Adult Social Care
Prevention Strategy for Older People 2025-2030

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Executive Summary

The fact that more people are living longer is to be celebrated. However, while many people experience a "gloriously ordinary life" in the place they call home, with the people and things they love[1], this is not the case for everyone. More people are living longer but not necessarily with the quality of life they would like.

This strategy sets out Gloucestershire County Council's plans for the delivery of its Adult Social Care statutory prevention duties and specifically how it will prevent, delay and reduce people's need for care and support as they age. With the profile of Gloucestershire's population changing significantly, this strategy is needed now to enable more people to live longer with good health and spend less time in need of care and support.

It is aimed at the Gloucestershire Adult Social Care workforce that supports older people who are at risk of losing independence, self-reliance or resilience through illness, disability, or the effects of severe and multiple disadvantage or marginalisation. We will also develop an Adult Social Care prevention strategy for adults of working age that will include those who may be living with complex life circumstances.

While the Care Act has been in place for 10 years, changes in our population and society mean we need to bring our preventative initiatives together and create a cohesive strategy and culture that focusses more on prevention. Given that there remains a lack of clarity around the country about prevention in social care, this strategy summarises Gloucestershire County Council's legal duties and sets them in our local context of a wider integrated health and care system.

The strategic direction is based on the evidence available about what works in prevention and progress already achieved. This strategy will contribute to delivering Gloucestershire County Council's vision for Adult Social Care by embedding a culture that values proactive preventative support and recognises how this contributes to ensuring a future where independence and wellbeing are prioritised at every stage of ageing.

Our ambition is that in 5 years we will evidence:

1. System leadership: Prevention is a collective responsibility.

2. Workforce: Prevention is core to how we work.

3. Intelligence-led: We use a population health management approach to identify opportunities to prevent, reduce and delay the need for Adult Social Care as people age.

[1] 'A "gloriously ordinary life": a spotlight on adult social care', House of Lords, 2022, committees.parliament.uk/oralevidence/9969/html/ accessed 2/8/24

4. Evidence-informed: We use evidence of what works in prevention to inform our decision-making, practice and approach to innovation.

5. Primary prevention: Our approach to enabling wellbeing focusses on preventing the need for social care as people age.

6. Secondary prevention: We are proactive in how we reduce the escalation of emerging needs.

7. Tertiary prevention: We delay the need for care in higher-cost, more intensive settings through personalised and integrated care.

Adult Social Care in Gloucestershire

Adult Social Care Vision and Mission

We make a difference by enabling people to help themselves and each other, doing everything we can to help people build resilience, thrive and live a good life.

Our mission

- Collaborate with family, carers, people, communities to promote good health, independence, positive risk taking, and prevent harm
- Be involved when we're needed, at the right time, for right length of time. Champion people's rights, treating them with dignity and respect
- Promote social and community connections, enabling people to thrive, supporting independence, wellbeing, and healthy lifestyles
- Act in a coordinated way that puts people at the centre, act on feedback and what people are telling us in a way that is responsive and flexible, listening to what is important to them.
- Challenge inequality and discrimination in all we do, poor quality wherever we see it, promote inclusion and communicate in an accessible and open way
- Do everything we can to support high quality services, making best use of intelligence, data and available technology, creating a learning culture to help improve what we do.

Introduction

"*Prevention is about helping people stay healthy, happy and independent for as long as possible. This means reducing the chances of problems from arising in the first place and, when they do, supporting people to manage them as effectively as possible. Prevention is as important at seventy years old as it is at age seven*."
Prevention is better than Cure, DHSC, 2018[2]

[2] Prevention is better than cure (publishing.service.gov.uk) accessed 2/8/24

The fact that more people are living longer is to be celebrated. However, while many people experience a "gloriously ordinary life" in the place they call home, with the people and things they love[3], this is not the case for everyone. More people are living longer but not necessarily with the quality of life they would like.

Although the Care Act has been in place for 10 years, changes in our population and society mean we need to bring our preventative initiatives together into a cohesive strategy and culture that emphasises prevention. This strategy sets out Gloucestershire County Council's plans to enhance the delivery of its Adult Social Care statutory prevention duties, specifically aiming to prevent, reduce and delay older people's need for care and support.

It is aimed at the Gloucestershire Adult Social Care workforce that supports older people who are at risk of losing independence, self-reliance or resilience through illness, disability, or the effects of severe and multiple disadvantage or marginalisation. It will be followed later by an Adult Social Care prevention strategy that will focus on adults of working age including those who may be living with complex life circumstances.

As there is a nationally recognised lack of agreement around a definition of prevention[4], we start this strategy by summarising Adult Social Care's statutory prevention responsibilities and place these in the wider context of the One Gloucestershire Integrated Care System's developing approach to prevention. Given that the anticipated demographic changes will impact on the whole health and care system, this strategy sets out how Gloucestershire County Council will work with partners to support older people to retain independence.

We recognise that our residents' health and wellbeing, and their experience of ageing, is influenced by a wide range of social and economic factors. This strategy has been developed in the context of One Gloucestershire Integrated Care System and its commitment to focus on prevention[5] and health equity. It acknowledges the crucial role of social and economic determinants of health, such as education, employment, housing, and community resilience. These factors are essential for longer, healthier lives. Although some aspects are beyond this strategy's scope, they are addressed in the Interim Integrated Care Strategy and Health and Wellbeing Strategy[6]. Combined efforts aim to help people live longer, healthier lives.

This strategy sets out how we will transform and shift the Adult Social Care pathway towards earlier prevention. It sets out how Adult Social Care will intervene early to help older people retain and regain their skills and confidence to prevent needs developing and delay deterioration wherever possible. In doing so it will enable us to be clearer about our alignment with health and care partners and our collective interest in joint proactive prevention for older people.

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[3] 'A "gloriously ordinary life": a spotlight on adult social care', House of Lords, 2022, committees.parliament.uk/oralevidence/9969/html/ accessed 2/8/24

[4] Prevention in social care - SCIE (accessed 2/8/24)

[5] Interim-Integrated-Care-Strategy-v1.1.pdf (onegloucestershire.net) accessed 2/8/24

[6] GCC 2596 Joint Health and Wellbeing Strategy Dev5.pdf (accessed 30/10/24)

For ease of reading, Gloucestershire County Council (GCC) is referred to as 'we' and includes both Adult Social Care and the wider Council. In doing so we are mindful of the key role of our integrated care partners in making our ambitions a reality.

Ambition

This strategy will enable Adult Social Care to develop a cohesive approach to discharging its statutory prevention duties. Embedding a culture into Adult Social Care that values proactive prevention will contribute to ensuring a future where independence and wellbeing are prioritised at every stage of ageing.

Our ambition is that in 5 years we will be able to evidence these statements by implementing the following recommendations:

1. **System leadership: Prevention is a collective responsibility.**
   - Foster corporate responsibility for prevention
   - Establish a shared and common language
   - Champion Adult Social Care's role in system approach to prevention

2. **Workforce: Prevention is core to how we work.**
   - Ensure that Prevention is an ongoing activity
   - Collaborate in developing a systemwide approach to commissioning of preventative services
   - Determine Adult Social Care's role in effective multi-agency, multi-disciplinary working
   - Commit to coproduction and engagement

3. **Intelligence-led: We use a population health management approach to identify opportunities to prevent, reduce and delay the need for Adult Social Care as people age.**
   - Better understand the social care needs of older people in Gloucestershire
   - Utilise data and technology for early identification and intervention
   - Develop a prevention offer for people paying for their own care

4. **Evidence-informed: We use evidence of what works in prevention to inform our decision-making, practice and approach to innovation.**
   - Integrate evidence and research about prevention into Adult Social Care decision-making
   - Promote innovation and learning in prevention
   - Use evidence to explore and apply artificial intelligence solutions to enhance the efficiency and effectiveness of service delivery.

