APPENDIX 1

Wellbeing and Prevention Strategy

The right help at the right time to promote independence.

DRAFT

a co-operative council

Telford & Wrekin COUNCIL

Title

Document Governance

Title	Vulnerable People Prevention Strategy
Purpose/scope	Prevent children, families, young and older people from becoming reliant on high cost specialist services.
Subject key words	Prevention, Demand Management, well being
Priority	Put our children and young people first Protect and support our vulnerable children and adults Improve the health and wellbeing of our communities and address health inequalities
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Contents

SECTION 1: INTRODUCTION

1.1 BACKGROUND INFORMATION

In Telford and Wrekin we are striving to help individual and families to achieve the **outcomes** that matter to them in life. We want children and young people to be kept safe, remain healthy and achieve at school, whilst being prepared for adulthood both financially and as active members of their local community. Equally as adults we want to see more local people living healthy, happy, more independent and fulfilling lives.

To achieve these ambitions we are working together with our residents, partners and local organisations to collectively deliver the best we can for Telford and Wrekin with the combined resources we have. Telford & Wrekin is a **Co-operative Council** with the following values underpinning our approach:

- Openness and Honesty
- Ownership
- Fairness and Respect
- Involvement

To reflect our ambitions the Council has worked with residents and partners to identify the following **Council priorities** for the mid term (2014 - 2016):

- put our children and young people first
- protect and create jobs as a 'Business Supporting, Business Winning Council'
- improve local people's prospects through education and skills training
- protect and support our vulnerable children and adults
- ensure that neighbourhoods are safe, clean and well maintained
- improve the health and wellbeing of our communities and address health inequalities
- regenerate those neighbourhoods in need and work to ensure that local people have access to suitable housing

We recognise that for some people and families the outcomes that we are striving to achieve for our residents will be more challenging and as such they will require additional support. We hope that they may find this support from within their families and communities. However for those who are most vulnerable we must ensure that they receive the **right help** at the **right time.**

In the current and ongoing financial climate, with reducing levels of public service funding from the Government, past service arrangements will no longer be financially sustainable. The focus must a shift to **managing down demand; preventing** people from becoming dependent on **high cost specialist services** or preventing the need from developing in the first place (Universal Services and Early Help)

1.2 LEGISLATIVE FRAMEWORK

The Children's Act 2004 and the Care Act 2014 provide the legislative framework for the Local Authority and its partners to promote wellbeing specifically with respect to its responsibilities towards children and young people and to carrying out its care and support function in relation to a person with an identified need. The table below illustrates the shared outcomes and also how these link with our local priorities and values.

Children's Act 2004	**Care Act 2014**
Duty to co-operate to improve the wellbeing of children in the local authorities area	Duty to promote wellbeing when carrying out any of care and support functions in respect of a person
Protect from harm and neglect (Council Priority)	Protection from abuse and neglect (Council Priority)

Physical and mental health and emotional well being (Council Priority)	Physical and mental health and emotional well being (Council Priority)
Education, training and recreation (Council Priority)	Participation in work, education training or recreation (Council Priority)
Contribution made to them by society (Co-operative Value: Involvement)	The individuals contribution to society (Co-operative Value – Involvement)
Social and Economic Wellbeing	Social and Economic Wellbeing
	Personal dignity - including treatment of the individual with respect (Co-operative Value: Fairness and Respect)
	Domestic, family and personal
	Suitability of living accommodation (Council Priority)

1.3 OUR LOCAL COMMITMENTS:

At the heart of the Wellbeing and Prevention Strategy are our commitment statements for Children, Young People and Family Services and for Adult Social Care Services.

1.3.1 Adult Social Care:

Alongside the Council's co-operative values, **Promoting Independence** will underpin our approach to supporting adults and their carers (family, friends, and neighbours) who may have social care needs. We will give priority to helping people recover, recuperate, and rehabilitate so that they are able to live as independently as possible. We will do this through:

- Effective Information and Advice
- Community based solutions
- Resources focused on eligible needs
- Empowering risk management & Safeguarding.
- Commissioning and working with providers
- Partnership with health professionals.
- Spending public money wisely
- Knowledgeable and informed workforce -
- Valuing carers

(Source Adult Social Care Services – Promoting Independence Commitment Statement: January 2014)

1.3.2 Children, Young People and Family Services:

We want to have thriving children and families in Telford and Wrekin, and thriving professionals working in a value driven organisation, whilst spending within or below budget. We will do this through:

- Continuing to help schools to improve
- Having a strong focus on targeted preventative work
- Continuing to grow a stable and skilled workforce
- Continually improving practice

(Source: Where we are now v 2.2 November 2014)

3.3.3 The role of the Wellbeing and Prevention Strategy in achieving these commitments:

The Wellbeing and Prevention Strategy sets out how we will work with health services, wider council services, the voluntary sector and the community to effectively **meet the needs of individuals and families** within significantly reduced resources.

