IASC/24/12
Health and Adult Care Scrutiny Committee
23 September 2024

Our role and approach on prevention and what Elected Members can do

Report of the Director of Integrated Adult Social Care and the Director of Public Health and Communities

Please note that the following recommendations are subject to consideration and determination by the Committee before taking effect.

1) Recommendation

That Committee be asked to:

(a) note the content of the report and the Integrated Adult social Care and Public Health approach to prevention
(b) recommend to Cabinet that prevention is a priority of the Council
(c) consider the questions within the LGA Elected Members guide on prevention as part of its on-going work on prevention (see appendix 1)
(d) use their roles in their communities, including through any wider roles in district, town and parish councils to support the prevention activity
(e) request that officers return in a year with an update and progress report to the new committee

2) Introduction

In the latest annual report of the Director of Public Health for Devon, 'Health in An Ageing Devon', the changing demographics of Devon are set out in more detail over the next 20 years. It is this timeframe that we need to start considering what our preventative action needs to be, and to have impact across.

This report sets out the Integrated Adult social Care and Public Health approach to prevention, the importance of getting it right and given the demographic and wider pressures we face. This report sets out the importance of embedding prevention within and across the strategies and everyday activities and services of all levels of local government, and our collective partners, so together we can create a healthier, more resilient society and reduce the long-term demand for care services by helping people to stay healthier and more independent for longer. Case study examples of this taken from the 'Health in An Ageing Devon are provided in appendix 2.

This report, and the on-going prevention conversation with the Health and Adult Care Scrutiny Committee, including the recent LGA Prevention Workshop, is providing the opportunity to reset our collective approach to prevention and ensure a collegiate and strategic response.

In section 7 of the report there are assessments provided on the return on investment on a range of preventative measures. These should not be viewed as savings opportunity, but as ways of reducing the impact of the increasing number and complexity of people accessing adult social care and health services. The return on investment figures are general figures and work will need to take place locally to understand how they translate to Devon.

2.1 Defining prevention

Primary prevention: Taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risk factors and their causes or by targeting high-risk groups e.g. vaccination, smoking cessation, cycle paths and walkways to encourage exercise, travel training for people with a learning disability, and information to keep young people safe on social media.

Secondary prevention: Systematically detecting the early stages of disease through screening and intervening early before full symptoms development. Supporting younger people and those approaching adulthood to learn skills for independence in adulthood.

Tertiary prevention: Softening the impact of ongoing illness or injury that has lasting effects**.** This is done by helping people manage long-term, often complex health, emotional and psychological challenges in order to improve as much as possible quality of life and life expectancy e.g. initiatives to help people with long term mental health conditions retain or enter employment, trauma informed support including helping manage challenging and harmful behaviours, support for carers and people with dementia, and reablement and rehabilitation services to help people return to their homes after a period in hospital.

