strengthening of the strategic framework for prevention in Cambridgeshire, delivering the objectives of the Adult Social Care Prevention and Early Intervention Strategic Plan, the Ageing Well Programme and the Council's Integrated Plan 2012-13.** **The report is based on the introduction of an initial three year Community Navigator project to contribute to the bridging of the gap between local communities, statutory and voluntary organisations, enabling older people to find services that meet their needs.** **This approach is an ambitious 'community facing' programme which is led by the needs, desires, and aspirations of Cambridgeshire's older people, supporting the countywide prevention framework aimed at delaying people's need for costly health and social care services and at the same time improving people's quality of life and reducing social isolation.**
Recommendation:	**Cabinet is being asked to endorse the principles of the Cambridgeshire Adult Social Care prevention framework through the development of a Community Navigator function across the county.**

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1. BACKGROUND

1.1 The Council's Integrated Plan 2012-13 commits to invest in prevention, stating, 'we will focus on services that help people early on, increasing their independence and choice and helping them to help themselves.'

1.2 The importance of this focus is made all the more pertinent by a number of demographic drivers, not least an increasingly older population, together with cultural shifts such as the growing demand for choice and higher expectations. These changes require a move away from reactive expensive services, accessed at a point of crisis, to a more enabling provision that is preventative in nature and seeks to promote healthy lifestyles and general wellbeing.

1.3 The requirement to engage people in preserving and improving their own health and wellbeing is outlined by a number of key local strategies including[1]:

- Adult Social Care Prevention and Early Intervention Strategic Plan (2009)
- JSNA Phase 5 Prevention of ill health in adults of working age (2011)
- JSNA Phase 4 Older people including dementia (2010)
- Physical disability and sensory services commissioning strategy (2011-14)
- 'Making Change Happen' – commissioning strategy for support for adults with a learning disability (2011-14)
- Framework for older people's joint commissioning strategy (2011-13)
- Mental health commissioning strategy
- Assistive technology commissioning strategy (2011-14)
- Carers commissioning strategy (2012 -16)
- Supporting people commissioning strategy (2011-15)

2. WHAT IS PREVENTION IN ADULT SOCIAL CARE?

2.1 Preventative services are often thought about in three levels:

- **Primary prevention** – universal services that are aimed at people who have no or particular social care needs or symptoms of illness (but including those who are at risk of needing social care support)
- **Secondary prevention** (early intervention) – services that aim to halt or slow down deterioration for people who have some social care need or illness
- **Tertiary prevention** (specialist support) – services that are aimed at minimising disability or deterioration from established health conditions or complex social care needs

2.2 Social care and support services have traditionally focussed on specialist support, often at the expense of preventative and community based interventions[2]. The continuum of needs and interventions model below demonstrates how the traditional model of care can be inverted and provides examples of what those low level interventions might look like in Cambridgeshire.