It is critical that our support systems across Children, Family and Adult Services promotes well being as well as independence from high cost services and does not just wait to respond when individuals and families are at crisis point. As such at the heart of our approach to improving outcomes particularly for the most vulnerable in our community is a strong emphasis on the **promotion of wellbeing** and the **prevention** of the escalation of need.

The overall aim of this strategy is to:

Prevent children, families, young and older people from becoming reliant on high cost specialist services.

We will achieve this by:

1. Developing effective **universal services** which prevent problems from arising in the first place

2. Intervening early with a more **targeted approach** for those with existing risk factors or those who are vulnerable

3. Taking a **holistic, systemic** approach where a family faces multiple challenges to support them to achieve sustained and significant change

4. Taking time to **understand the outcomes** that matter to individuals so that we can help them to recover, recuperate and rehabilitate so that they are able to live as **independently** as possible.

5. Supporting individuals and families to **step down** from high cost specialist / statutory services where it is appropriate and safe to do so.

Effective **commissioning** will be central to achieving these aims. We will ensure that our commissioning plans are person and family focussed and deliver social value by working together to support local communities, economies and the environment to make the Telford £ go further.

1.4 CONTINUUM OF NEED:

The diagram in Appendix 1 and 2 set out the continuum of need for children, young people and families and for adults. It then maps out the individual or family journey through the range of preventative services. There are some elements of prevention that are delivered to the whole population and make up our **universal** offer. Conversely some individuals and families are at a higher risk of experiencing inequalities which may lead to poorer outcomes and as such require a more **targeted** approach to prevention dependent on the needs identified.

From this point forward our strategy will divide into two sections setting out how this translates into service delivery for Children, Young People and Families and for Adults (as highlighted above).

However the final section will identify where by taking an **all age** approach we can avoid duplication but also address gaps in provision e.g. it will give us the opportunity to improve outcomes for young people in **transition.**

SECTION 2:

WELLBEING AND PREVENTION FOR CHILDREN, YOUNG PEOPLE AND FAMILIES

This section will be developed from March 2015; central to this will be the Early Help Strategy and Phase 2 of the Department for Local Government and Communities (DCLG) Troubled Families Programme.

SECTION 3: WELLBEING AND PREVENTION FOR ADULTS

3.1 THE WELLBEIING OF OUR RESIDENTS:

3.1.1 The national picture:

The health and social care needs of the population in England are changing, as they are in every country in the developed world. Over the next 20 years, the number of people aged over 85, will more than double. People living this long may be unable to live independently, especially if they have no family to help them. People who are living longer are often doing so in ill health, with long-term conditions that can only be managed, not cured. People with Long Term Conditions (LTC) currently account for 70% of all health and care spending. Furthermore there is a likelihood that people will be living with multiple LTC which will demand a more holistic approach to care.

In the future three quarters of people aged over 65 will need care and support at some point in their later years

- 19% of men and 34% of women will require residential care
- 48% of men and 51% of women will require domiciliary care only
- 33% of men and 15% of women will never need formal care

Our challenge through this strategy is to delay or prevent this need from developing and where possible reduce the length of time in high cost specialist services.

More specifically over the next 30 years the number of people living with dementia is set to double.

(Source: Redesigning Health and Social Care: Challenges and opportunities from an IT perspective Jan 2015)

3.1.2 The local picture:

Our Market Position Statement (MPS) highlights some of the key demographic changes that will drive the need to manage demand through a preventative approach. Headline messages are as follows:

<u>The changing Adult Population profile:</u>

- The largest rate of growth (32%) will be amongst the population aged 80 plus increasing from 6,000 to 7,900 in 2026. They will make up 5% of the total adult population (an increase from 4%)

- Amongst **64-79 year olds** the growth will be 19% increasing from 21,600 to 26,000 in 2026. They will make up 18% of the total adult population (an increase from 16%)

- The smallest rate of growth (5%) will be amongst the population aged **18-64 years** increasing from 108,400 to 113,600 in 2026. They will make up 77% of the total adult population (a decrease from 80%)

- In 2014 there were 2367 people with a **severe disability** and 8028 with a **moderate disability**; PANSI forecasts show growth to be fairly limited between now and 2030.