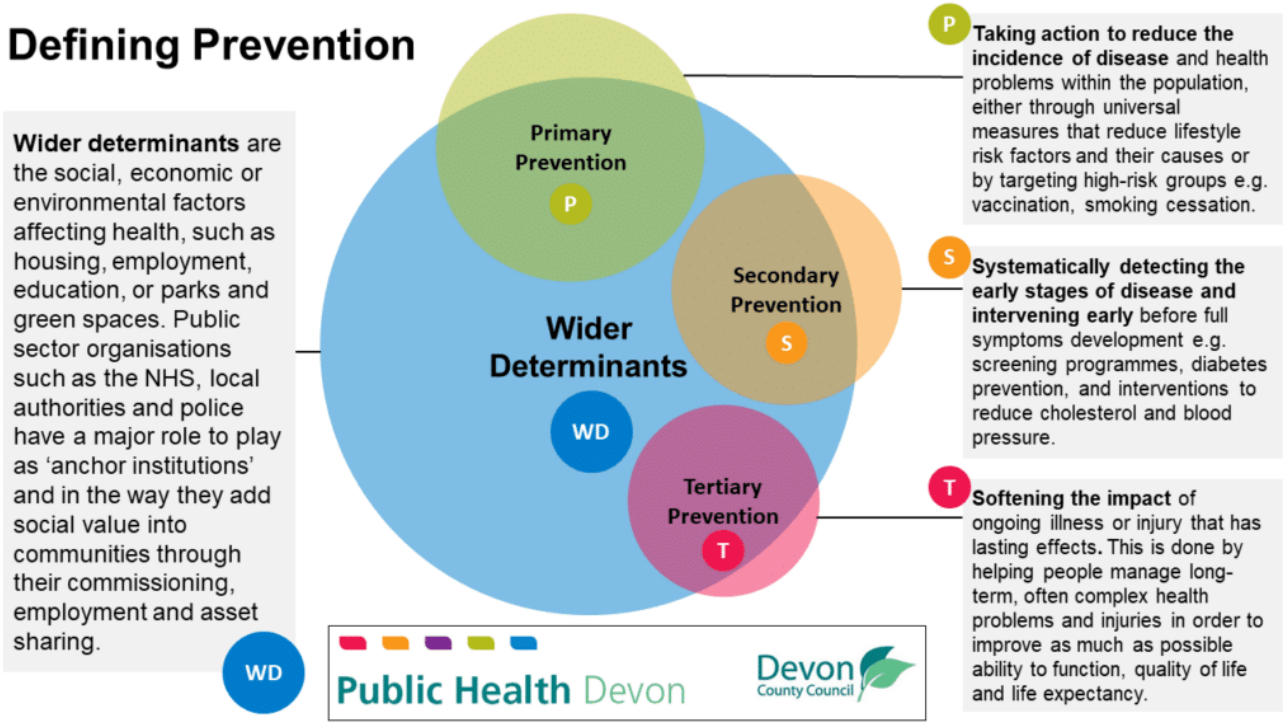

Diagram 1: defining prevention

All three of these types of prevention sit within the context of the wider determinants of health, by this we mean the social, economic or environmental factors affecting health, such as housing, employment, education, or parks and green spaces. The things that 'anchor institutions' such as all tiers of government, all NHS organisations, the police and education providers contribute to significantly. The diagram below demonstrates how prevention activity maps across Public Health and Adult Social Care.

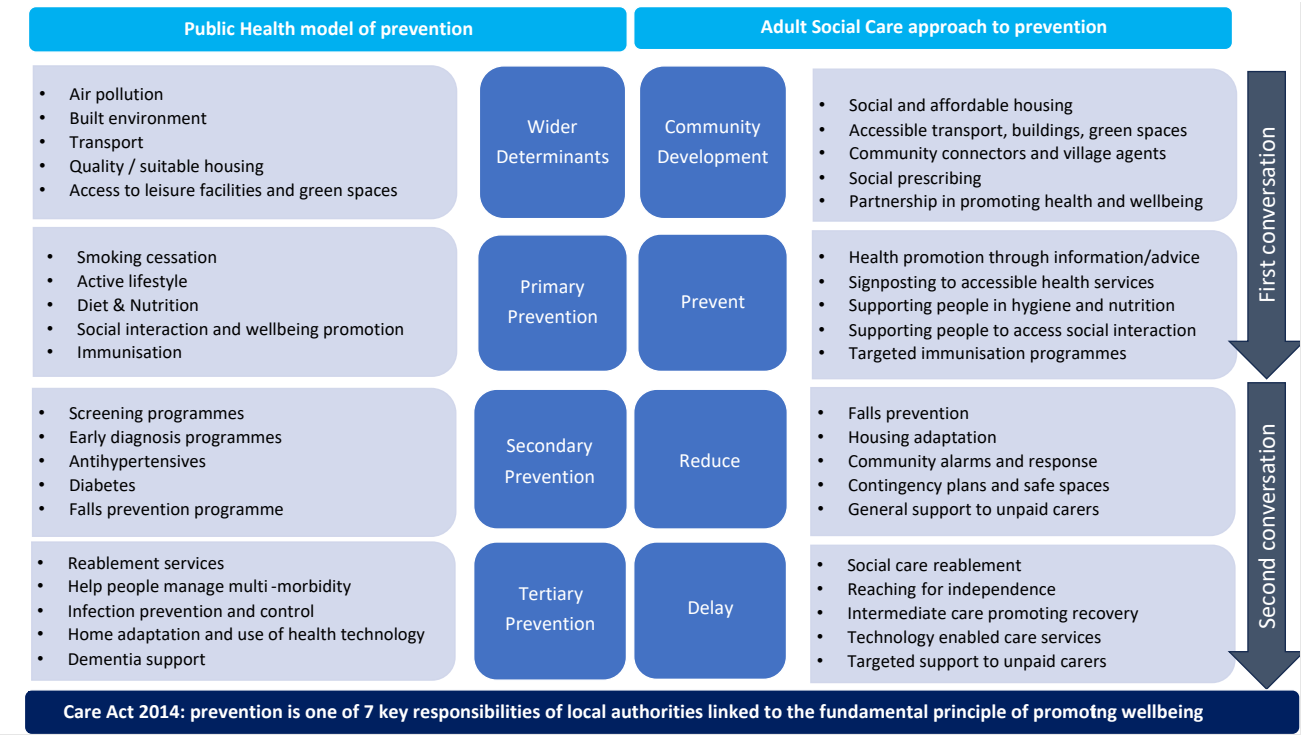

Diagram 2: models and approaches to prevention across public health and adult social care

Appendix 3 provides projections from the Annual Public Health Report 2024 dashboard illustrates the underlying trend in health conditions in older people without preventative interventions

3) Main Body

3.1 Prevention in Public Health

Public Health core prevention duties encompass a range of responsibilities aimed at improving population health and reducing health inequalities. Public Health activity addresses both immediate health concerns and the underlying factors contributing to long-term health and wellbeing. Public Health duties include:

- **Health Improvement**: Promoting healthier lifestyles and behaviours among the population, such as initiatives to reduce smoking, obesity, and substance misuse.
- **Health Protection**: Ensuring robust measures are in place to protect the population from infectious diseases and environmental hazards, including vaccination programmes and response plans for health emergencies.

- **Healthcare Public Health**: Supporting healthcare services by providing evidence-based information and analysis to improve health outcomes, manage demand, and ensure effective service delivery.
- **Wider Determinants of Health**: Addressing factors that influence health and wellbeing, such as housing, employment, education, and social connections.
- **Reducing Health Inequalities**: Implementing targeted interventions to reduce disparities in health outcomes between different population groups and communities.
- **Data and Intelligence:** Collecting, analysing, and utilising health data to inform public health policy, planning, and practice.
- **Commissioning and Delivery:** Planning and commissioning effective public health services, ensuring they meet local needs and are delivered efficiently.