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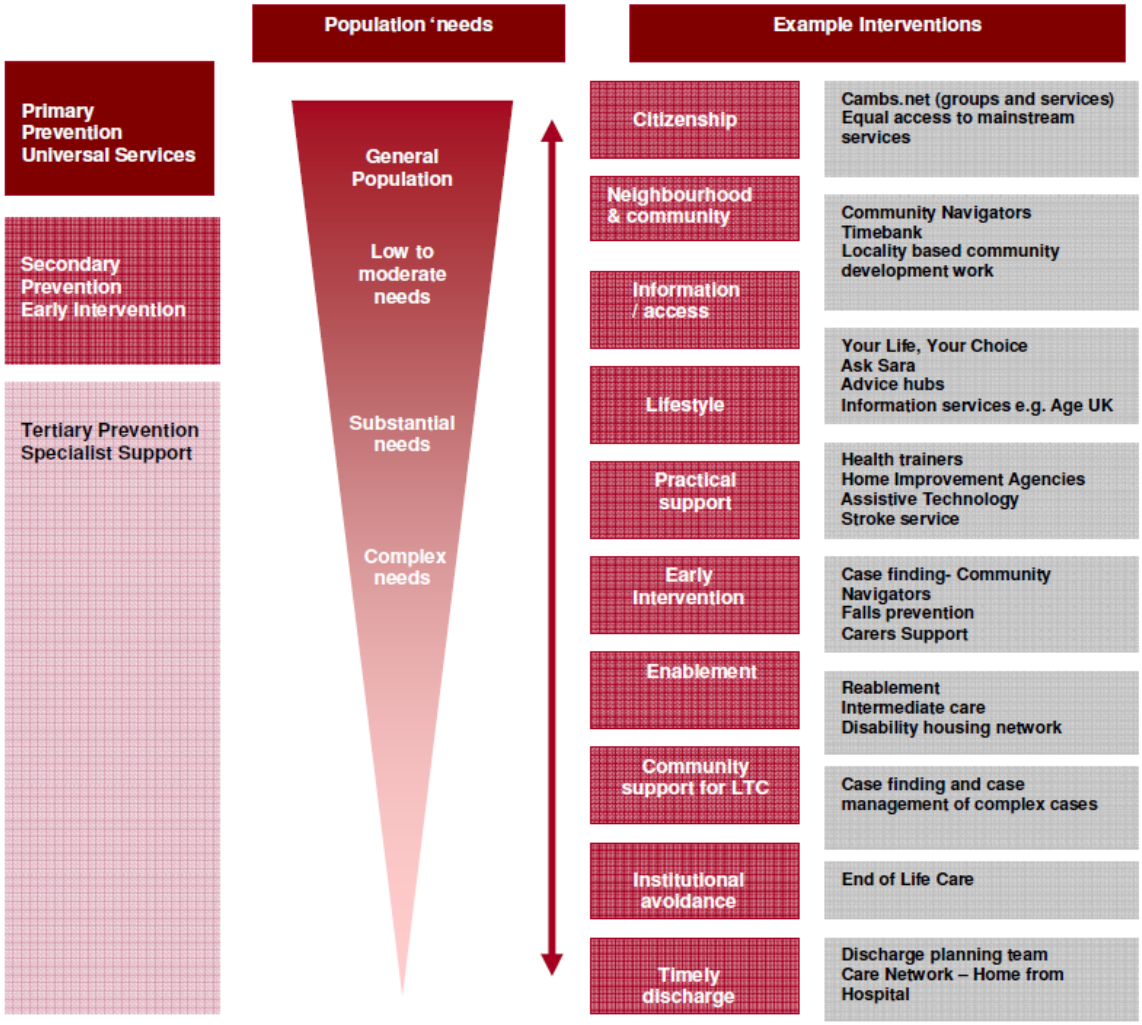
[1] For hard copies of the above strategies please email sundeep.singh@cambridgeshire.gov.uk

[2] 'All Our Tomorrows: Inverting the triangle of care', ADASS & LGA, October 2003 www.adass.org.uk/old/publications/other/alltomtext.pdf

Fig 1: Continuum of needs and interventions - Cambridgeshire



3. WHAT DO WE KNOW?

3.1 Demographic projections show that Cambridgeshire has an ageing population; data from the Older People's JSNA demonstrates:

- By 2021 the 15-64 age group will reduce by 31%, with increases in over 65s by 59% and over 75s by 54%, with the largest increase, in South Cambs; 81% [3]
- There will be corresponding increases, of over 50%, in people with dementia[4]
- There will be increasing demands for services at home and extracare[5]
- The importance of health promotion and physical activity for older people
- A focus on falls prevention and improved nutrition

[3] Cambridgeshire County Council Research Group Mid-2006 district level population forecasts by age and gender
[4] Dementia UK
[5] Extracare housing is used to describe developments that comprise self-contained homes with design features and support services available to enable self- care and independent living

3.2 These demographic changes mean that there is the potential for a significant increase in the numbers of people accessing social care and health services in the years to come. This is largely due to increases in the aging population but we are also anticipating an increase in demand for services to support people with disabilities and mental health issues. This increase in demand is clearly taking place within a period of considerable financial pressure. Therefore, there is a need to invest in lower level prevention aimed at maintaining people's health and social connections to reduce and/or delay the likelihood for more expensive statutory services.