- In 2014 there were 16,529 adults with a **common mental health disorder**; PANSI forecasts show growth to be fairly limited between now and 2030.

- In 2015 approximately 3295 **adult carers** provide more than 50 hours of care per week, which is forecast to increase to 3,700 in 2020. However in 2013 it was estimated that there were actually 16,200 adult carers providing unpaid care. There are currently approximately 600 **young carers** in Telford and Wrekin.

Key areas of need for care and support (Older People)

The table below sets out population forecasts for Telford and Wrekin for particular needs and which create potential demand for care and support
(Please refer to Projecting Older People Population (POPPI) and Office of National Statistics)

Adults aged 65 years plus	**2015**	**2020**	**2025**	**2030**
People living with dementia (POPPI)	1,747	2,084	2,551	3,091
People with a limiting long term illness (Office of National Stats.)	14,804	16,917	19,057	21,454
People unable to manage at least one self care task (POPPI)	8,917	10,443	11,983	13,856
People unable to manage at least one domestic task (POPPI)	10,862	12,781	14,696	16,941

3.2 FINANCIAL CONTEXT:

3.2.1 Current financial situation:

Adult Social Services expenditure equates to 30% of the Council's net budget. The total projected expenditure for 2014 / 2015 is £57.6million and includes the following key areas:

Community Care (e.g. Homecare, Daycare)	£15.1 million
Residential and Nursing	£23.1 million
Equipment	£0.4 million
Direct Payments	£2.9 million

Through good financial management the Council has already delivered over £70,000,000 of savings and protected front line services as far as possible. Despite unprecedented Government cuts, we have sought to protect front line services for children, adults and the environment. The proportion of cuts to adult services in Telford & Wrekin is well below the national average and the cuts that we have made have been achieved in ways that protect vulnerable adults.

3.2.2 Looking forward:

The Council's 2015-16 budget strategy identifies further savings of £9.4million of which £2.691m relates to Adult Social Service. A cost improvement plan is in place to drive the achievement of these savings targets and also to address any ongoing over spends. However whilst work on this plan is being progressed the service will continue to experience financial pressures from a number of issues including:

- high cost placements,
- a lack of supply in key market areas such as Elderly Mentally Infirm (EMI) placements
- the Deprivation of Liberty Safeguards (DoLS) changes
- the costs arising from clients transitioning from Children's to Adults services with an eligible need
- ongoing under-funding of continuing healthcare cases in the Telford & Wrekin area compared to most other parts of the country.
- additional activity arising from the implementation of the Care Act in April 2015 (although money has been allocated to the Council to cover this it may prove insufficient)

In addition the Government have indicated an amount of funding within the BCF for the Care Act of £409k which can only be made available if savings from reduced admissions to hospital can be realised.

The Wellbeing and Prevention Strategy provides a framework within which the cost improvement plan proposals will be delivered. More importantly it reflects the councils focus on upstream solutions and social responsibility and action, namely:

Demand Management: ensuring that our resources are targeted at those residents most in need

Channel Shift: providing information and services in the most efficient way
Social Action: promoting volunteering and seeking community based solutions
Social Responsibility: Encouraging residents to do more to help themselves and others

3.4 THE LOCAL APPRAOCH TO WELLBEING AND PREVENTION

The Care Act recognises that there is no one definition which constitutes preventative activity it can range from *"wide scale whole population measures aimed at promoting health through to more targeted individual interventions aimed at improving skills or functioning for one person or a particular group or lessening the impact of caring on a carer's health and wellbeing" (Care Act 2014 paragraph 2.4)*

The Care Act breaks down prevention into three general approaches. Below we have set out what these approaches will look like for Telford and Wrekin so that we can actively promote wellbeing and independence and reduce dependency on high cost specialist services.

3.4.1 Prevent: primary prevention/promotion of wellbeing:

Our **Living Well Board** will take the lead on primary prevention / promotion of well being aimed at individuals who have no current particular health or care and support needs. Its purpose is to realise the collective potential of communities, partners and the council in Telford & Wrekin to **promote wellbeing** and **reduce inequalities** in health. The Board promotes social responsibility e.g. Five Ways to Wellbeing which encourages people to help themselves to prevent needs developing in the first place.