3.2 Prevention in Adult Social Care

Through the Care Act 2014, local authorities are required to take steps to prevent, reduce, or delay the need for care and support. Those steps span across the definitions above and include:

- **Information and advice:** Providing comprehensive and accessible information and advice about how people can stay well, healthy, active and employed. And for younger people particularly, to support to help them have agency in their life and future
- **Early Intervention**: Identifying individuals at risk of developing care needs early and providing timely support to prevent escalation. Supporting young people with various diagnosis or trauma, and their families, through coping strategies and targeted therapeutic and emotional support to build life-long resilience
- **Community engagement**: Working with local communities to identify and utilise existing resources, facilities, and voluntary groups that can support individuals.
- **Providing preventive services**: Offering services that help people maintain their independence and wellbeing such as reablement services after a hospital stay.

In doing this local authorities must:

- **Assess community needs**: We do this through the Joint Strategic Needs Assessment, and the annual reports of the Director of Public Health
- **Collaborate with partners**: We work with other organisations in many ways including through Local Care Partnerships, through joint strategies like the Joint Forward Plan, and with the VCSE, including through the VCSE Assembly and the new civic agreement, all to provide a coordinated approach to prevention and community resilience.
- **Promote wellbeing**: We ensure that all care and support activities focus on improving the wellbeing of individuals.
- **Be person centred**: We ensure that the individual is at the heart of everything we do and that we are responsive to their specific circumstances and aspirations, enhancing their quality of life and well-being

Although the Care Act is adult social care legislation, responsibility for local delivery spans the whole council. This is acknowledged through the CQC Inspection Framework of local authorities Care Act Part 1 duties.

As described in the introduction, prevention activity takes place beyond IASC and PH, the following sections provides an indication of that activity.

3.3 Prevention across our local government partners and partnerships

District local authorities play a crucial role in prevention, particular on the wider determinants of health, by implementing measures to reduce the need for more intensive care and support services, this includes:

- **Health promotion**: District councils often provide leisure and recreational open spaces and may offer programs to promote healthy lifestyles, such as exercise classes, and healthy eating initiatives.
- **Housing and environment**: Ensuring safe and healthy living conditions through housing inspections, appropriate housing as a way of preventing, reducing and delay adult social care needs. Environmental health services undertake inspections and run initiatives to reduce pollution and ensure food safety and infectious disease control
- **Community engagement**: Working with local communities to identify needs and provide support through local resources, facilities, and voluntary groups.
- **Early Intervention**: Identifying individuals at risk of developing care needs early and providing timely support to prevent escalation.

There is also a significant role for Town and Parish Councils, as the first tier of local government and those closest to the neighbourhoods and communities we all serve.

3.4 How we work with NHS organisations on prevention

The NHS and local authorities collaborate to provide a comprehensive approach to population health, addressing both clinical needs and the broader factors influencing health and wellbeing. The NHS has a responsibility for inclusion health and to address health inequalities in terms of access, experience and outcomes.

The Council is committed to working as a partner of Local Care Partnerships where work with the NHS and wider partners on prevention comes together at a place level.

The NHS has a clinical and individual-focused approach but works with local authorities and partners to take a broader, community-oriented perspective. Community Prevention activities include:

- **Vaccination Programmes and Campaigns**: Administering vaccines to prevent diseases such as influenza, measles, mumps, rubella, and COVID-19.
- **Cancer Screening**: Providing routine screening for early detection of cancers
- Delivering Public Health funded services such as NHS Health Checks, Sexual Health Services and commissioned PH services in Primary care such as shared care

- **Smoking Cessation Programmes**: Offering support services, nicotine replacement therapies, and counselling to help individuals quit smoking in NHS settings.
- **Mental Health Support**: Offering preventative mental health services which may include trauma support, bereavement support, counselling, and early intervention services for mental health conditions and social prescribing
- **Health related Campaigns**: Supporting national and local campaigns to promote health and wellbeing relating

These activities are designed to prevent illnesses, manage risk factors, and promote healthier living, ultimately reducing the demand on healthcare services and improving population health.

3.5 Why more people are seeking care and support

Older people aged 65+:

- A more aged and rapidly ageing population than nationally with growing levels of frailty and dementia.
- Specifically, a forecast increase in people aged over 85 in Devon of 60% by 2040.
- When 85 is the average age at which older people begin to receive adult social care support.
- Service costs rising more rapidly than elsewhere, especially for older people.
- High levels of social isolation resulting in loneliness among older people and their carers exacerbated by the pandemic.
- A sparse and predominantly rural population with patterns of hidden and hard-to-reach deprivation.
- Significant inequalities in healthy life expectancy between the most and least deprived parts of the county.
- Improvements in health-related behaviours in younger age groups not mirrored by older generations.
- A working age population that is not growing at the same rate as the non-working population, this means a growing lack of capacity to provide care for those who need it, and a reducing tax base to pay for it.

Working aged adults aged 18-64:

- Although the working age population is growing more slowly, extending life expectancy and increasing complexity of need of people with learning and physical disabilities, means we are working with younger adults for longer, and more intensely, and they represent a larger proportion of the people we support.
- Parent-carers dying or becoming incapable of supporting their adult children with disabilities.
- The growing number of people with long-term conditions with sometimes insufficient capacity to address.
- A changing profile of mental health needs including growth in demand from autistic people.
- More younger adults being served than is typical, especially those with learning disabilities.