3.3 Further analysis of the Cambridgeshire population was undertaken in the *Adult Social Care Prevention - Summary Report of Current Activity in Cambridgeshire (*Appendix 1). This report highlights that target groups can be analysed in the following way:

- **Adults 50 – 64** – There are estimated to be 114,000 adults aged 50-64 living in Cambridgeshire (source: LGSS RP mid-2010 estimates). The concentration of people falling into this group is higher in rural parts of Cambridgeshire than elsewhere in general.

- **Adults over 65** – There are estimated to be 99,000 adults aged 65+ living in Cambridgeshire (source: LGSS RP mid-2010 estimates). The concentration of people falling into this group amongst the general population is higher in and around Wisbech, March, St Ives and the villages immediately surrounding Cambridge City. This group is forecast to increase to approximately 140,000 by 2021 (source: LGSS RP mid-2010 forecasts).

3.4 Appendix 1 highlights best practice examples such as the Department of Health's - Partnership for Older People Projects (POPPS) models. The evidence base indicates that approaches aimed at promoting health, well-being and independence can prevent or delay the need for higher intensity or institutional care.[6]

3.5 The report (Appendix 1) analysed this best practice, and using Dorset POPPS as a case study, suggests that primary level prevention works best with an active, community-led approach, building on a base of community grassroots activity, and enabling communities to identify their own needs and provide support with addressing them. The report also highlights the mix and coverage of community activity in Cambridgeshire through analysis of www.cambridgeshire.net which provides a directory of local services, activities and groups.

3.6 The report details that there are just under 4000 services listed on Cambridgeshire.net. These services span a range of categories from arts and culture to health and wellbeing groups. A report undertaken for the Older People's Reference Group 'Cambridgeshire Community Study: Unsung Heroes in a Changing Climate (Feb, 2010)[7] highlighted the range of services

[6] National Evaluation of Partnerships for Older People Projects: final report (DH, 2010) www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111240

[7] Cambridgeshire Older People's Reference Group report. Older people's access to and experience of different services in Cambridgeshire (D.Runnicles, Feb 2010). Email sundeep.singh@cambridgeshire.gov.uk for a copy

on offer to older people in Cambridgeshire and highlighted the importance of signposting people to these services and supporting people to access them. Examples of these services include:

3.7 We now know (from this summary report and previous mapping of services commissioned from the voluntary sector), that there is much activity in Cambridgeshire which already meets a prevention approach, but that a coherent countywide infrastructure is missing and that, at a local level, there is low awareness of these activities and services.

3.8 National research (the Wanless Report) has also identified three main trigger points for the need for adult social care (around bereavement, personal health issues and housing), which requires further exploration in Cambridgeshire.

3.9 It is in fact hard to overstate the effects of social isolation (on individuals and service systems), or the importance of responding effectively. Health risks associated with social isolation have been compared in magnitude to the well-known risks of smoking cigarettes and obesity (House 2001[8]). Numerous aspects of isolation have been linked to mortality, increased morbidity, diminished immune function, depression, and although later life is not always characterised by social isolation, the health risks of social isolation loom especially large for older adults[9].