5. **Primary prevention: Our approach to enabling wellbeing focusses on preventing the need for social care as people age.**
   - Harness opportunities for prevention across the system

- Champion a strengths-based approach to independent living

6. **Secondary prevention: We are proactive in how we reduce the escalation of emerging needs.**
   - Embed secondary prevention principles into Adult Social Care
   - Raise public awareness
   - Target early support
   - Facilitate early and quick access to equipment and enablement

7. **Tertiary prevention: We delay the need for care in higher-cost, more intensive settings through personalised and integrated care.**
   - Join up case management for people with complex needs and their unpaid carers
   - Promote use of reablement, rehabilitation, community equipment and adaptations
   - Provide a coordinated and rapid response to crises in the community
   - Ensure self-directed support includes preventative approaches

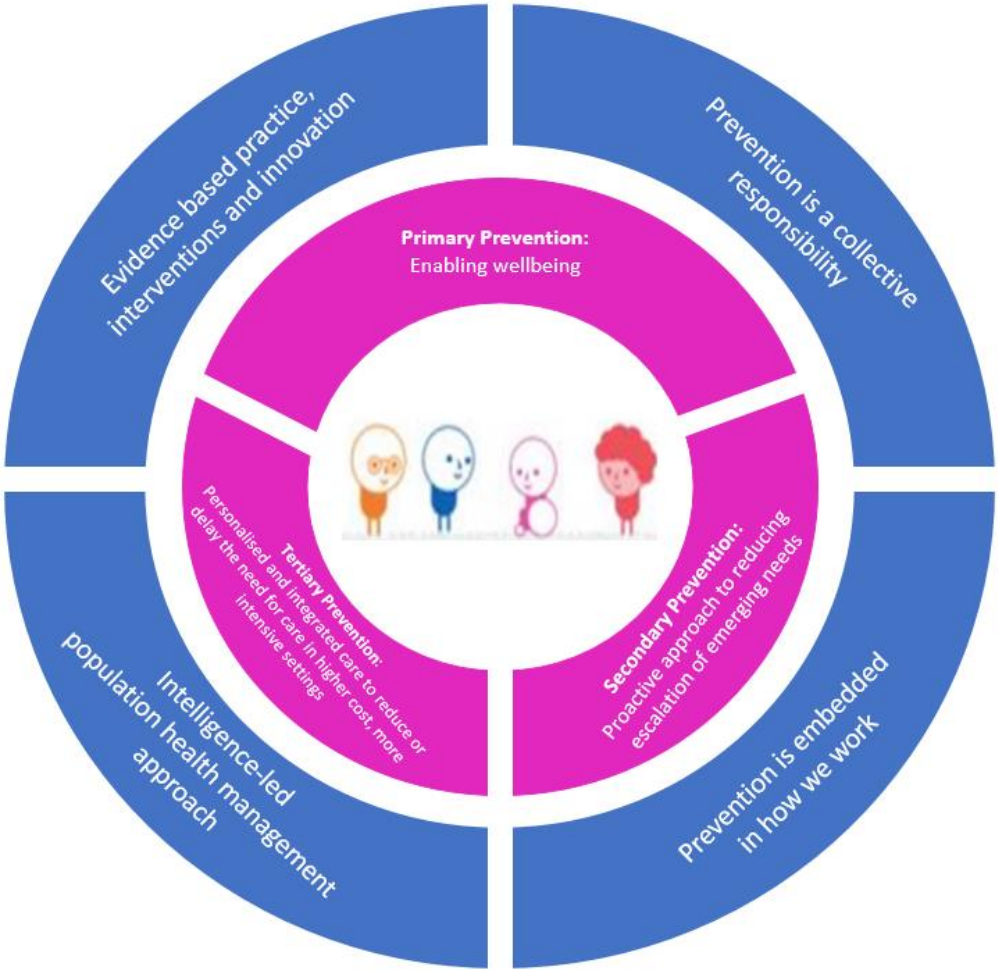

Figure 1: Our Approach

Adult Social Care Statutory Prevention Duties

Prevention in relation to Adult Social Care is not an optional 'nice to have', it is a statutory duty. Local Authorities have duties under the Care Act 2014 "*to promote wellbeing*" and "*to prevent, reduce and delay the need for care and support*". The Care Act Statutory Guidance states that: '*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*' (Para 1.14c, Care and Support Statutory Guidance. DHSC, 2016[7]).

The Care and Support Statutory Guidance aligns prevent, delay and reduce with the health concepts of primary, secondary and tertiary prevention.

Care Act 2014: three approaches to prevention (Prevention in Social Care, SCIE, 2021) [8]

- **Prevent – primary prevention/promote wellbeing**

Applied to everyone, encompassing a range of services, facilities and resources that will help avoid the need for care and support developing. It could include information and advice, promoting healthy and active lifestyles, and reducing loneliness and isolation.

- **Reduce – secondary prevention/early intervention**

Targeted at individuals at risk of developing needs where support may slow this process or prevent other needs from developing. It could include carer support, falls prevention, housing adaptations or support to manage money.

- **Delay – tertiary prevention/formal intervention**

Aimed at people with established complex health conditions, to minimise the effects, support them to regain skills and to reduce their needs wherever possible. This could include rehabilitation/reablement services, meeting a person's needs at home, and providing respite care, peer support, emotional support and stress management for carers

Our prevention duties apply to all adults and are separate to our duties to meet the eligible care and support needs for people and support for carers.

Care Act 2014: Our prevention responsibilities apply to all adults

- People who do not have any current needs for care and support
- Adults with needs for care and support, whether their needs are eligible and/or met by the local authority or not
- Carers, including those who may be about to take on a caring role or who do not currently have any needs for support, and those with needs for

[7] Care and support statutory guidance - GOV.UK (www.gov.uk) accessed 2/8/24
[8] Prevention in social care - SCIE accessed 2/8/24

support which may not be being met by the local authority or other organisation.

(Para 2.3, Care and Support Statutory Guidance, DHSC, 2016[9]).

Prevention is part of '*promoting wellbeing'* and is an ongoing process, not just a one-time event. As circumstances change for an individual or their carer, the type of preventative support they need may also change. Prevention should be continuously considered throughout all stages of life; it involves many different people working in partnership and is not solely the responsibility of Adult Social Care.

The Care Act Statutory Guidance describes wellbeing as:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal relationships
- suitability of living accommodation
- the individual's contribution to society

(Para 6.111, Care and Support Statutory Guidance, DHSC, 2016[10]).

'Promoting wellbeing' means actively considering all the aspects above in a person's life during every step of their care, from giving advice to reviewing their support plan. Wellbeing includes a wide range of factors, and what's important can vary depending on each person's individual needs and situation.

What does prevention look like?[11]

The Social Care Institute for Excellence (SCIE) describes prevention as:

- Increased independence, including navigation of prevention and community services and effective self-care
- Improved quality of life and wellbeing for people who need care and support and carers
- Reduced social isolation and loneliness
- Delayed and/or reduced need for care and support.

[9] Care and support statutory guidance - GOV.UK (www.gov.uk) accessed 2/8/24
[10] Care and support statutory guidance - GOV.UK (www.gov.uk) accessed 2/8/24
[11] Prevention in social care - SCIE accessed 6/8/24

Preventative measures in Adult Social Care for older adults often take time to show their full impact. Initiatives that aim to reduce decline over the long term by supporting independence and wellbeing may not produce immediate results. Benefits often accumulate gradually, and meaningful changes, like reduced hospital admissions or improved quality of life, may only become evident after sustained intervention. These actions are meant to prevent, reduce or delay problems before they start, so can be difficult to measure. Even though changes may not be seen straight away, investing in prevention is important. Over time, it can greatly improve quality of life and reduce the need for more intensive care and support later.

Why is this strategy needed now?

A strategic approach to prevention is needed now because, in summary, without changing how we work and taking steps to support the population in preventing, reducing, and delaying their need for care and support we are unlikely to meet the significant increase in care demand projected over the next twenty years.

Our Market Position Statement highlights a significant growth in Gloucestershire's older adult population, up 25.6% since 2011[12]. Over the next 20 years, the number of those aged 65+ will rise by 38%, with those 85+ increasing by 84% (Figure 2).

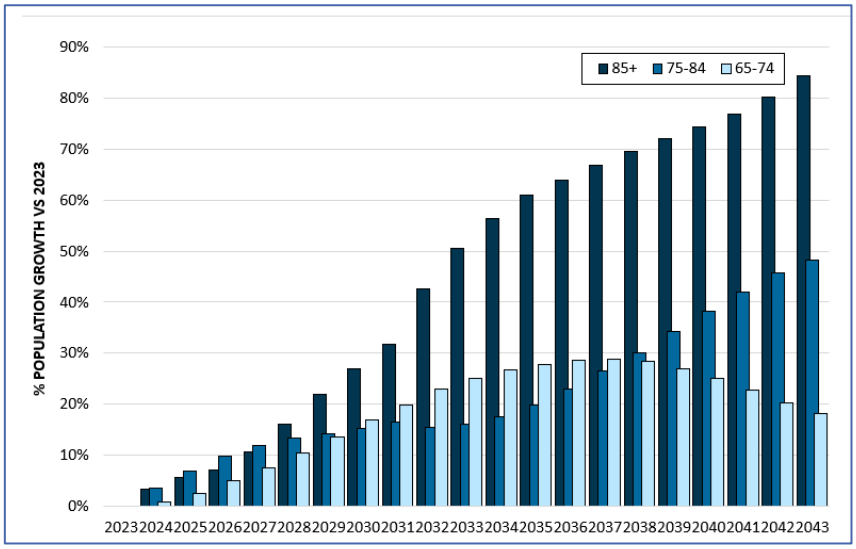

Figure 2: Estimated Population Growth for Older People, GCC Market Position Statement (2024)

The experience of ageing is not the same for everyone living in Gloucestershire and many people will never need social care. The Chief Medical Officer's 2023 report highlights that while life expectancy has increased, the quality of those extra years can vary significantly[13]. In Gloucestershire, life expectancy is higher than the national average, but there are stark inequalities. Those in more deprived areas not only have shorter life expectancies but also spend a longer proportion of their lives in

[12] GCC Market Position Statement 2024
[13] Chief Medical Officer's Annual Report 2023 – Health in an Ageing Society

poor health[14]. Figure 3 highlights the impact of living in poorer health in later life, showing that a Gloucestershire male could expect to live 24.8 years of their life with a significant condition, while a Gloucestershire female could expect 30.8 years.