- A disparity between the quality of indoor and outdoor environments in Devon.
- Incomes lower than the national average, house prices higher, and housing quality variable.
- Changes in the benefits system having unforeseen consequences, exacerbated in rural areas.
- The growing number of people with often multiple unpaid caring responsibilities.

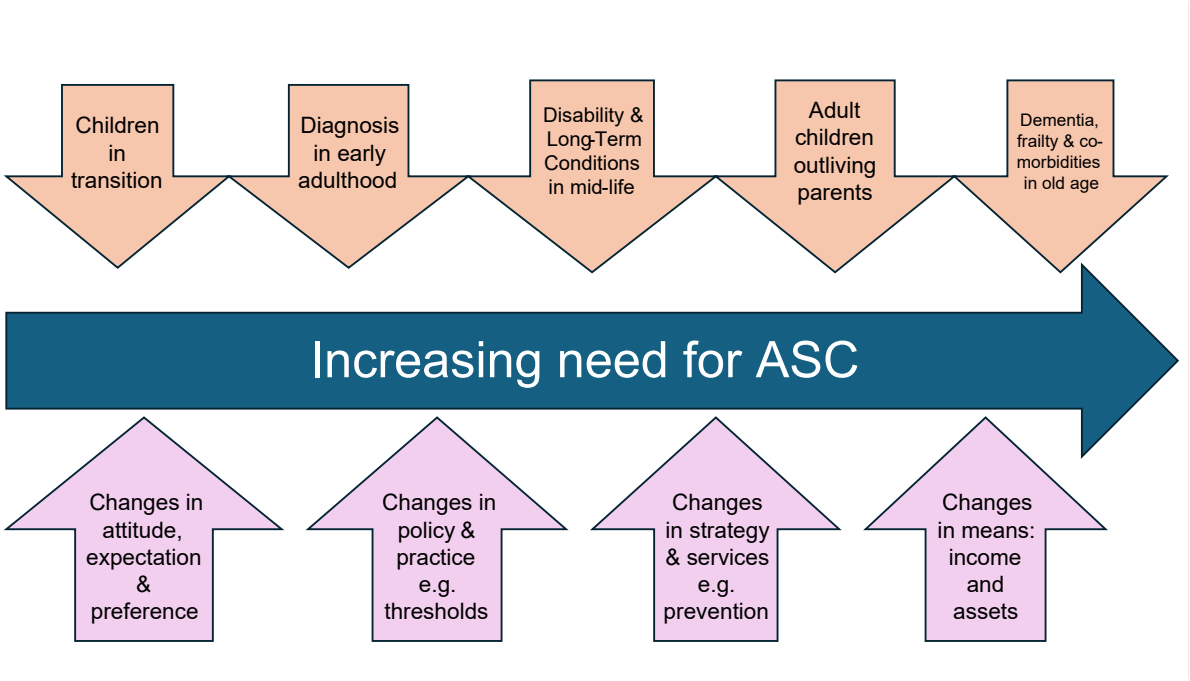

Diagram 3: summary of reasons for increasing need for ASC

3.6 The IASC strategic approach to prevention

In 2023 we refresh and published our Promoting Independence vision and strategies. Our vision and strategies are a response to most people telling us that what matters to them is to stay living safely at home in their community, surrounded by their family and friends, where they can retain as much of their independence as possible for as long as possible, living the life they want to lead by doing what matters to them

Our vision and the aims, outcomes and priorities are developed in our strategies:

'Living Well in Devon' focuses on people of working age with a learning disability, autistic people, those with mental health needs and/or physical or sensory disabilities and aims to maximise their capacity for independent living.

'Ageing Well in Devon' focuses on the needs of people as they get older to sustain their capacity, including interventions that prevent, delay and reduce care needs.

'Caring Well in Devon' focuses on unpaid carers who look after a partner, family member, or friend.

What this means in practice is the way in which people are best supported depends on their needs and circumstances. For most people, our universal offer comprises information and advice and community development. For those on the edge of care, we target preventive approaches to avoid, delay and reduce the need for ongoing support. For some, this will mean providing them with short-term services following a crisis to help them recover, rehabilitate and be re-abled. And for a few, we provide ongoing care and support to meet their long-term needs. In delivering this, our skilled workforce is guided by the 3 conversations approach set out in section 3.8.

3.7 Prevention models and approaches across Adult Social Care

Previous changes to our operating model brought together the Care Direct service that responded to first contacts from the public and the Care Direct Plus service that conducted phone-based assessments and reviews, co-located with arranging support and safeguarding functions.

Our integrated Community Health and Social Care Teams that undertake work with people with more complex needs face-to-face remain embedded in local communities. These arrangements are intended to:

- Ensure staff with professional and local knowledge are responding to people's needs at first contact.
- Put more emphasis on information and advice, signposting, strength-based support in the person's network and community, and short-term interventions as solutions.
- Prevent, delay and reduce the development and escalation of needs that may limit people's independence and require on-going support.
- Reduce the number of hand-offs experienced by people making contact and needing an assessment for the first time.
- Enable the recording and tracking of contacts such that a history of interventions can be maintained, and their effectiveness assessed.