The Focus of the Board's work programme is to co-ordinate and maximise collective action to promote positive wellbeing, healthy lifestyles and root causes of poor health such as housing and employment. By targeting our **working age population** (but not exclusively) the aim is to prevent individuals from developing needs for care in the future.

The Board uses an asset based approach to maximise the use of **collective resources** (including finance, people, facilities, environmental assets etc). It will also use intelligence gathered from the front door of Adult Social Care to identify the prevalence of different support needs so that the universal offer can be shaped accordingly.

3.4.2 Reduce: secondary prevention / early intervention

Where individuals have an increased risk of developing needs we will:

- Help people to continue to **live in their neighbourhoods and communities** where we can safely meet their assessed need and this is affordable.
- Offer the right level of support according to the individuals **assessed need** and working with each person and their own network to find the solutions.
- Use **community based solutions** including **assistive technology** where these will enable people to remain safe and meet their care needs.
- Establish a **domiciliary care offer** that is based on the principles of promoting independence
- Identify **carers** early so that they can be supported to carry out their caring role effectively and to look after their own health and wellbeing.

Our **Early Help Strategy for Children, Young People, Families and Carers in Telford and Wrekin** recognises that everyone needs some help and support at different times in their lives and has a vision, objectives and supporting action plan which make a significant contribution to our primary and secondary preventative approaches.

3.4.3 Delay: tertiary prevention

Where individuals have established or complex health conditions (including progressive conditions such as dementia), the commitments set out in the above paragraph also apply. Additionally we will:

- Carry out **assessments over a reasonable period of time** to ensure that we have not made long-term decisions about people before we have had a chance to work with them through a recovery or recuperative plan.
- Give priority to helping individuals to **recover, recuperate and rehabilitate** so that they are able to live as independently as possible
- Only use **residential care** when we have explored other options and have found that this is the only way to meet someone's care and support needs in a safe way.
- Use **personal budgets** to ensure that individuals requiring longer term care can take as much control over their lives as their needs allow, ensuring that where appropriate they receive additional personal health budgets to meet their needs.

3.5 HOW WE WILL DELIVER OUR LOCAL APPROACH TO WELLBEING

3.5.1 Remodelling of the Adult Social Care System:

The current model of social care is based upon diversion, non-engagement, enablement and theoretical concepts of choice and control. As such we face the following challenges:

- Minimal progress in Direct Payments ,
- Review figures are still unacceptable ,
- Conversion from Initial Assessment to Community Care Assessment is still high,
- Assistive technology is not embedded
- Enablement is not reducing costs or dependency on traditional services
- There is an over reliance on traditional models of service delivery

(Source: Rationale for Adult Social Care Restructure December 2014)

We have developed an **Adult Social Care Commitment Statement** which communicates how we will redress this situation by promoting independence. The Council's **Target Operating Model (TOM)** for Adult Social Care translates our commitments into reality, setting out the journey for adults with a need and how our service will be re-modelled with wellbeing and prevention at its heart. The model has four key components:

The first point of contact: will aim to resolve as many enquiries as possible at the front door by providing high quality information and advice and by sign posting to community based solutions e.g. voluntary organisations and community groups.

An Asset Library: will be a collection of the community assets available to our residents to either prevent a need from developing in the first place or to reduce and delay an identified need. It will be a culmination of local intelligence from practitioners, voluntary organisations, providers and residents alike.

Virtual Hub: where issues cannot be resolved at the first point of contact the virtual hub will provide rapid response where appropriate or alternatively identify a key worker to explore further the identified need and possible community based solutions drawing upon Asset Library in the first instance.

Unmet Need: where there are multiple complex needs the focus will be on outcomes based personalised care. The assessment process will identify any unmet eligible need and aim to maximise the use of personal budgets/direct payments to maximise value for money.

The TOM also identifies opportunities within the adult social care system where the Council can work more collaboratively with health partners to improve outcomes and reduce costs.

3.5.2 Integration with Health:

The £5.3 billion Better Care Fund (BCF) creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of

health and care services. Each Health and Wellbeing Board (HWB) area has developed a BCF Plan to improve outcomes through delivering more integrated care and support.

The focus for the BCF is adults needing **high levels of health or social care support**, particularly frail older people at risk of and/or suffering as a result of:

- Falls
- Dementia
- Long term conditions /End of Life
- High risk of admission to hospital or care home
- Discharged from hospital with a need for rehabilitation and/or enablement

BCF will drive the integration of services commissioned by the Council and Telford & Wrekin Clinical Commissioning Group (CCG) through the creation of a **pooled budget** (and joint commissioning arrangements) from April 2015. The main priorities are to **increase and build community capacity** and **enhance and build more community services** as an alternative to hospital provision.