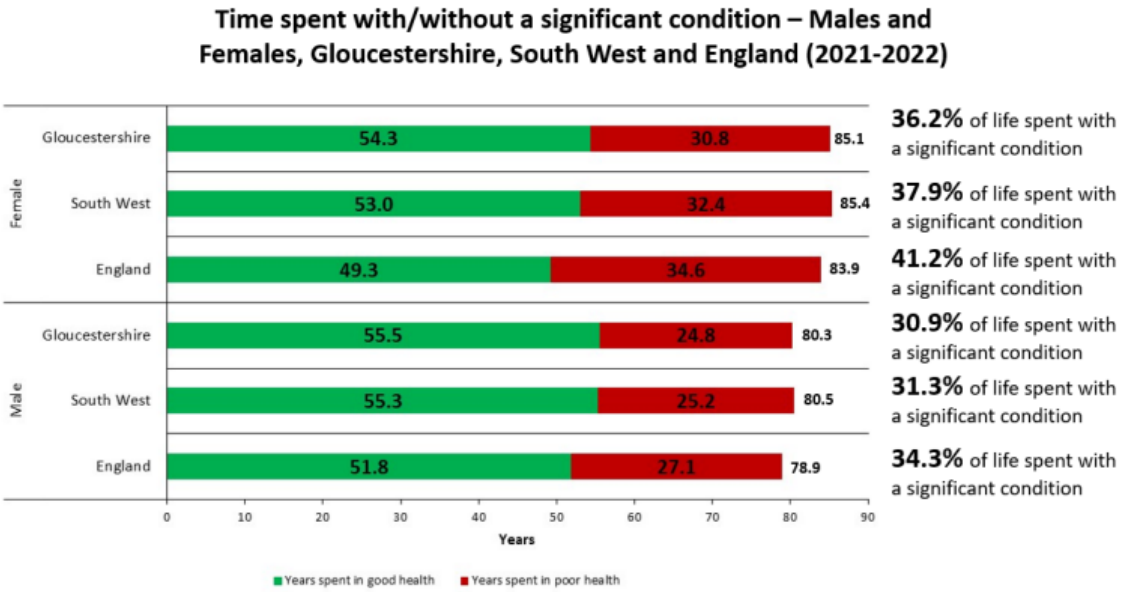

Figure 3: Time Spent with/without a significant condition Males and Females, Gloucestershire, South West and England (2021-2022)

Meanwhile, the working-age population will grow by just 5% by 2043, potentially leading to a care staff shortage (Figure 4) as a result of the increasing dependency ratio, which signifies a growing proportion of older adults relative to the working-age population. In Gloucestershire in 2021 for example, for every 100 working age people, there were 36 dependents aged over 65 years, higher than England and a narrowing gap to the Southwest[15]. This demographic shift underscores the importance of sustainable economic growth and innovation to ensure adequate resources and support systems for an aging population. This is outlined in the county's recently published economic strategy.[16]

Care costs are rising which affects all who use it. The care we provide is means tested and not free at the point of delivery, unlike the NHS (other than in a small number of specific circumstances). Currently, GCC purchases 52% of older adults care.[17]

[14] https://www.gloucestershire.gov.uk/media/2l5dootr/life-expectancy-report-final.pdf
[15] https://www.gloucestershire.gov.uk/media/szofuc4l/current-population-of-gloucestershire-2021.pdf
[16] Gloucestershire's Economic Strategy (2024-2034) | Gloucestershire County Council (referenced 29/10/24)
[17] Provision not purchased by GCC | Gloucestershire County Council accessed 2/8/24

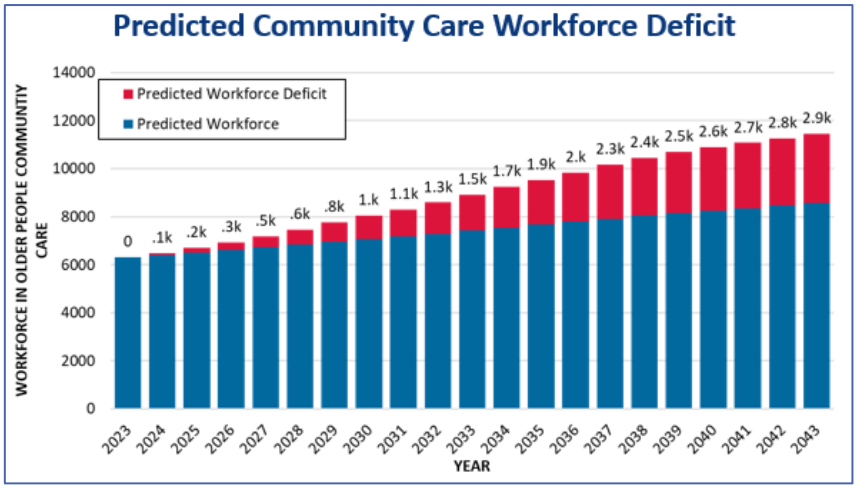

Figure 4: Predicted Community Care Workforce Deficit, GCC Market Position Statement (2024)

In summary, our needs assessment, evidence review, and service mapping undertaken for this strategy indicates that:

- Our ageing population will become more diverse, so services must accommodate this diversity to avoid exclusion and/or widening inequalities.
- Whilst the number of people currently using social care services remains stable, demographic changes, particularly the ageing population, are expected to drive a significant increase in demand for these services over the next decade[18]. This indicates that both the number and proportion of people needing social care are expected to grow due to demographic changes.
- Gloucestershire has an estimated 51,862 people providing unpaid care, this is equivalent to 8.5% of the population[19].Carers frequently experience considerable stress, so effective prevention strategies must provide support for both the carer and the person they are caring for.
- Proactively providing lower-intensity support can delay or reduce future care needs, helping individuals maintain their independence, health, and well-being longer.
- Identifying frailty early can prevent issues such as falls, self-neglect, carer breakdown, infections leading to delirium, and avoid unnecessary hospital or long-term care admissions.

[18] GLOUCESTERSHIRE MARKET POSITION STATEMENT 2024
[19] Census 2021: Health, disability and unpaid care – a briefing, Inform Gloucestershire (Accessed 23/10/24)

- About 84% of health influences are outside clinical care[20]. Inequalities increase the risk of ill-health and preventable hospital admissions, including the effects of overlapping inequalities.[21], [22]
- Using linked data and analytics helps address inequalities by enabling us to accurately identify and target those most in need and at risk. This approach enhances our ability to focus resources where they are most effective, improving outcomes and reducing future care demands.

Prevention at system level

The opportunities and challenges resulting from the demographic changes will impact on the whole population of the county. This will, in turn, impact across the public sector in Gloucestershire. To truly make an impact, we need to continue to collaborate strongly on the prevention agenda, recognising partners across the system have different but equally valuable roles: As the population ages and people live longer, the increasing demand for services, coupled with tighter funding, means that resources must be used more efficiently to support older adults and enhance preventive measures.

Figure 5: Prevention in a joined-up local system (SCIE 2021[23])

[20] Interim Integrated Care Strategy Interim-Integrated-Care-Strategy-v1.1.pdf (onegloucestershire.net) accessed 2/8/24
[21] Tackling Health Inequalities | Seven Priorities For The NHS | The King's Fund
[22] Interventions to reduce inequalities in avoidable hospital admissions: explanatory framework and systematic review protocol | BMJ Open
[23] Prevention in social care - SCIE accessed 6/8/24

Adult Social Care is a partner in delivering the One Gloucestershire Interim Integrated Care Strategy vision of '*making Gloucestershire the healthiest place to live and work – championing equity in life changes and the best health and care outcomes for all*' [24]. The Integrated Care Strategy also refers to primary, secondary and tertiary prevention and includes quaternary prevention[25]. More recently One Gloucestershire has adopted a broad definition of prevention to allow all partners to share a common language and be aligned.[26]. It describes prevention as:

- about supporting and enabling people stay healthy, thriving and independent for as long as possible; stopping problems arising in the first place, not just treating people when they become ill
- not only about preventing illness and dependency, but actively promoting a positive state of health and wellbeing.
- There is an increasing shift towards a focus on how we "create health" and whether "prevention" may be too deficit focussed[1]