The public wishing to access information and advice about adult social care and our staff supporting them are supported by a number of online resources.

Equipment and adaptations are fundamental to delivering on our vision. There are an estimated 90,000 people in Devon currently benefiting from community equipment. They are being supported to live independently and safely in their own home using the least intrusive forms of support appropriate to their needs. Community equipment is an important element of our promoting independence approach and vision. Features of our offer include:

- The use of a wide range of Technology Enabled Care Services.
- The wider use of apps and smart technology.
- Promotion of aids and adaptations through our Independent Living Centre.
- Provision of equipment via the Devon Independent Living Integrated Service through our provider Millbrook Healthcare.

- Disabled Facilities Grants are delivered jointly with District Councils through the Better Care Fund.

We have developed our short-term services offer with the NHS, focussed on:

- Rehabilitation, Reablement and Recovery for those who experience a health-related crisis.
- Avoidance of admissions into hospital.
- Supported discharge from hospital.
- Preventing, delaying and reducing the escalation of care needs.
- Enabling people to gain the skills knowledge and confidence they need to maximise their independence.

We continue to deliver adult social care provision where we believe the market is less able to do so (primarily these short-term interventions that prevent, delay and reduce the need for ongoing support) including:

- Reaching for Independence services to help people develop their capacity to live independently.
- Social Care Reablement services to help people recover from crises or periods in hospital.
- Respite care for people with learning disabilities.
- Specialist residential care for people with dementia.

All the regulated services that Devon operates are currently rated Good or Outstanding by the Care Quality Commission.

3.8 The 3 conversations approach

Nobody has an ambition to draw on adult social care support, but it absolutely needs to be available when people need it. We always start from the position that people want to be supported to be as independent as possible in their communities; our promoting independence approach is explicit about this.

The 3 Conversations approach in adult social care is a strengths-based model designed to transform the way professionals interact with individuals needing support. It focuses on building relationships and finding solutions that promote independence and well-being. The approach emphasises collaboration, personalisation, and the use of community resources to support individuals in leading fulfilling lives.

The 3 Conversations approach is a collaborative approach, and success is dependant on a range of factors across a range of organisations. Critical to success is an understanding of the approach and a willingness of the people we work with, their unpaid carers, and their families to embrace it. The approach is also dependent on a strong, vibrant and diverse community offer accessible to all.

Conversation 1: **Preventative conversations**
Providing advice and information including of TECS and equipment, carer support and other ideas that can prevent or reduce the need for care and support in the future. They should be solution-focused, compassionate and empowering and be 75% of IASC conversations

Conversation 2: **Empowering conversations**
Offering short-term or one-off interventions or support such as Reaching for Independence or Social Care Reablement, that can help people reconnect with their community and achieve their goals. They should involve goal setting, reviewing progress and thinking TECS first. The empowering conversation should be 20% of IASC conversations

Conversation 3: **Enabling conversations**
Undertaking Care Act assessments, determining eligibility, considering fair and affordable care, least restrictive options and involving providers and networks. They should also revisit preventative and enabling conversations to maintain or regain independence and monitor goals. The enabling conversation should be 5% of IASC conversations

3.9 How we are doing

The following section is adapted from the Integrated Adult Social Care self-assessment document, produce as part of the our preparations for CQC inspection.

What we can be proud of:

- Our overall satisfaction ratings for service users and their quality-of-life indicator based on survey questions about their lived experience were among the best in the country, ranking 11/152 and 27/152 respectively, with recent data indicating this performance will also be sustained.
- Our workforce has embraced the 3 conversations model and is making progress and innovating

What we are concerned about:

- Financial sustainability, with the cost-of-living crisis impacting on people who use our services and their carers; people who might become vulnerable; the viability of our providers; and county council budgets.
- Hospital discharge and system flow, with delays sometimes due to lack of capacity in community-based health and care services, which can mean people don’t get the right care at the right place at the right time to optimise their recovery.
- Working across the council and its partners to address the social isolation of carers, with its impact on their wellbeing highlighted in recent surveys as being of particular concern, especially in rural areas, despite higher than average access to carers’ breaks.
- Demand pressures from those aged 18-64, with activity levels higher in Devon than elsewhere, and market costs rising more rapidly than is typical, especially for services to older people, both residential and community based.

- Operational waiting lists for assessments and reviews, for financial assessment, and for Deprivation of Liberty Safeguards assessments with our own capacity constrained, demand increasing, and people's circumstances changing more frequently.

The challenges ahead:

- Delivering on our 'Promoting Independence' vision and 'Living Well', 'Ageing Well', and 'Caring Well' strategies including maintaining people at home and not in hospital or a care home wherever possible.
- Living up to the vision that people should be supported to live their best possible life in the place they call home, with the people and things they love, in communities where people look out for each other, doing what matters to them and be independent, informed, secure, and connected.
- Managing within a budget that while increasing is under pressure from rising demand, increasing costs and complexity, insufficient supply, cost of living pressures, and some reducing national funding streams for ASC

In general, there are limitations on evidencing how successful specific prevention activity has been within a complex and multifaceted set of approaches delivered by many partners. Where we do have evidence, it is limited to a specific cohort of people and a very narrow focus e.g.. older people leaving hospital, remaining at home and not requiring further services. There is also performance data on people accessing information about support.