Therefore the BCF provides a substantial opportunity to not only prevent the need for unnecessary hospital admissions but also to improve the pathway for adults from hospital and back into the community

The BCF Implementation Plan sets out in detail how we will work with our health partners to deliver improved integrated care using the following outcomes as measures of success:

- Reduction in hospital admissions
- Reducing non-elective hospital admissions, re-admissions and length of stay.
- Reducing permanent admissions to residential and nursing care.
- Patient experience
- Reducing delayed transfers of care.
- Improving the effectiveness of re-ablement/rehabilitation services.

3.5.3 Co-production with communities and the Voluntary Sector

We are committed to ongoing dialogue with the community and voluntary sector so that together we can build upon what works to ensure that we are providing the best outcomes possible for our residents. We recognise that the current financial climate makes it even more critical that we explore opportunities and take the journey through service transformation in a joined up way.

3.5.4 Information and Advice:

"Information and advice is fundamental to enabling people, carers and families to take control of, and make well-informed choices about, their care and support and how they fund it. Not only does information and advice help to promote people's wellbeing by increasing their ability to exercise choice and control it is also a vital component of preventing or delay in people's need for care and support." (Care Act 2014 paragraph 3.2)

Our Information and Advice Strategy 2014 to 2016 is fundamental to the prevention agenda and the councils focus on "channel shift" (see section 3.2). It sets out how we will meet our statutory obligations in providing good and effective information and, to all residents across the borough. We have identified the following outcomes that we are seeking to achieve:

- An effective public information and advice service will be available
- Information and advice service will be co-produced with key strategic partners
- MyLife, or other agreed e-system, will be the key local directory, encouraging public and professional use to support 'self help' and to promote independence
- Local providers will be commissioned and encouraged to provide information and advice services
- Appropriate and accessible signposting to independent financial advice will be available

3.5.5 Outcomes Based Commissioning:

Moving forward we will assess how well our current arrangements are promoting independence by mapping the services, facilities and resources available against these three general approaches to prevention (See Appendix 3). We recognise that services can **cut across any or all of the approaches** and our aim is that prevention is an ongoing consideration in any of our future strategies and commissioning plans. In undertaking this exercise, we will seek to remove any duplication and wastage from the system and address any gaps that may exist.

3.6 OUR PRIORITIES FOR ACTION:

Within the context set out in the previous sections the following priorities are emerging which would form the basis of an overarching action plan, which signposts out to existing strategies and implementation plans.

1. Promotion of Wellbeing to prevent need from developing in the first place
   Living Well Board Plan

2 Building and Mapping Community Assets
   BCF detailed implementation plan
   Adult Social Care TOM
   Strategic Commissioning Group Plan

3. An integrated first point of contact
   BCF detailed implementation plan
   Adult Social Care TOM

4. Effective Information and Advice
   Information and Advice Strategy and Action Plan

5. Mainstream the use of Assistive Technology throughout Adult Social Care
   Assistive Technology Project (Telford & Wrekin Council)

6. A whole family approach to identifying and addressing need
   Multi-Agency Strategy for Carers 2013 – 2016
   Young Carers Strategy 2012 – 2015

7. Outcome focussed and cost effective transition arrangements.

8. Workforce Development
   Telford & Wrekin Council – Care Act Workforce Plan

SECTION 3: AN ALL AGE WHOLE FAMILY APPROACH

Once section 1 has been developed (Wellbeing and Prevention for Children and Families) this section is an opportunity to consider where there are opportunities to take a more joined up approach between adults and children and family services, to take a whole family / household view when identifying and meeting need.

A systemic approach will not only achieve more sustainable outcomes for the individual with the presenting need but in parallel could prevent other needs from arising or escalating with other members of the family / household.

By making every contact count i.e. reaching out to family members through the person with the presenting need, this will help to manage demand away from high cost services not just in the immediate but in the longer term.

An all age approach allows us to look more closely at transition.