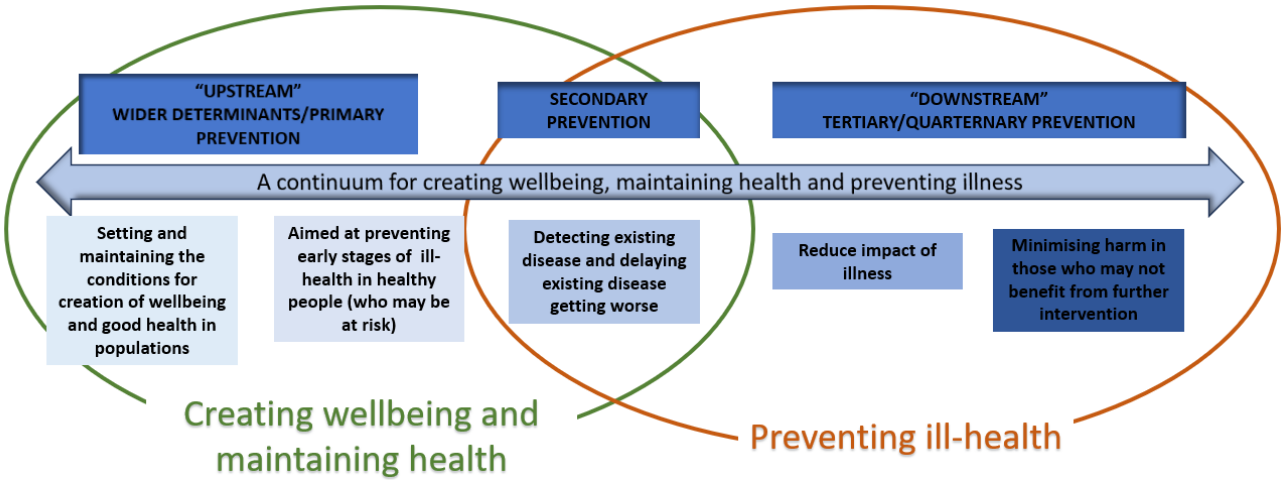

Figure 6: The Gloucestershire approach to tackling health inequalities[27]

There is also an opportunity to build on the successes of the Working As One Programme which has tackled the underlying challenges in urgent and emergency care. Widening the collective system focus to include earlier admission avoidance for older people will help to address the Care Act prevention agenda to everyone's benefit.

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[24] Interim-Integrated-Care-Strategy-v1.1.pdf (onegloucestershire.net) accessed 2/8/24

[25] The Care and Support Statutory Guidance does not refer to quaternary prevention. Quaternary prevention refers to the risks associated with overmedicalisation. Structured medication reviews can help address this risk for older people. BGS Joining the Dots - A blueprint for preventing and managing frailty in older people.pdf

[26] Prevention definitions FINAL (ppt August 2024), produced by the GCC Public Health and Communities team in partnership with ICS colleagues

[27] ibid

"*The incidence of preventable admissions to hospital and long-term care is a strong indicator of both the local social, demographic and economic environment and the degree of system cohesion in supporting person-centred and coordinated care, support, treatment and safeguards*" (LGA High Impact Change Model, 2021[28])

A clear priority for supporting independence and reducing the impact of health inequalities is ensuring diverse housing options for older people are included in local plans and in our commissioning strategies. We are refreshing our Housing with Care strategy at time of writing.

In line with the Association of Directors of Adult Social Services (ADASS) roadmap for reforming care and support in England, "Time to act"[29] we need to support system working which

- Increases the number and variety of accessible homes across tenures
- Provides easy access to retrofitting and adaptations
- Designs and builds more options for homes with care and support

By collaborating with partners to develop a shared understanding of prevention, we have an opportunity to influence and inform the wider system with a clear agenda outlined by this strategy.

Health Inequalities and Prevention

Work on prevention and health inequalities go hand in hand – if there's inequality there is an opportunity for prevention; if you target one you will impact the other. Therefore, the impact of health inequalities contributes to need for Adult Social Care.

Health equity is realised when every individual has a fair opportunity to achieve their full health potential. Differences in health status, access to social care, treatment, and outcomes between individuals and across populations that are systemic, avoidable, predictable, and unjust are often referred to as 'health inequalities' (or disparities).

In terms of prevention in social care, inequalities can lead to late and differential access to care through variation in cultural competence, high distances to travel for rural communities, differential quality of care amongst other drivers which can lead to avoidable and unjust early loss of independence, reduced quality of life, and avoidable experience of crisis. These differences result in people who are worst off missing out on life chances, experiencing poorer health and having shorter lives.

Inequalities in what?
Health inequalities can relate to:

- Health status e.g. healthy life expectancy

[28] Reducing preventable admissions to hospital and long-term care – A High Impact Change Model | Local Government Association, 2021 (accessed 19/8/24)
[29] adass-time-to-act-april-2023-1.pdf 2023 (accessed 31/10/24)

- Access to high quality care e.g. access to clinical appointments
- Quality and experience of care e.g. patient satisfaction
- Health and care outcomes e.g. long-term condition management
- Behavioural risks to health e.g. alcohol consumption
- 'Wider (or core) determinants of health' e.g. quality of housing, employment, income, community connectedness and the environment.

Inequalities among whom?
Health inequalities occur between people or groups due to social, geographical, biological, or other factors.

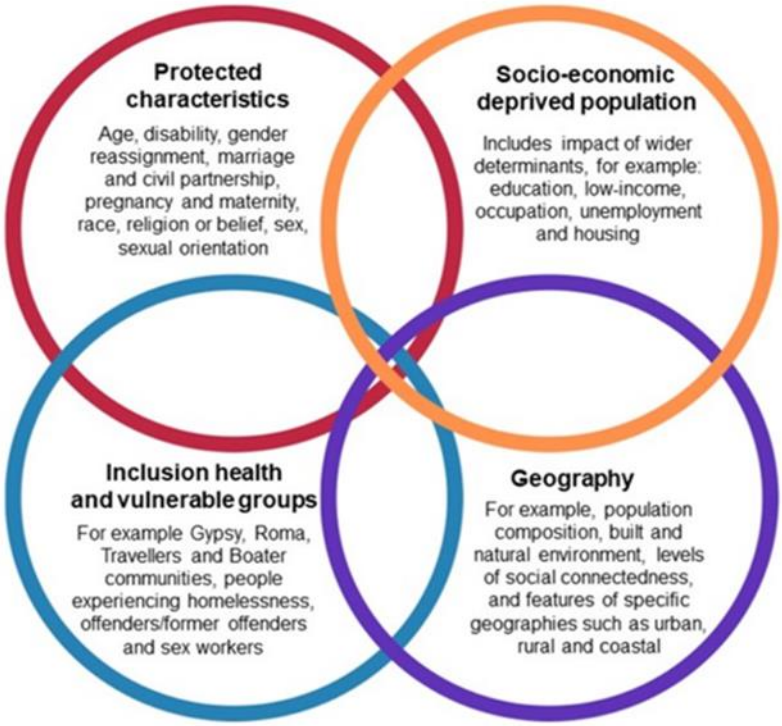

Figure 7: Inequalities between whom?[30]

There is a well-documented tendency for those who most need a service or intervention to be least likely to receive it, thereby widening health inequalities – this phenomenon is known as the 'inverse care law' and if prevention services or interventions are implemented poorly is the likely outcome. Adopting a 'proportionate universalism' approach i.e., resourcing and delivering universal services and interventions at a scale and intensity that is proportionate to need, can help to mitigate this risk.

Where are we now?

Despite local and national efforts to improve the wider determinants of health and implement preventative interventions, we have seen an increase in health and care

[30] Prevention definitions FINAL (ppt August 2024), produced by the GCC Public Health and Communities team in partnership with ICS colleagues

needs. This rise is due to demographic changes, the COVID-19 pandemic, global cost of living pressures, as well as increased demand on NHS services. These factors have hindered the step change in that investment in upstream prevention sought to make in stemming the downstream demands. It is therefore now more important than ever that we renew our commitment and focus to develop a culture of prevention, where proactive support and early interventions facilitate independence and wellbeing at every stage of the life course, and especially during ageing.

When implementing the Care Act 2014, we focussed on managing and redesigning our services to ensure equity, improved outcomes and cost-effectiveness. We have mapped the initiatives that the Council support against the three types of prevention, and these are summarised at the end of this document (Appendix 1).

Considerable progress is underway both within Adult Social Care and with One Gloucestershire NHS partners. There are opportunities for further synergy, particularly in relation to proactive care and frailty; this forms a solid foundation from which to work. The NHS England Proactive Care Guidance implicitly recognises the importance of taking a holistic approach:

"*The onset or progression of frailty can be slowed by taking a biopsychosocial approach and putting in place personalised and preventative measures that address a person's range of needs in a timely way, enabling them to live independently and healthier for longer*" (National Proactive Care Guidance 2023)

We recognise that there are many more initiatives supported and delivered by GCC and our ICS partners across Gloucestershire that support improving the wider determinants of health and individual prevention activities, as well as tackling health inequalities on a broader scale. Emerging technologies and data insights are allowing us to further enhance and personalise services, making now the ideal time for innovation.

Appendix 2 lists the strategic developments in place and underway both within Adult Social Care and the wider ICS that are particularly relevant to this strategy.

What do people think?

Co-production is crucial for advancing the prevention agenda as it ensures that the voices of people who use services, carers, and community members are integral to the design and delivery of services involved in prevention. This approach makes sure that services truly meet the needs of those they are meant to help.

The Adult Social Care Service User Survey[31] reveals that while satisfaction with care is around 50% in community settings, issues like loneliness persist and people feel there is limited choice to the options available for care and support services. Residential and nursing care generally shows higher satisfaction, but similar challenges remain. The survey underscores the need for improvements in social

[31] adult-social-care-survey-full-report-2022-23.pdf (gloucestershire.gov.uk)

contact, independence, and overall well-being for older adults in both community and residential care[32].