Information has been provided in appendix 4 setting out our comparative performance within the Adult Social Care Outcomes Framework on:

- Proportion of older people who receive reablement/rehabilitation services after discharge from hospital
- Proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
- The outcome of short-term services: sequel to service
- Proportion of people who use services who find it easy to find information about support
- Proportion of carers who use services who find it easy to find information about support

And within the Public Health Report 2024 dashboard on:

- Falls prevention for people aged over 65
- Health Checks for people aged 40-74
- Dementia diagnosis

3.10 Recommendations:

That Committee be asked to:

(a) note the content of the report and the Council approach to prevention
(b) recommend to Cabinet that prevention is a priority of the Council

(c) recommend to the new Health and Adult Care Scrutiny Committee post May 2025 that prevention is a key work programme item, continuing the work of the current committee
(d) consider the questions within the LGA Elected Members guide on prevention as part of its on-going work on prevention (see appendix 1)
(e) use their roles in their communities, including through any wider roles in district, town and parish councils to support the prevention activity
(f) request that officers return in a year with an update and progress report to the new committee

4) Options / Alternatives

N/A

5) Consultations / Representations / Technical Data

N/A

6) Strategic Plan

Prevention links clearly to the Council's Strategic Plan 2021 – 2025, particularly

- Tackle poverty and inequality (address poverty, health and other inequalities)
- Improve health and wellbeing, including any public health impacts
- Help communities be safe, connected and resilient

7) Financial Considerations

7.1 Impact of managing demand through prevention

There is no signal figure for the return on investment for prevention in general, but the following provides an indication of the impact prevention activity can have in responding to pressure and demand for services. These figures should not be viewed as potential savings that could be achieved, rather potential impact of investment.

The impact also contributes to better quality of life for individuals by promoting independence and reducing the need for more intensive care services. Investing in preventive measures can lead to substantial benefits for individuals, health and care systems, and society as a whole.

Public health prevention: A systematic review on return on investment of public health interventions: found a median return on investment of public health interventions of ~14:1.

For every £1 invested in public health, £14 will subsequently be returned to the wider health and social care economy.

Preventive Home Care and Support Services: Providing early support services, such as home adaptations, community-based care, and assistive technologies, can help individuals remain independent longer and delay the need for more intensive and expensive services like residential care. It has been estimated that for every £1 spent on such preventive measures, there can be around £1.50 to £3.00 reduced healthcare costs and delayed need for residential care (GOV.UK) (The Health Foundation).

Falls Prevention: Falls are a significant issue in adult social care, leading to injuries that often result in hospital admissions and increased care needs. Programmes aimed at preventing falls, including strength and balance training and home hazard assessments, can save £1.68 for every £1 spent. The savings come from reduced hospital admissions and the need for long-term care (GOV.UK).

TECS: The use of technology to monitor health and provide support remotely can also lead to cost savings. For example, telecare systems can help manage chronic conditions more effectively, potentially saving £2 for every £1 spent by reducing emergency admissions and allowing for earlier interventions (GOV.UK).

Reablement Services: These services focus on helping individuals regain skills and confidence to carry out daily activities following a health crisis or hospital stay. Reablement services have been shown to reduce ongoing care needs, with estimates suggesting a return of up to £4.28 for every £1 invested due to decreased demand for long-term home care services (GOV.UK) (The Health Foundation).

8) Legal Considerations

Prevention is a statutory duty for local authorities, towards the whole population, set out in the Care Act.

9) Environmental Impact Considerations (Including Climate Change, Sustainability and Socio-economic)

N/A

10) Equality Considerations

Prevention activity and opportunities need to have equality of access, experience and outcome across all protected characteristics. Prevention activity and opportunities need to work for everyone. Data collection, monitoring and performance reporting across all protected characteristics can support this.

11) Risk Management Considerations

Prevention activity is not sufficiently accessible or impactful to reduce growing demand for adult social care support and funding.

12) Summary / Conclusions / Reasons for Recommendations

This report sets out the Integrated Adult social Care and Public Health approach to prevention, the importance of getting it right and given the demographic and wider pressures we face. This report sets out the importance of embedding prevention within and across the strategies and everyday activities and services of all levels of local government, and our collective partners, so together we can create a healthier, more resilient society and reduce the long-term demand for care services by helping people to stay healthier and more independent for longer.

Name
Tandra Forster, Director of Integrated Adult Social Care

Steve Brown, Director of Public Health and Communities

Electoral Divisions: All

Cabinet Member for Integrated Adult Social Care & Health: Councillor Phil Bullivant

Cabinet Member for Public Health, Communities and Equality: Council Roger Croad

Local Government Act 1972: List of background papers

Background Paper
Date
File Reference

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Appendix 1

The following questions are adapted from the LGA Election members guide on prevention. I've linked to them within the recommendations – but we may want to be explicit in some of these being our recommendations?