SECTION 4: PERFORMANCE MANAGEMENT

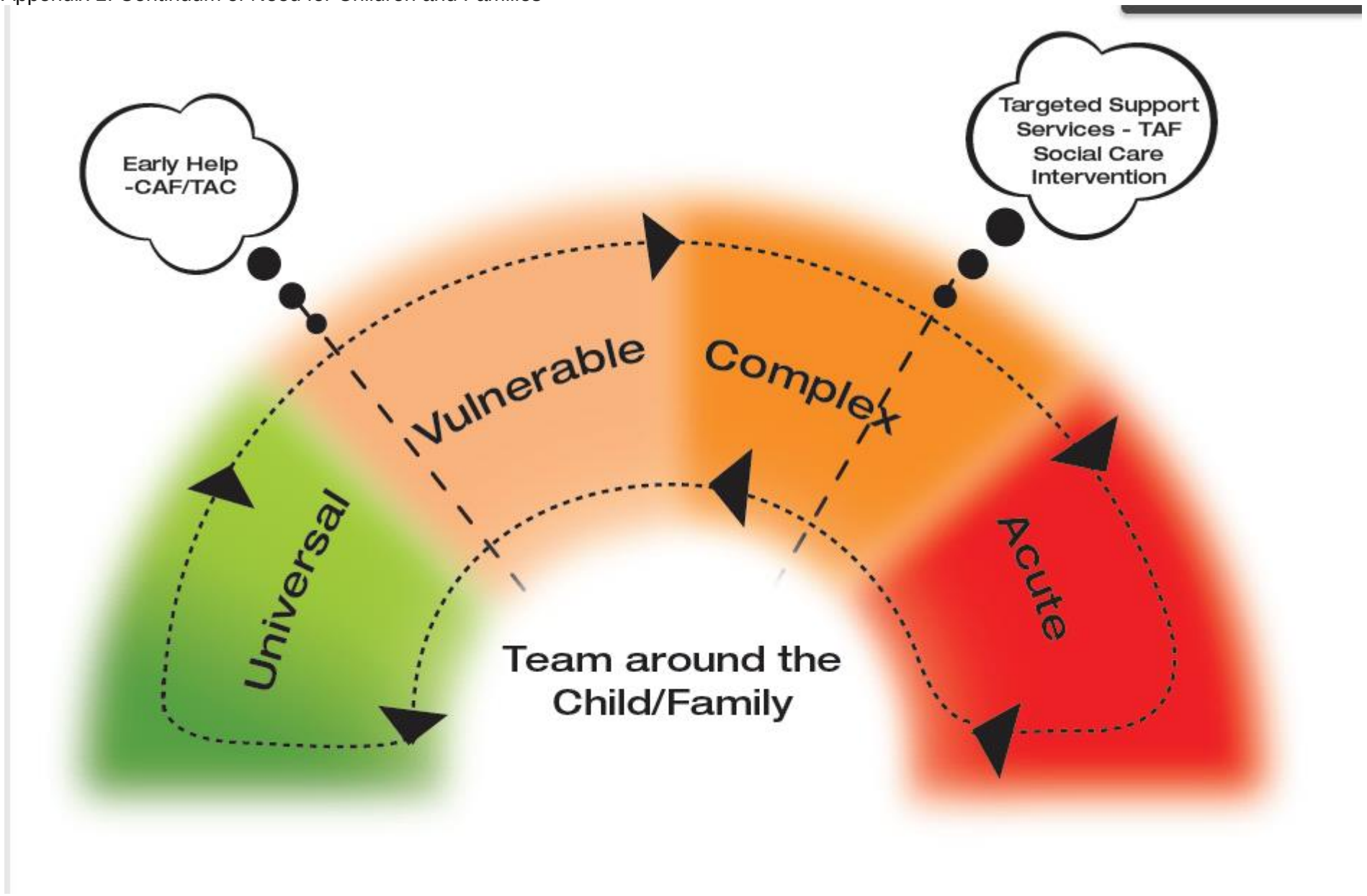
One option being considered is to link the performance management of this strategy to a local Outcomes Plan which will allow us to draw down funding from the Department for Communities and Local Government (DCLG) Troubled Families Programme Phase 2.

Phase 2 of the programme gives Local Authorities more scope to identify population outcomes which matter the most at a local level and to develop measures that will demonstrate progress. It also has service transformation at its heart.