The Gloucestershire Carers Survey in 2021/22[33] reveals a decline in satisfaction with support services and involvement in care decisions compared to 2018/19. Challenges persist in accessing helpful information and advice, with many carers feeling socially isolated and lacking sufficient support. Additionally, a significant portion of carers reported struggles with self-care and control over their daily lives, indicating unmet needs in these areas. The data suggests a need for improved support and engagement strategies for carers to enhance their quality of life and care experience.

The 2023/24 Healthwatch Gloucestershire Annual Report[34] highlights "*Joined up care for older adults*" as a top priority. Feedback revealed that many face tough choices between necessities and healthcare, impacting mental and physical well-being. Transport issues, especially in rural areas, hinder access to health and care services. The report highlights significant issues in accessing social care, especially during the Care Act assessment process. People find it difficult to navigate the complex range of available services, and many are unaware of how or when to seek a care assessment, leading to delays. Inconsistent communication with professionals and a lack of adequate advocacy support further complicates the process, potentially resulting in unmet needs for both individuals requiring care and their unpaid carers. These challenges highlight the need for better access and more straightforward guidance in social care services.

Delivering our ambition

At the start of this document, we outlined our seven Adult Social Care statements for prevention that we want to be able to evidence progress against in five years' time. Below, we expand upon these and propose the ways in which we intend to achieve them. They will be supported by an implementation plan which, together with the strategy will be reviewed annually as a minimum. Our actions will complement rather than duplicate or replace existing health and social care system strategies and plans, giving focus and helping prioritise our activity over the next five years, ensuring a deliberate, strategic and genuinely collaborative model for preventative activity.

We aim to develop and implement prevention activities that are inclusive and accessible to everyone, actively working to reduce health inequalities. We want to focus on reaching diverse and underserved communities, addressing barriers to access, and ensuring that prevention efforts do not unintentionally widen existing disparities. To make our ambition a reality, Gloucestershire needs to become a more age-friendly county. Gloucestershire County Council plays a crucial role in enabling people to be healthier and more resilient so they can grow older in the places they

[32] Note: Results for adults aged 65 and over who receive long term care
[33] Gloucestershire County Council, (2023) Carers Survey 2021/22 https://www.gloucestershire.gov.uk/media/hicncrwk/carersurvey_202122_findings.pdf
[34] Healthwatch (2024) Gloucestershire Annual Report 2023/24 PowerPoint Presentation (healthwatchgloucestershire.co.uk)

call home. This approach benefits them and will help mitigate the potential increased demand on care services.

1. System Leadership: Prevention is a collective responsibility

This ambition demonstrates our intention to create a positive culture where prevention is everybody's business[35] We want Gloucestershire to be a place where Council staff and our partners enable people to age well and live a "gloriously ordinary life" in the place they call home, with the people and things they love[36].

Foster corporate responsibility for prevention

The Adult Social Care workforce will understand and be able to articulate what we mean by 'prevention'. Colleagues will ensure that prevention is integrated into every aspect of our work.

Establish a shared and common language

We will develop and promote a shared understanding of prevention in Adult Social Care to ensure that everyone working with older people is clear about their role and the contribution they make.

Adult Social Care will work with system partners to embed a clear and consistent prevention narrative in relation to care and support. This shared definition will drive collaborative efforts to prevent, delay, and reduce the need for more intensive social care services, which will enhance the quality of life and independence for individuals in our community. How we all talk about ageing is important because talking in a negative way can shorten people's lives[37]. We will be alert to the risk of widening health inequalities and adopt a 'proportionate universalism' approach.

Champion Adult Social Care's role in system approach to prevention

Prevention is in everyone's interest. Adult Social Care will continue its leadership to promote prevention across our whole system to ensure an integrated approach to prevention in Adult Social Care. It is anticipated that this strategic leadership will translate to strong sustainable preventative programmes which are appropriate, relevant and impactful for local communities.

How we will do this

- With ICS partners, including those in the health and voluntary sector, we will develop a shared understanding of prevention in social care. We will work with wider system partners to embed this shared understanding through ensuring

[35] Prevention in Social Care: everyone's business, everyone's challenge, Jonathan Van-Tam, Newton Consulting Community of Practice, 2024 (accessed 29/7/24)
[36] 'A "gloriously ordinary life": a spotlight on adult social care', House of Lords, 2022, committees.parliament.uk/oralevidence/9969/html/ accessed 2/8/24
[37] See references to stereotype embodiment and stereotype threat 'That Age Old Question, how attitudes affect our health and wellbeing' RSPH and Calouste Gulbenkian Foundation, (accessed 8/8/24)

that our shared activity has clear objectives relating to preventing, reducing or delaying need for acute or long-term care.
- When Adult Social Care strategies are reviewed, they will be aligned with this strategy.
- Each GCC service plan will include a prevention requirement to identify their contribution and an action that will be taken in the life of the plan.
- Consider prevention in social value procurement requirements.
- Ensure Adult Social Care participates in the Prevention Community of Practice
- Ensure that equalities are embedded structurally and culturally much more explicitly in Adult Social Care and wider corporate approaches.

2. Workforce: Prevention is core to how we work

Ensure that Prevention is an ongoing activity

"Front line social care practitioners now need, at every contact, to consider which needs can be prevented; which could be reduced; which might be delayed; and which need support now" (SCIE, 2024)

We will establish prevention as an ongoing process rather than a one-time activity. With greater understanding of what we mean when we talk about prevention, the types of effective prevention interventions that exist, and how to find appropriate information and advice, staff will be able to contribute to reducing and delaying need as well as primary prevention.

Collaborate in developing a systemwide approach to commissioning of preventative services

Integrated commissioners will work with housing, health, care and community partners to develop a collaborative system-wide approach to commissioning effective preventative services for older people that address the wider determinants of health such as social isolation, housing needs/conditions etc. This will help build a more coherent holistic system offer and make more efficient use of the Gloucestershire pound.

We will work with our commissioned providers and grant funded services, so they identify opportunities to enhance health and wellbeing, strengthen independence and prevent, reduce and delay future care needs in a way that is relevant to their service or project.

Determine Adult Social Care's role in effective multi-agency, multi-disciplinary working

Adult Social Care plays an important part in working with system partners to benefit local communities and the older people living in them. We will work with Integrated Locality Partnerships (ILPs) to promote our role in prevention, engaging in locally based population health management initiatives focused reducing the impact of the wider determinants of health, deprivation and inequity. We will collaborate in the development of Integrated Neighbourhood Teams and establish a clear and proportionate role for Adult Social Care that contributes to effective place-based working which provides holistic and preventative care for individuals. This will include

working with ICS colleagues to implement the 'What Matters to Me' approach to care and support planning and embedding personalised care and shared decision making into practice across Adult Social Care.

Commit to coproduction and engagement

We will ensure that this strategy aligns with our Quality Strategy by actively involving individuals, their families, unpaid carers, and staff in the development and improvement of prevention activities. This approach will prioritise what matters most to those we support, including collaboration in decision-making, incorporating feedback to continuously refine practices, and embedding both user and staff perspectives to shape services and policies that reflect their needs and values.

How we will do this

- Collaborate in the development of a shared ICS prevention framework that includes common definition, goals and outcomes that fit with our Care Act 2014 duties.
- Incorporate preventative measures into service specifications by ensuring all commissioned services for older people include specific goals and measures for prevention such as reducing hospital admissions, falls and other interventions targeted at primary prevention (health education, lifestyle support, support to access NHS health checks, screening).
- Review the funding of interventions to identify opportunities to fund upstream interventions that stem downstream demand.
- Clearly articulate Adult Social Care's role in multi-agency, multi-disciplinary working, including its' role in proactive care and the development of Integrated Neighbourhood Teams, ensuring preventative objectives are shared
- Review the Make the Difference Model and consider how to increase prevention at the point of first contact with GCC and at all points along the pathway.
- Review Adult Social Care prevention workforce needs alongside system partners for example:
    - To understand the opportunities for Occupational Therapists to support prevention, exploring emerging practice opportunities collaboratively with the university of Gloucestershire
    - Strengthening Occupational Therapy support to the Adult Helpdesk to enable improved utilisation of fast-track minor adaptations and signposting to preventative health and wellbeing opportunities within people's local communities
    - To understand what our reablement and therapy workforce need to support their role in people regain independence and preventing admission
    - Clarify how GCC care navigators and care coordinators based in Primary Care complement one another
    - Opportunities for greater use of Trusted Assessor roles exploring opportunities with minor adaptations and equipment provision, whilst strengthening DFG offer
    - Develop a technologically enabled care competent workforce
    - Encourage staff to take up training and development opportunities appropriate to their role – e.g. Personalised Care Institute

- Review training needs analysis to ensure training and development opportunities align to our prevention aspirations
- Work towards improving information sharing so there is a single shared view of the person

3. Intelligence-led: We use a population health management approach to identify opportunities to prevent, reduce and delay the need for Adult Social Care as people age

This approach will align with the successful implementation of our ICS-wide frailty, dementia, palliative and end of life care strategies, all of which draw on a Population Health Management approach and will enable us to better identify people who may benefit from these strategies.