1. *How do you know that your council is doing all it can to deliver on prevention?*
2. *Are you satisfied that the prevention strategy or strategies developed through the health and wellbeing board reflect needs identified in the joint strategic needs assessment and include a range of primary, secondary and tertiary prevention measures?*
3. *Does the HWB regularly consider progress on indicators in the Public Health Outcomes Framework and local prevention indicators?*
4. *What action is taken to tackle poor performance?*
5. *What work is taking place to implement the prevention plans of the ICS, and how is your council engaged in this?*
6. *Are all council departments contributing to prevention through their relevant functions?*
7. *What measures are in place to engage with communities to increase their role in prevention?*
8. *What has been done to develop a health in all policies approach?*
9. *Has HiAP been used as a framework for collaborative planning on complex health issues?*
10. *Is there expertise and capacity in public health to support HiAP?*
11. *Are prevention strategies evidence-based and well costed?*
12. *Is there expertise and capacity within public health to advise on health economics to inform investment decisions?*
13. *Is prevention being embedded in your ICS and other integrated arrangements?*

Appendix 2

Case Study: Seachange
Seachange is a charity which provides an inspiring new approach to community support. Working on the basis that good health and happiness are closely linked, offering easy access to practical support for all generations, young and old, within its area of Exmouth, Woodbury and Budleigh Salterton.

Their programme of events is all designed to increase social cohesiveness, reduce isolation, and loneliness whilst improving the health and happiness of our community. They also support other community organisations, such as Launchpad, who provide training for adults with learning challenges in catering and hospitality.

Case Study: CVD Prevention (Devon Integrated Care System)
Public Health Devon is working with the NHS, the Voluntary and Community Social Enterprise (CVSE) sector and community groups to help identify undiagnosed high blood pressure in adults in Devon.

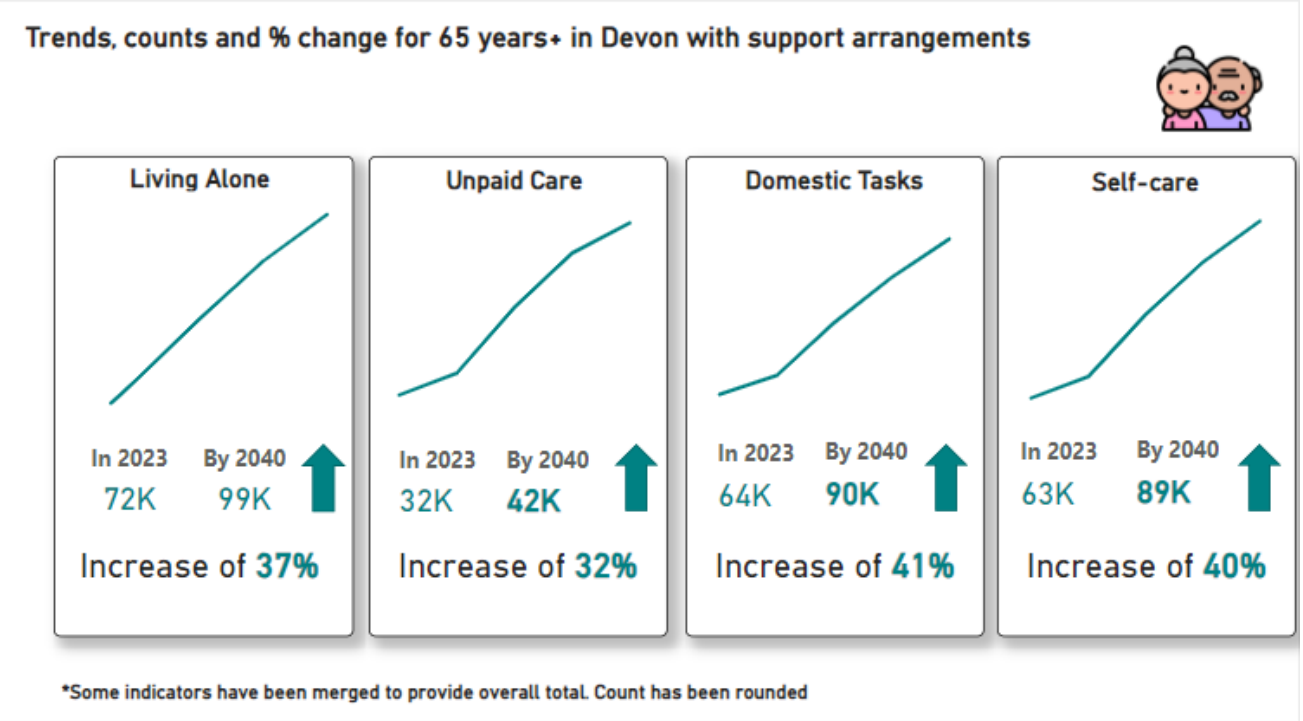
Blood pressure monitoring in community pharmacy settings, followed by home based monitoring, is a high impact intervention to reduce the impact of cardiovascular disease, with the potential to increase the identification of hypertension, reduce the burden on health services and promoting healthier behaviours, saving both the NHS and local authorities money. Furthermore, high cholesterol identification and risk stratification has also been identified as a low-cost intervention, adaptable to local systems, with the potential to save lives, reduce hospital admissions and cut costs.

Case Study: Outreach NHS Health Checks
Outreach health checks, targeted to populations less likely to seek an NHS health check in primary care are being piloted in Devon. Devon PH have partnered with the RDUH Vaccination Outreach Service to test the approach which builds on their learning from the Pandemic.