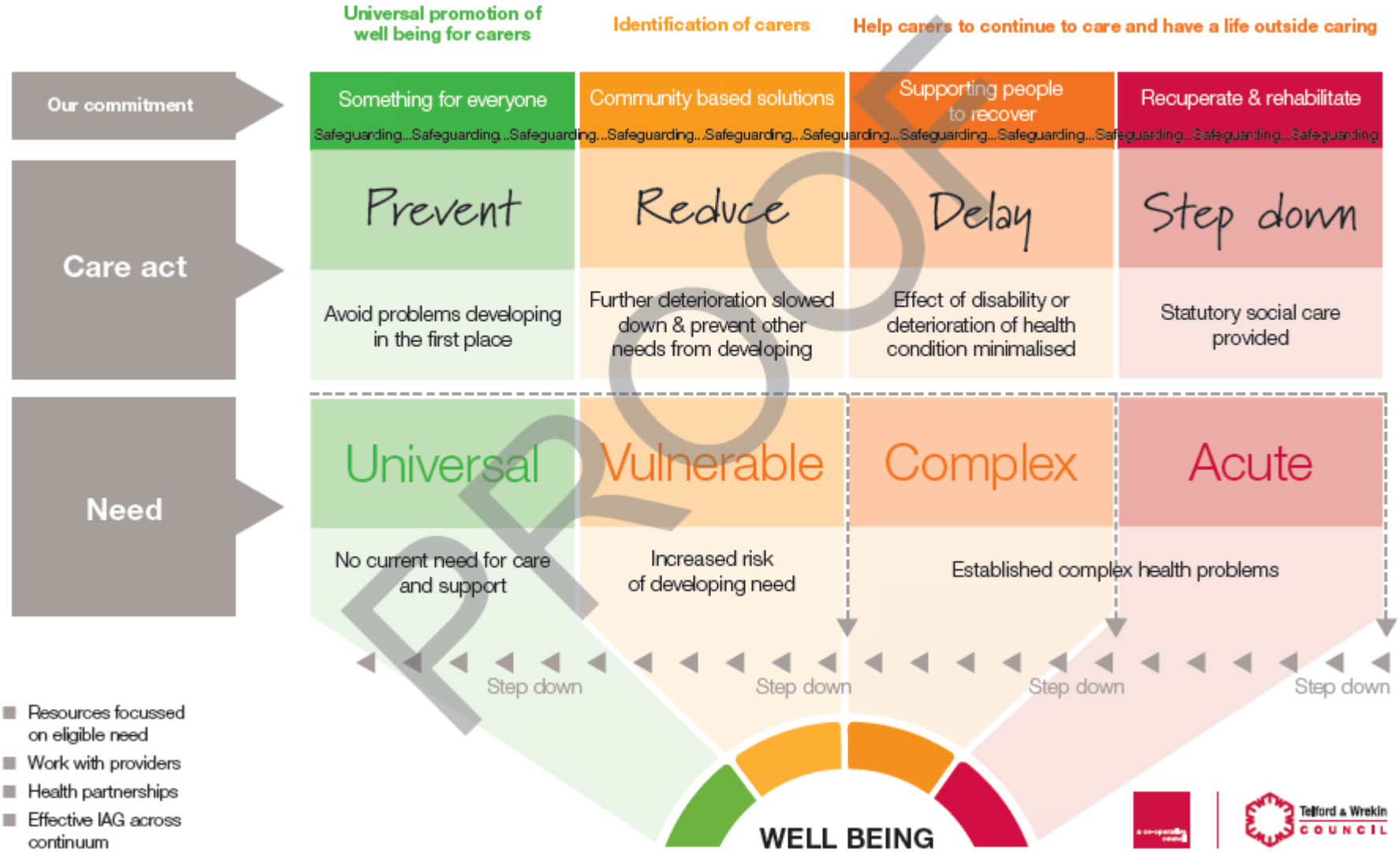
Section 5: SUPPORTING DOCUMENTS

1. Telford and Wrekin Health and Wellbeing Strategy 2013/14 to 15/16
2. Service and Financial Planning 2015/16 to 2017/18 Cabinet Report (8 January 2015)
3. Adult Social Care Account 2013 – 2014
4. Adult Social Care Commitment 2015 – 2016 (draft)
5. Redesigning Health and Social Care: Challenges and opportunities from an IT perspective Jan 2015)
6. Telford and Wrekin Market Position Statement (draft February 2015)
7. Telford and Wrekin Information and Advice Strategy (draft)
8. The Early Help Strategy for Children, Young People and Carers in Telford and Wrekin
9. Living Well Board Terms of Reference
10. Children and Families Integrated Working Toolkit
11. BCF Implementation Plan