Population Health Management (PHM) is the way we work together to understand and improve the health of people and communities using joined-up health and social care records.

Better understand the social care needs of older people in Gloucestershire

We will use available data to gain a greater insight into which people are likely to need Adult Social Care, and who could benefit from earlier intervention. To ensure prevention is delivered appropriately more work is needed to better understand the diversity of our ageing population. This includes how intersectionality is impacting on needs, use and experience of Adult Social Care services and what different prevention approaches and adjustments are needed to address health inequalities.

Utilise data and technology for early identification and intervention

With these insights we will offer preventative services more proactively and facilitate timely entry into Adult Social Care and appropriate progression to more intensive services. We will identify older people who are most likely to benefit from preventative support using a population health management approach. Using tools that analyse data will help us identify individuals known to Adult Social Care who might benefit from extra support before their situation deteriorates. These tools look at data, like how often services were used in the past and health records, to help spot potential problems early.

Develop a prevention offer for people paying for their own care

People with assets over £23,350 are usually required to pay for their own care[38]. As the threshold for paying for care has not changed with the increase in cost of services, we need to understand the impact this is having on our ageing and older residents and how this will change demand for Adult Social Care in the future.

How we will do this

- Review whether collected Adult Social Care data is sufficient to evidence the impact of prevention interventions

[38] GCC Booklet Paying for Your Care (accessed 24/10/24)

- Analyse Adult Social Care data held on GCC systems to better understand the profile of people contacting GCC, those who are assessed and their outcomes.
- Review and extend the content of the Linked Health and Social Care Dataset to better understand who may develop potential future Adult Social Care needs, particularly:
    - Better understand the levels of frailty experienced by people using Adult Social Care.
    - Unpaid carers
    - People without children
    - People with protected characteristics
    - Prevention needs of those for whom GCC pays for their care and those who fund their own care.
    - Test whether we can identify people 12/18 months in advance and proactively intervene earlier to promote resilience – by drawing on the risk algorithms being developed in the Frailty and Falls work

4. Evidence-informed: We use evidence of what works in prevention to inform our decision-making, practice and approach to innovation

This priority focusses on identifying which approaches best promote quality of life for older people and which interventions or services prevent or delay the need for care in higher-cost, more intensive settings. It is dependent on the successful implementation of our Adults, Communities and Wellbeing Data and Intelligence Strategy and our Adult Social Care Quality Strategy (currently draft) which together will improve our oversight and decision making and our ability to turn data into intelligence with which our staff can make decisions.

"*By its very nature, prevention activity is an investment; it involves acting now to realise benefits over an extended period of time. Benefits come in the form of enhanced health and wellbeing outcomes for individuals and driving efficiency in the delivery of public services*."
People at the heart of care – Adult Social Care Reform Paper (2021), para.4.58[39]

Integrate evidence and research about prevention into Adult Social Care decision-making

We will ensure that staff are empowered, through leadership and training, to take a quality improvement approach which prioritises prevention opportunities to promote wellbeing and to reduce deterioration.

We will drive robust decision-making processes in Adult Social Care by drawing on evidence and research on prevention relating to social care. This will ensure that policies, practices, interventions, and commissioned services are informed by the latest and most relevant data and research findings about prevention in Adult Social Care which in turn will enhance the effectiveness and efficiency of care delivery. This approach will enable informed decisions that better target resources, anticipate

[39] People at the Heart of Care – Adult Social Care Reform White Paper (publishing.service.gov.uk)

future needs, and improve outcomes for individuals and communities while also ensuring we avoid approaches that do not effectively address inequalities and may inadvertently worsen access to care and support.

Promote innovation and learning in prevention

We will encourage a learning culture that develops and tests innovative approaches to prevention in Adult Social Care, understanding that not all will succeed, and that failure provides valuable insights. This will include establishing clear criteria for success and failure in pilot projects and ensuring that all pilot initiatives include evaluation plans. Projects that do not meet established outcome thresholds may be discontinued based on rigorous evaluation and research, allowing us to reallocate resources towards more effective strategies that demonstrate proven results. This approach will support a culture of continuous learning and evidence-based practice in the field of Adult Social Care.

Use evidence to explore and apply artificial intelligence solutions to enhance the efficiency and effectiveness of service delivery.

We will use evidence and emerging guidance to explore and implement artificial intelligence (AI) and other technology solutions that enhance prevention service delivery efficiency and effectiveness. This includes assessing current practices, researching relevant technologies, and ensuring ethical considerations are at the forefront of AI implementation. We will pilot and integrate AI tools while monitoring their impact, refining processes, and sharing insights to promote transparency, fairness, and accountability in our use of technology.

How we will do this

- Develop and implement a logic model for preventative interventions and include proven approaches
- Establish and maintain a framework for monitoring and evaluating prevention activities, including pilot/test and learn projects, to measure their effectiveness, efficiency, and continuous improvement. This will enable real-time adjustments, comparison across projects and summation of progress including discontinuation if objectives are not met.
- Develop clear processes to ensure research findings related to prevention are regularly reviewed and applied in service planning, commissioning, and delivery.
- Actively engage with initiatives like the ConnectED[40] programme, which links evidence to decision-making through National Institute for Health Research (NIHR) funding.
- Promote CPD opportunities related to improving prevention approaches: Quality, Service Improvement and Redesign (QSIR)course, Quality Improvement test & learn projects, systems improvement coaching and evidence-based decision-making.
- Undertake further work to understand potential barriers such as social isolation or fear of discrimination that may prevent people with protected characteristics,

[40] https://www.researchinpractice.org.uk/adults/content-pages/open-access-resources/connected/

such as older LGBTQ+ adults, from engaging with services, ensuring that all interventions promote equity and inclusivity[41].
- Involve practitioners, people who use services, and other stakeholders to identify specific needs and contact points where AI could provide solutions.
- Investigate and test AI tools and platforms that can free up time for more value-added activities such as automating routine tasks, support case note management, data entry and report generation.
- Engage in national, regional and local forums to share best practice and innovation
- Participate in existing populational health management project groups across the county via ILPs

5. Primary prevention: Our approach to enabling wellbeing focusses on preventing the need for social care as people age

Harness opportunities for prevention across the system

We will work with wider Council and system colleagues to identify when and where they have opportunities to provide information and advice, promote healthy and active lifestyles, and reduce loneliness and isolation.

We will engage system partners to ensure that our joint approach to loneliness, social isolation and physical activity sufficiently addresses the needs of older people. This will include monitoring the demand and capacity to respond so we can identify further opportunities.

Champion a strengths-based approach to Independent Living

We will ensure that services are designed to help individuals live independently in their own homes and communities for as long as possible, reducing the need for more intensive care. This means we will champion a personalised strengths-based approach, emphasising the capabilities and resilience of each person.

How we will do this

- Review current prevention information and ensure it is available in a range of formats, which is easy to find and promoted to community groups that are representative of our diverse communities. Be mindful that not everyone has access to the internet - co-produce to ensure the communication is inclusive and accessible.
- Refresher training and education for GCC services such as libraries, adult education, transport, planning coroners & registration service, trading standards in identifying their role in primary prevention.
- Review and address opportunities for prevention to people following life-changing events. (The Care Act Statutory Guidance refers to 'trigger points'[42])
- Review how we commission and grant fund community-based initiatives with system partners to ensure the wellbeing benefits they deliver contribute to

[41] Older LGBTQ+ people and social care (scie.org.uk) (accessed 19/8/24)
[42] Care and Support Statutory Guidance paragraph 3.26 (accessed 24/10/24)

preventing and the need for care and support as people age (e.g. initiatives that build social networks and resilience, such as peer support group, befriending, social prescribing, access to transport.)
- Review our public facing presence and communication to support and enable people to access information and guidance to support them in self-purchase and self-management such as for equipment, minor adaptations as well as community-based groups

6. Secondary prevention: We are proactive in how we reduce the escalation of emerging needs

We will proactively identify and address emerging needs, target support to reduce and delay escalation and the risk of crises. We will focus our efforts on early intervention to maintain individuals' stability and independence, aligning with the overarching goals to prevent, delay, and reduce the necessity for more intensive care services.

Embed secondary prevention principles into Adult Social Care

We will embed secondary prevention principles into all aspects of Adult Social Care, from initial contact through ongoing service delivery. This means people can expect a personalised response that maximises what they can achieve, whether that be increasing, regaining or retaining resilience and independence, or delaying the loss of resilience.

Raise public awareness

We will raise public awareness and confidence about the importance of early intervention and prevention and how to access information, advice and support. We will make it easier for people and carers to navigate the care system and make informed, timely, decisions.

Target early support

We will develop how we can take a more proactive approach to identifying the emerging needs of individuals who contact Adult Social Care. We will explore opportunities to intervene earlier in the Adult Social Care journey so that issues can be addressed before they become more serious. As part of meeting our Care Act information and advice duties we will ensure these individuals receive appropriate information, advice and guidance and early interventions to prevent future crises and reduce the likelihood of their needs escalating. This will include housing options.