4. WHAT LOCAL OLDER PEOPLE SAY

4.1 A key purpose of this proposal is also to respond to the views expressed locally by Cambridgeshire residents and stakeholders, through a number of consultation events including; Ageing Well, Somersham Community Planning and the Melbourn Locality Commissioning workshops. These consultations reinforce the findings of previous local and national consultations through highlighting that older people want to be able to remain in their own home and

[8]. Social Isolation Kills, But How and Why? (House, James S. 2001) www.psychosomaticmedicine.org/content/63/2/273.x
[9] SCIE Research briefing 39: Preventing loneliness and social isolation: interventions and outcomes (2011) www.scie.org.uk/publications/briefings/briefing39/

to live healthy active lives for as long as possible. A number of main themes have been identified as being important to older people including:

- Access to a range of social and community activities in order to help tackle social isolation and loneliness
- Access to high quality information to enable access to services
- Ensuring there are the means to develop ways of providing "that bit of help" at the right time, such as a listening ear, help with gardening etc
- To help people plan for a fulfilled older age
- To reach out into communities to engage with hard to reach and isolated older people

4.2 The significance of community based preventative work is further supported by a piece of local research recently published by the University of Cambridge, who were commissioned on behalf of the Cambridgeshire Older People's Reference Group to explore older people's access to, and experience of, different services in Cambridgeshire[10].

4.3 One of the key research questions asked was – "What services do older people use in Cambridge?" The report highlighted that health services were vital and were used by everyone. Most people used the bus and were reliant on their free bus pass. The library was an important service for those in the 50-64 yrs old age groups. It was very apparent from the research that services that provide social interaction and social activities are very highly valued, particularly amongst the 'older' old age groups (65+yrs). Several participants involved in the research described the social activity they took part in as a "lifeline". People also described wanting to get out and meet people and to avoid being lonely.

4.4 The most common issue raised in this report was social isolation which was also highlighted in the Ageing Well Consultation. Here the voluntary sector organisations provided highly valued social activities that helped to keep the older people who participated in the research 'happy and positive'.

"I always look forward to Wednesday and Monday, it gets me out of the house. I have been coming here for over 15 years. It is an absolute lifeline. Without it I would be lost. It is a lifeline. It is incredibly lonely on your own. I don't look forward to weekends. They are so lonely".

5. WHAT DO WE NEED TO DO?

5.1 From the evidence outlined above and a number of community conversations with older people, there is a need to:

- Coordinate existing activity (organisational and individual) at a local level

- Raise awareness of, and connect people to, existing activities and services

[10] Service use amongst older people in the Cambridge area A report for the Cambridge Older Peoples' Reference Group (Cambridge University, Jan 2012) Email sundeep.singh@cambridgeshire.gov.uk for a copy

- Ensure high quality information is available in key locations (eg with GP's and Parish Councils) within communities, alongside trusted individuals who can help interpret it

- Reach out to isolated and lonely people at a local level, to reduce the (health) impact of loneliness, and to avoid the adult social care pathway starting with an expensive crisis, as far as is possible

- Use local intelligence to identify, and propose solutions to, gaps (or poor quality) of provision

- Identify duplication of effort or resource, enabling more rational deployment

- Focus attention on those at risk of requiring adult social care, through a better understanding of trigger events (eg bereavement; even loss of loved pets) their precursors, and effective responses

- Create a District and Countywide infrastructure to enable coherence in the "whole system"; to gather further information about trigger events, and to be able to disseminate training, learning and to deploy any relevant future agreed resource

- Work with strategic partners to identify common objectives (eg the Public Health Outcome Framework, which outlines four domains; (1) improving the wider determinants of health; (2) health improvement; (3) health protection and (4) preventing premature mortality[11].

- Encourage vibrant local activity through the leadership of the voluntary sector, supported by statutory partners

- Help develop (then deliver) a "universal offer" to every older resident in Cambridgeshire about access to services which will support independence, health and wellbeing

- Through collaborative working and enhanced localised activity, increase communities' own capacity to support their own members and increase overall community resilience

5.2 In order to achieve this, the new and job-neutral idea of "Community Navigators" is being proposed, to focus and coordinate current activity. There are many people in Cambridgeshire who are currently engaged in the above activities, especially at the local level. They may be paid or unpaid; supported through an organisation, or simply active members of their local community, struggling to advise or support their neighbours to navigate their way through a complex arena of service provision.