Appendix 1: Continuum of Need for Children and Families



Adult and Social Care Right help, Right time to promote independence



- Resources focussed on eligible need
- Work with providers
- Health partnerships
- Effective IAG across continuum

Services facilities and resources that are available to prevent reduce or delay needs

Telford & Wrekin Council Preventi

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Step down

Involves:	Delivers:	Outcome:
■ MDT at AMU ■ GPs ■ Case Managers ■ Home from Hospital ■ Specialist Independent Advocacy ■ Voluntary Sector ■ Private sector care providers	Specialist services (acute and complex) with the aim to avoid admission into long term services ■ Rapid Assessment & Diagnostics ■ Design Care/Treatment plan for Community Services ■ High End Social Care Accommodation Based Services ■ Residential Nursing/EMI ■ End of Life	■ People who have complex needs which require acute interventions know they will receive high class, specialist care matched to their needs ■ Will be supported to be as independent as possible and involved in decisions and discussions about their lives

Delay

Involves:	Delivers:	Outcome:
■ MDT Integrated Team ■ Enablement team/Social Workers ■ Rapid Response ■ Specialist Teams e.g. respiratory, CMHT ■ GP practices, Therapy services ■ Admiral nursing ■ Independent Advocacy ■ Voluntary Sector ■ Brokerage ■ Personal Assistants ■ Private sector care providers	Services that the council and CCG have a statutory obligation to provide in the community ■ Rapid intervention within 2 hours ■ Intensive Home Treatment/Care and Reablement ■ Domiciliary Care including Telecare ■ Community based health care ■ FACS eligible social care services ■ Social Care Services in the home ■ Reduce/delay admissions: care/health/social care residential services ■ Carer Support ■ Rehabilitation ■ Personal Care/Carer Support ■ Case Management of individuals (service Users/patients)	■ People with complex health conditions including progressive conditions e.g. diabetes receive: ■ Rehabilitation so they can carry on doing things for themselves ■ Have access to resources or facilities which help them to remain as independent as possible e.g. community equipment ■ Receive a seamless service across health and social care ■ Know that their carer are also being supported ■ Feel more able to cope with the ongoing day to day stress caused by their condition

Reduce

Involves:	Delivers:	Outcome:
■ Team around the GP practice ■ Admiral Nursing ■ Health Services ■ Council Services ■ Supporting People services ■ Sheltered Housing ■ Community Meals/Alarms ■ Voluntary sector ■ Brokerage/Personal Assistants ■ Voluntary Sector	**Higher level:** Services in the community that are preventative and not statutory ■ Finding and supporting vulnerable people that pose future risk of hitting higher tiers appropriately ■ Rehabilitation ■ Personal Care, Carer support ■ Case Management of individuals (service Users/patients) **Lower level:** ■ Prevention Strategies, e.g. Falls Prevention ■ Maintain skills/abilities to remain independent, with support ■ Befriending Schemes	People are helped to stay in the community by: ■ Receiving early help to deal with 'problems' ■ Able to attend a 'falls prevention clinic ■ Get help with adaptations to the home ■ Can easily 'borrow' things like wheelchairs ■ Can use Assistive Technology easily ■ Go to screening clinics for health conditions ■ Getting advice e.g. how to prevent strokes or heart conditions

Prevent

Involves:	Delivers:	Outcome:
■ Self Care ■ Public Health ■ Community Engagement ■ Voluntary sector Patients/Service Users ■ Carers Support Services ■ Community Neighbourhood and Voluntary Sector Public Health ■ Libraries, Leisure Centres, The Place ■ Surgeries, Chemists ■ Supermarkets/serving their community ■ Religious & belief communities ■ Health Champions	Local approaches to keeping people healthy and in control of their wellbeing ■ Campaigns to increase physical activity ■ Lifestyle interventions ■ Behavioural and lifestyle campaigns to prevent long term conditions ■ Initiatives to reduce excess winter deaths and summer deaths ■ The promotion of community safety ■ Initiatives to tackle social exclusion ■ Drug and alcohol misuse services ■ Advice on obesity and nutrition ■ Campaigns, support and initiatives to improve emotional health and wellbeing	■ People stay healthy, avoid getting ill, keeping active and independent ■ Information, Advice and guidance ■ Voluntary sector/communities (major input) Individuals/families engage with local communities ■ Aware of how to look after themselves: good diet, regular exercise (walking/swimming/gardening) etc. ■ Befriending schemes in place (link to Voluntary Sector) ■ Develop a strong community through peer support and building social capital