Facilitate early and quick access to equipment and enablement

Timely provision is crucial for enabling people to live safely at home, as it reduces the risk of falls and associated health and social care needs. It empowers individuals to make choices that reflect their lives, allowing them to continue important activities for longer and reducing wait times for interventions. Beyond equipment and minor adaptations, it’s essential to help people navigate complex systems, acknowledging that barriers to participation can be more than just physical. The role of enablement

in preventing care and support needs is significant, and we should explore ways to strengthen and support this resource.

How we will do this

- Use the implementation of the new Technology Enabled Care Service to undertake a public communications campaign promoting secondary prevention messages e.g. smart home devices, assistive technologies, home adaptations that can help safety and independence, support for carers.
- Training for frontline care and health staff so that they recognise early signs and direct individuals to appropriate secondary prevention support and provide consistent messages across the county.
- Identify and explore opportunities at the Adult Social Care Front Door which could include:
    - Review the Help Desk offer and re-frame the thinking from 'demand management' to 'prevention'
    - Investigate reasons behind high frequency/intensity callers
    - Prevention-focussed decision-support tools that help identify suitable response according to level of frailty
    - Describe a suite of targeted secondary prevention interventions.
- Trial ways of providing more active earlier input to resolving or reducing needs without onward referrals. Consider:
    - a proactive outreach hub
    - service models focussed on secondary prevention, capable of providing quick assessments and targeted interventions for individuals identified as at risk. This service model could coordinate with existing services to deliver timely, targeted support that stabilises situations before they become crises.
    - how data and AI could be used to identify individuals e.g. identifying a subgroup of people e.g. mild frailty 12/18 months in advance and proactively intervene earlier to promote resilience – by drawing on the risk algorithms being developed in the Frailty and Falls work
    - the type of staff needed to do this and where in the pathway they can be most effective, e.g. trialling an Adult Social Care Prevention Officer role.
    - When planning the development of the Care Navigator Model consider opportunities for synergy with Care Coordinators in primary care (& other roles such as wellbeing progression coordinators and social prescribers)
- Investigate ways to develop easier and quicker access to equipment, minor adaptations and DFG, including the self-service models that are key in enabling this.
- Collaborate with Gloucestershire ICB and public health teams to identify health interventions that will benefit people using social care, e.g. to reduce the risk of chronic conditions, the risk of falling and opportunities for screening and vaccination.

7. Tertiary prevention: We delay the need for care in higher-cost, more intensive settings through personalised and integrated care

"*Prevention reduces the likelihood or severity of acute demand*"[43].
This ambition is most likely to benefit older people living with moderate or severe frailty, those receiving palliative care and/or in their last phase of life[44]. It applies equally to people and their unpaid carers wherever they may be living, including care homes. We will ensure that changes in an individual's circumstances or condition prompt a reassessment of preventative support needs. Prevention should be continuously considered, not just at the time of diagnosis, assessment, or annual review. This approach will be outcomes-focused, avoiding crisis-driven interventions and allowing multiple pathways and points of entry for support. We will collaborate with partners to widen our focus on hospital avoidance to include people's homes.

Join up case management for people with complex needs and their unpaid carers

Having developed better insight into when and why people's care needs increase, we will be able to identify people who may benefit from coordinated multi-agency, multidisciplinary case management. Adult Social Care will work with Integrated Neighbourhood Teams to manage people's needs and exacerbations. This will include Adult Social Care staff having the knowledge, skills and attitudes necessary to be competent to provide high-quality care and support for people approaching the end of life and their families (this includes advance care planning and ReSPECT).

Promote use of reablement, rehabilitation, community equipment and adaptations

"*Every older person can benefit from rehabilitation in some way and chronological age alone should never bar access. Timely rehabilitation, when needed, is a right for every older person*".[45] British Geriatric Society, 'Reablement, rehabilitation, recovery: – everyone's business'

This will include introducing more 'Step-Up' intermediate therapy-led interventions to prevent admission to hospital or long-term care, during a hospital stay as well as for those being discharged from hospital.

Provide a coordinated and rapid response to crises in the community

This means that social care will become part of the urgent response which prevents crises from escalating to admissions. Focus on empowering individuals and their carers to manage situations effectively, ensuring timely access to resources and guidance to maintain stability and prevent unnecessary admissions to long term care.

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[43] A preventative approach to public services: How the government can shift its focus and improve lives (instituteforgovernment.org.uk) (accessed 6/8/24)
[44] Planning Ahead – personalised care and support planning : NHS Gloucestershire ICB (nhsglos.nhs.uk) (accessed 16/8/24)
[45] BGS Reablement rehabilitation recovery - Everyones business.pdf accessed 8/8/24

Ensure self-directed support includes preventative approaches

We will ensure that those who direct their own support, such as with direct payments and employing a personal assistant, will benefit from this strategy.

How we will do this

- Undertake a quality improvement test and learn project with a small number of staff who are given dedicated and protected time and permission to proactively find people at risk of crisis and work with them systematically to review and find prevention opportunities so that they avoid reactive care (e.g. highest cost cases or people who are going to hit crisis in next 12 months)
- Review arrangements for providing adult social care input to multi-agency multi-disciplinary discussions
- Work with system partners to broaden the ambition in relation to intermediate care, by developing understanding of service models that work. For example:
  - Arrangements for providing an urgent social care response to avoid admission to hospital
  - A reablement service that is targeted at reducing admissions to hospital and maintaining independence in people's homes, that is available to everyone to support short- and long-term assessment and care planning
- Review ASC's prevention role in relation to advanced care planning.
- Consider how people in receipt of Direct Payments can use these payments for broader preventative activity including use of equipment

Implementation

We will engage with adult social care colleagues and system partners to develop the implementation plan for this strategy. We are committed to work with people drawing on adult social care, carers and people who may have future care needs. This will inform the development of the implementation arrangements that will be put in place to deliver this strategy and where appropriate these will complement other existing arrangements. A steering group will be established to drive and have oversight the monitoring and evaluation framework that will manage the implementation and enable adjustments to be made as progress is made.

Appendices

Appendix 1: Service Mapping
Appendix 2: Older People: Summary of GCC's Strategic Current Position
Appendix 3: Glossary

Appendix 1: Service Mapping

GCC Initiatives that contribute to preventing, reducing and delaying older people's need for care and support (includes initiatives, ways of working and commissioned/grant funded initiatives)

For more information on prevention duties see: Care and support statutory guidance - GOV.UK (www.gov.uk), Section 2 : Preventing, reducing or delaying needs and Prevention in social care - SCIE)

Type of prevention Making the Difference Tier	**Prevent – primary prevention/promote wellbeing – for all older people to avoid the need for care and support developing** **Tier 1: Something for everyone**	**Reduce: secondary prevention/early intervention for people at risk of developing care and support needs** **Tier 2: A bit more while it's needed**	**Delay – tertiary prevention/formal intervention for older people with established complex health, wellbeing and mental health conditions** **Tier 3: More help for fewer people**	**Initiatives that fall into more than one type of prevention**

Adult Social Care
 	
(including Integrated Commissioning initiatives jointly developed between ASC and NHS, Better Care Funded initiatives)
	• Accessible housing register
	• Thriving Communities Grants (including activities to reduce loneliness or isolation)
	• Know Your Patch Networks
	• Advice and information: Your Circle website for activities that promote healthy & active lifestyles and reduce loneliness and social isolation
	• Digi-Hubs – localised provision of basic IT/digi-skills to those who can't/won't use tech
		• GCC Help Desk which can provide:
		  ○ Fast track equipment
		  ○ Signpost to Glos Carers Hub
		  ○ OT Referrals to GHC
		• Enablement Team
		• Technology and equipment for the home: Telecare (Pendant Alarm, Sensors)
		
		Housing Health and Care Team
			• Blue Badge
			• The Care Advice Line (information and advice for people planning and paying for care)
			• Dementia Advisors
			• Direct Payments, Personal Assistants
			• Carers Breaks
			• Funding for safe lifting equipment for Telecare Responder Service
			• Home Clean Up Service – Pilot using ADF funding
			• GCC Day Centres which also offer respite (Tewkesbury DC, Prestbury DC, Foxes Bridge DC)
				All types of prevention:
				• Housing Health and Care Team system role in the Gloucestershire Housing Partnership and Housing Health and Care in Partnership (HHCiP)
				• Your Circle Website
				• Gloucestershire Care and Support Guide
				
				Secondary and Tertiary Prevention:
				• Online financial assessment (not submitted)
				• Care Navigators
				• Trusted Assessors in Acute Hospital
				• Locality Teams Making the Difference 3 conversation