[11] Improving Outcomes and Supporting Transparency; A Public Health Outcomes Framework for Health 2013-16 (www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132559.pdf)

5.3 It is proposed to develop a voluntary sector led infrastructure that will better coordinate and develop such activity.

5.4 This structure will help facilitate the required linkages across the "whole prevention system" in Cambridgeshire and link with other initiatives in local government (housing and transport), health and the voluntary sector itself. For example, for many people their first stop for information is to their GP, who are themselves looking closely at prevention and early intervention as in the project being run by the Borderline Group.

5.5 To encourage local creativity, a small "Innovation Fund" is proposed (see below)

5.6 To this end, we are negotiating a position with Care Network, a voluntary organisation which is heavily involved in prevention activity, and which already has a base in each District. This will enable the project to begin with the infrastructure outlined below:

- **Countywide Community Navigator Coordinator**- (1 paid post) would steer and coordinate the Navigators, develop and support a cross sector steering group, make strategic links to partners and develop a robust funding portfolio to ensure sustainability. This role would also oversee the collection of data, linking into JSNAs and the further research into the triggers that bring people into statutory services, return on investment modeling and the facilitation of external evaluation.

- **District Navigator Facilitators** - (1 paid post per district) would coordinate and facilitate partnerships with local, voluntary and statutory sector partners, identify gaps in services and stimulate innovation through a bespoke Innovation Fund. The Facilitators would also develop a training package for the Community Navigators.

- **Community Navigators** - are an essential part of the programme. The Community Navigators are friendly and approachable first points of contact who are out and about in Cambridgeshire's communities. These Navigators could be staff or volunteers used by a range of voluntary organisations that are already active in communities. Through the Community Navigator approach these people would be offered some focused training in aspects of statutory, voluntary and community services and activities; enabling them to find and support people with unmet needs within their community.

  The Community Navigators will provide advice and/or support to help older people live active, independent lives The Community Navigators will know what is available to support older people in their communities. This might range from access to home adaptations, such as grab rails on the front step to stop someone having a fall in their own home, to benefit advice to ensure people are financially secure, or support to access a local friendship club to stop someone feeling isolated.

  In similar schemes around the country a number of case studies have emerged which show the impact of the Navigator function:

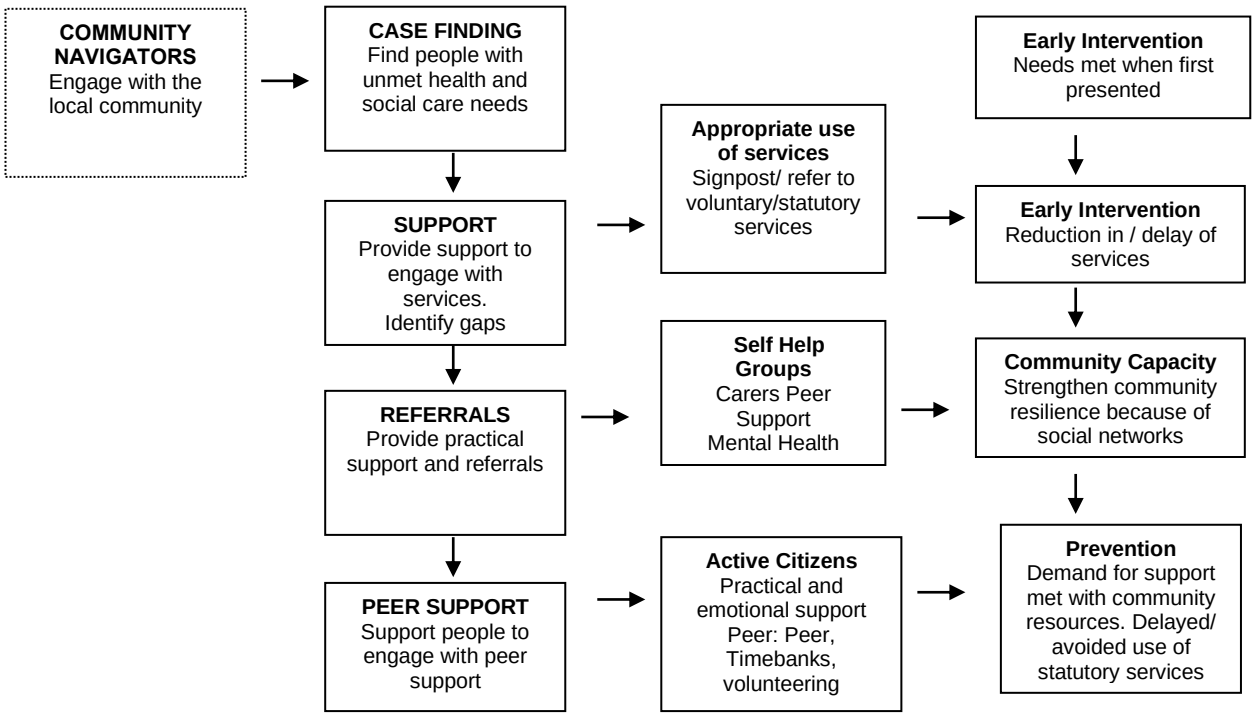
I recently visited a lady who in the last 2 years has lost her husband and then suffered a stroke – leaving her without use of her left side. She also has cataracts on both eyes and is awaiting the operation. She doesn't go out at all and her family all live some distance away. I visited her because she wanted a cleaner and someone to do her shopping – I immediately referred her to Age UK. As we got chatting about what she used to like to do she mentioned that she misses reading. I asked her if she knew about the Home Library Service – her reply was she couldn't read because she couldn't see well with her cataracts but "she really missed reading a good romance" I then went on to tell her about Spoken Word Books available on either CD or tape – her face lit up! I straight away referred her to the home library service that will ensure that she can listen to a good book even if she can't actually read it! It's a small thing but I really felt it was going to make a difference to her![12]

- **Innovation Fund** - funding would be used to kick start, inject life or enhance existing community based services or activities. The grant pot would be available to the community/ voluntary organisations to support innovation or respond to an identified need which will improve the quality of life of older people in Cambridgeshire.

6. OUTCOME

6.1 The overall broad aim of the Community Navigator approach is to help people move from vulnerability to social isolation and regain a sense of contribution and social capital. The flow of service users entering this project is captured in the diagram below:

Figure 2: Proposed pathway - Community Navigator Function



[12] Essex Village Agents Case Studies (2010)
www.villageagents.co.uk/Docs/Case%20Studies%202%20August%202010.pdf

6.2 To support the development of a coherent prevention framework in Cambridgeshire, a number of other pieces of work are also underway which will complement the Community Navigator approach. These include:

- A review of adult social care records over the past 10 years to more closely identify the events and triggers that lead individuals to need adult social care services
- Developing better understanding of the types of prevention, early intervention and support that can best ameliorate these events and triggers
- Better understanding of the relationship between prevention, early intervention and support and the more 'mainstream' adult social care services
- The development of an "avoided costs" model to measure the return on investment impact of prevention and early intervention services. This tool will support the Community Navigator approach and will form part of the evaluation of the project
- An examination of the extent to which, in a general shift to a prevention approach, the Council can sustainably move beyond its current approach to eligibility (ie of only offering adult social care packages to meet critical and substantial needs)

7. EVALUATION OF THE NAVIGATION APPROACH

7.1 To support greater understanding of the impact of the Community Navigator project, the University of Cambridge; Cambridge Centre of Housing and Planning Research (CCHPR) could undertake independent evaluation. The research team have a reputation as a leading academic research institution and are currently undertaking an evaluation of the FirstStop information and advice service for older people that is funded by the Department of Communities and Local Government (DCLG)[13]. The evaluation has been assessing the value for money of the initiative and analysing what savings to the public purse investment in the project is generating.