	• Tech Enabled Care Service – new provider will be looking at proactive and reactive measures	• Refresh Housing with Care Strategy 2020 (Winter 24/25) • Home Adaptations, Disabled Facilities Grant (includes several initiatives to improve the pathway & reduce waits) • Pooled budget arrangement: DFG flexibilities, social care capital, community grants • Specialist Housing OT to support DFGs • Reducing fuel poverty projects • Homeshare (with Age UK Glos) • Role in Discharge Hub • Trusted Assessors in Care Homes	• Falls Prevention and Response Programme in Care Homes • Commissioned services: extra care housing, care homes	model, Huddles, Multi-disciplinary team working with primary care, Discharge Hub, Audit arrangements • Gloucestershire Carers Hub • Carers Emergency Service • Advocacy Service (POhWER) • Crossroads Hospital to Home Service/Age UK Out of Hospital Service • Great Western Court • Home First/Reablement Service • Gloucestershire Equipment Loan Service • Occupational Therapy Service • Complex Care at Home Service • Community Catalysts - Development of Micro-enterprises • Domiciliary care • Adult Safeguarding • Quality Board
Public Health and Communities	• NHS Health Checks for people 40-74, inc. signs of dementia if ≥65 • Go Volunteer Glos – volunteering portal	• Glos Mental Wellbeing Helpline • Glos Support After Suicide Service • Community and Accommodation-based Support Services • Drug and Alcohol Recovery Service • Domestic Abuse Services • Oral Health • Nutrition	• Community and accommodation-based Support	Primary and secondary prevention Healthy Lifestyles Service: stop smoking, increase physical activity, reduce alcohol consumption, weight management. Contribution to the ‘we can move’ physical activity system enabling programme
Wider GCC Services	• Adult Education • Library Services (including digital literacy	• Age and disability related bus passes	• GFRS Responder Service	All levels of prevention • Complaints Team • Communications Team

	initiatives, Library of Things, The Library Choir, The Lab) • Transport (The Robin bookable bus service) • Trading Standards (Enforcement Policy) • Coroners and Registration Service	• GFRS Safe and Well Checks		• Legal Services? • Environment/planning?

Acronyms: DFG- Disabled Facilities Grant, GCC – Gloucestershire County Council, GFRS – Gloucestershire Fire and Rescue Service, GHC – Gloucestershire Health and Care NHS Foundation Trust, OT – Occupational Therapy

Appendix 2: Older People: Summary of GCC's Strategic Current Position

This table lists the strategic developments in place and underway both within Adult Social Care and the wider ICS that are particularly relevant to this strategy.

Table: Older People: Summary of GCC's Strategic Current Position[46]

<table>
<tr>
<td>Adult Social Care Strategies
• Technology Strategy
• Data and Intelligence Strategy

Strategies in development
• Quality Strategy (draft)
• Ageing Well/Older People Strategy
• Living Well Strategy
• Integrated Equipment</td>
<td>Adult Social Care CQC Self-Assessment
Developments planned:
• Prevention Strategy (older people, working age adults)
• Review of Making the Difference Model
• Review of Occupational Therapy Services
• Review of Inhouse Services
• Development of Care Navigator Model
• Fairer Contributions Policy implementation
• Implementation of TEC Service
• Delivery of a Care Home Capital Project
• Development of a Quality Assurance Framework for whole care provider market</td>
</tr>
<tr>
<td colspan="2">Adult Social Care Market Position Statement
System challenges identified:
• supporting independence
• focussing on rehabilitation, recovery and reablement
• creating flexible and sustainable long-term support
• appropriate housing</td>
</tr>
</table>

[46] Sources:
Adults Data & Intelligence Strategy 2023 (accessed 5/8/24)
Adult Social Care Technology Strategy FINAL.pdf (gloucestershire.gov.uk) (accessed 15/8/24)
CQC assessment of Gloucestershire Adult Social Care | Gloucestershire County Council(accessed 6/8/24)
Dementia Strategy_October23 FINAL.pdf (gloucestershire.gov.uk) (accessed 5/8/24)
End-of-Life-StrategyFinal_22pdf.pdf (nhsglos.nhs.uk) (accessed 5/8/24)
FrailtyStrategy_FINALOct22.pdf (nhsglos.nhs.uk) (accessed 5/8/24)
Making the Difference Model: About Gloucestershire and its population (accessed 6/8/24)
Gloucestershire VCS Alliance/One Gloucestershire Memorandum of Understanding (accessed 15/8/24)

• working in partnership across the system	

One Gloucestershire (ICS with GCC as a partner) Strategies
• Interim Integrated Care Strategy – including focus on prevention and health equity
• Gloucestershire Health and Wellbeing Strategy
• Gloucestershire VCSE Alliance /One Gloucestershire Memorandum of Understanding
• Frailty Strategy
• Dementia Strategy
• Palliative and End of Life Strategy
	One Gloucestershire (ICS with GCC as a partner) Developments
	• Working as One Programme
	• Personalised Care Programme
	• Population Health Management Programme
	• Housing with Care Strategy (update in development)
	• Unpaid Carers Strategy
	• Implementation of Integrated Neighbourhood Teams
	• Ageing Well Programme
	  ○ Proactive Care Strategic Plan (draft)
	  ○ Providing proactive care for people living in care homes – Enhanced health in care home framework[47]
	• Review and implementation of Social Prescribing Model
	• Implementation of Joining Up Your Information 2 (JUYI2)
	• Virtual Wards

Appendix 3: Glossary

Anchor Organisations	Anchor organisations are large organisations that are unlikely to relocate and have a significant stake in their local area. They have sizeable assets that can be used to support their local community's health and wellbeing and tack health inequalities.
ConnectED	The ConnectED programme is an initiative funded by the National Institute for Health and Care Research (NIHR). It aims to enhance decision-making in Adult Social Care by increasing the capacity to use research effectively. This programme is part of NIHR's broader efforts to link evidence to decision-making, ensuring that research findings are actively integrated into practical applications.
CQC	Care Quality Commission
CPD	Continuing Professional Development
DHSC	Department of Health and Social Care

[47] Providing proactive care for people living in care homes – Enhanced health in care home framework, Nov 2023 NHS England » Providing proactive care for people living in care homes – Enhanced health in care homes framework (Accessed 8/8/24)

Frailty	Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves
GCC	Gloucestershire County Council
ICB	Integrated Care Board
ICS	Integrated Care System. For more information visit One Gloucestershire
INT	Integrated Neighbourhood Team: these aim to provide proactive, personalised, coordinated, holistic multidisciplinary care for people with more complex needs for a neighbourhood. In Gloucestershire these are being developed on the Primary Care Network footprint.
Intersectionality	Intersectionality is a concept that describes how different social categories like race, gender, class, and others overlap and interact to create unique experiences of discrimination or privilege.
Know Your Patch	Know Your Patch builds networks for those working with individuals and groups to help people stay independent for longer and to lead full and happier lives. There is a network of organisations in each district in Gloucestershire.
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning
NIHR	National Institute for Health and Care Research
Personalised Care	Personalised care means that people have choice and control over the way their care is planned and delivered. It is based on 'what matters to them and their individual strengths and needs (source: NHS England » Comprehensive model of personalised care)
PHM	Population Health Management Population health management is an intelligence driven approach which supports evidence-based decision making at all levels of an integrated care system. Its fundamental ingredients are linked data assets, system-wide analytical capabilities, widespread cultural adoption and leadership, a constant cyclical review of impact, system planning and evaluation. A PHM approach applies to individual interactions, enabling care professionals and patients alike to access and link key information and identify more readily need, capacity to benefit and pathway eligibility (primary use) as well as to whole population analysis where it helps identify key factors like health needs, epidemiological trends, health inequalities and support evidence based strategic priority setting (secondary use) (One Gloucestershire, ICS Strategy 2022).
PCN	Primary Care Networks are made up of a group of GP practices working together, in partnership with community, mental health,

	social care, pharmacy, hospital and voluntary services in their local area.
Proactive Care	Proactive care is personalised and co-ordinated multi-professional support and interventions for people living with complex needs. It aims to improve health outcomes and patient experience by: - Delaying the onset of health deterioration where possible - Maintaining independent living - Reducing avoidable exacerbations of ill health, thereby reducing use of unplanned care The national guidance prioritises providing care and support for people living at home with moderate or severe frailty[48] Source: NHS England » Proactive care
QI	Quality Improvement
QSIR	Quality, Service Improvement and Service Redesign
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment. The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. These recommendations are created through conversations between a person, their families, and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment.
SCIE	Social Care Institute for Excellence
VCSE	Voluntary Community and Social Enterprise
Virtual Wards	Virtual wards allow patients to get hospital level care at home safely and in familiar surroundings, helping speed up their recovery while freeing up hospital beds for patients that need them most. Source: NHS England » What is a virtual ward?
What Matters To Me (WMTM)	The 'What Matters to Me' project, part of the One Gloucestershire Personalised Care Programme, promotes a universal personalised care approach. It fosters equal partnerships between health professionals and individuals, focusing on 'what matters' conversations to plan and deliver care based on personal needs and preferences. This information is recorded in accessible care plans within the 'What Matters to Me' (Orange) Folder for those with complex/long-term conditions. The ICS workforce will be trained in personalised care competencies, including Coaching and Motivational Interviewing. The project also integrates signposting to self-management tools, social prescribing, digital technology, and Personal Health/Wellbeing Budgets.

[48] Proactive Care: Providing care and support for people living at home with moderate or severe frailty, Dec 2023, NHS England » Proactive care (Accessed 2/8/24)