7.2 The evaluation programme would run a number of processes to evaluate the Community Navigator project including:

Meetings and feedback - There would be an inception meeting to discuss the project, evaluation aims and methods, with interim meetings with the Steering Group as necessary.

Literature, policy and existing evidence review - A literature and policy review of existing and ongoing work in this field will provide a context to the evaluation and will feed into any cost benefit analysis if this is identified as part of the evaluation.

Data collection system - The evaluation team will work with the Community Navigators and the Countywide Coordinator to develop a simple monitoring system and standard system for data collection at the beginning of the project. This will capture the inputs, outputs and outcomes of the casework.

[13] http://www.communities.gov.uk/newsstories/housing/1896913

Interviews - Over the three year project, at appropriate intervals, interviews would be conducted with the Countywide Coordinator, District Facilitators and the Community Navigators to analyse progress, successes and challenges.

Survey - A short survey would be conducted of users of the service to collect information on their experience, identify success/challenges, outcomes, alternative outcomes if the service had not been used etc. The survey would be ongoing throughout the three year project and the mechanism for distributing the survey would be built into the scheme from the beginning.

Analysis - The analysis of the data would explore how the project is meeting its objectives. It is possible that some simple value for money analysis could be carried out.

Evaluation reporting - Interim reports would be produced throughout the evaluation depending on the timetable agreed with a final report at the end of the evaluation period.

8. EXIT STRATEGY

8.1 At the core of this project is the aim of supporting a mixture of paid staff and volunteers. It is a goal that the approach associated with this project will be embedded in organisations across the county. Supported by independent evaluation, a review of the impact of the project will also be done. This will help shape the business case for continuing to commission this approach through the appropriate channels.

9. ALIGNMENT WITH PRIORITIES AND WAYS OF WORKING

9.1 **Developing the local economy for the benefit of all**
Although it is difficult to draw an exact parallel with mainstream economic development, the benefits in terms of an ageing population staying fitter and more active for longer can be seen, even as more active consumers of all types of services for longer. A reduced reliance on statutory services also implies a greater use of (possibly commercial) alternatives.

9.2 **Helping people live healthy and independent lives**
The report above sets out the implications for this priority in paragraph 2-7.

9.3 **Supporting and protecting vulnerable people**
The report above sets out the implications for this priority in paragraph 2-7.

9.4 **Ways of Working**
The new Integrated Plan identifies three characteristics of our new approach to tackling our priorities:

- Developing our leadership role
- Working at the local level
- Investing in growth

Paragraphs 1, 3, 4-8 of this report sets out the implications for leadership, working locally, investing in growth.

10. SIGNIFICANT IMPLICATIONS

10.1 **Resource and Performance Implications**

There is a strong likelihood that successful prevention (delaying or reducing the need for statutory services) will have a positive impact on resources, although this has to be seen in the context of the overall demographic changes and increasing demand. Creating a Community Navigators infrastructure will also enable the whole system to work more efficiently, and lead to more certainty that intensive and expensive interventions are brought into play at the right time and not prematurely.

There is a continuing need to analyse benefits and to which organisation they are falling because there is no straightforward correlation between the spending organisation (e.g. the Council) and the beneficiary of efficiencies (eg the NHS). A better understanding of this will enable a more rational "whole system" approach to investment.

10.2 **Statutory, Risk and Legal Implications**

There are no significant implications for any of the prompt questions within this category

10.3 **Equality and Diversity Implications**

The following implications have been set out in the attached Community Impact Assessment (Appendix 2)

10.4 **Engagement and Consultation**

The report above sets out details of significant implications in paragraph 2, 3, 4 and 5.

Source Documents	**Location**
Listed in the footnotes above	3rd floor, C wing Castle Court Shire Hall Cambridge