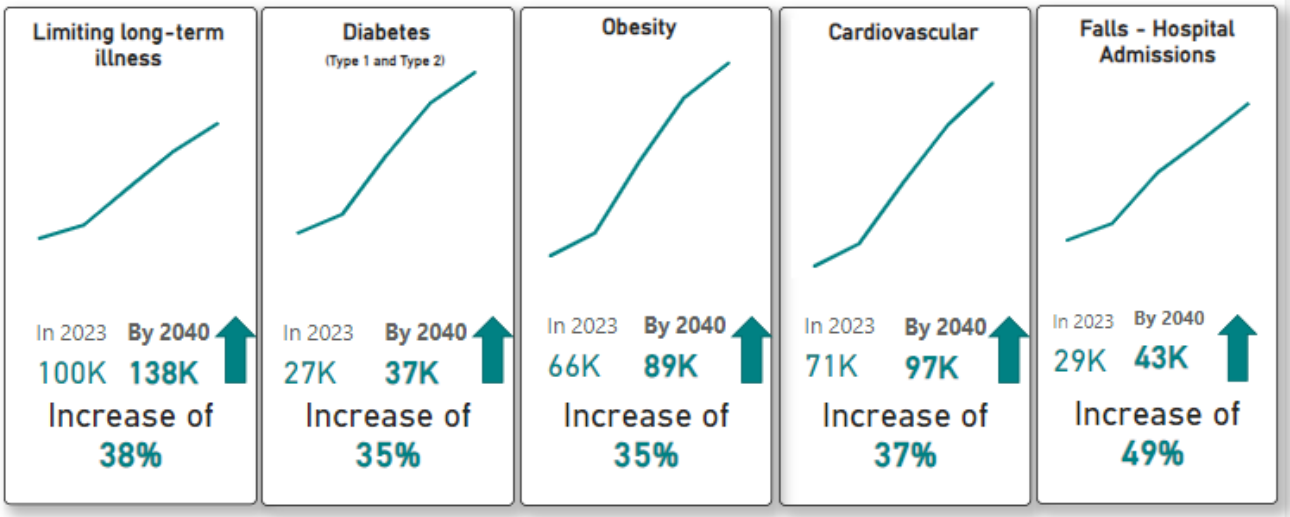
The aim of this work is to narrow health inequalities by improving access to the check which helps people understand their personal CVD risk profile, engage in conversations around what matters most to them and how to seek ongoing support if required.

Appendix 3

Projections from the Annual Public Health Report 2024 dashboard illustrates the underlying trend in health conditions in older people without preventative interventions



Trends, counts and % change for 65 years + in Devon with long term health issues

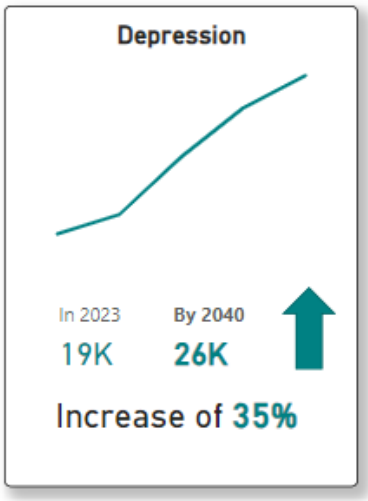


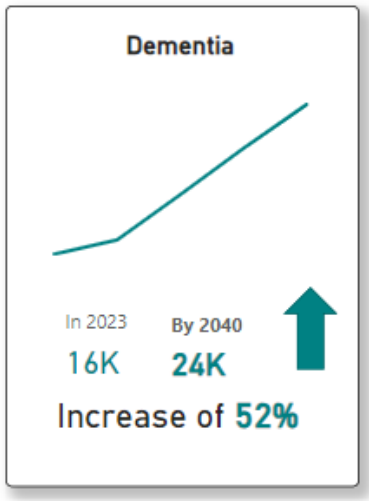
*Some indicators have been merged to provide overall total. Count has been rounded

Trends, counts and % change in 65 years + in Devon for bronchitis, mobility and continence

*Some indicators have been merged to provide overall total. Count has been rounded

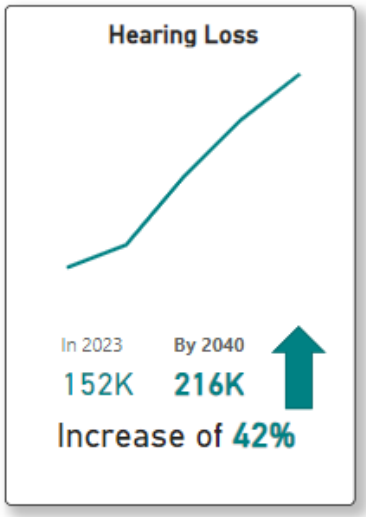
Trends, counts and % change for 60 years + in Devon for mental health and cognitive Impairment

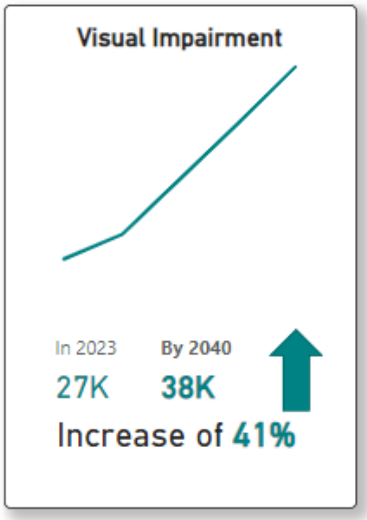




*Some indicators have been merged to provide overall total. Count has been rounded

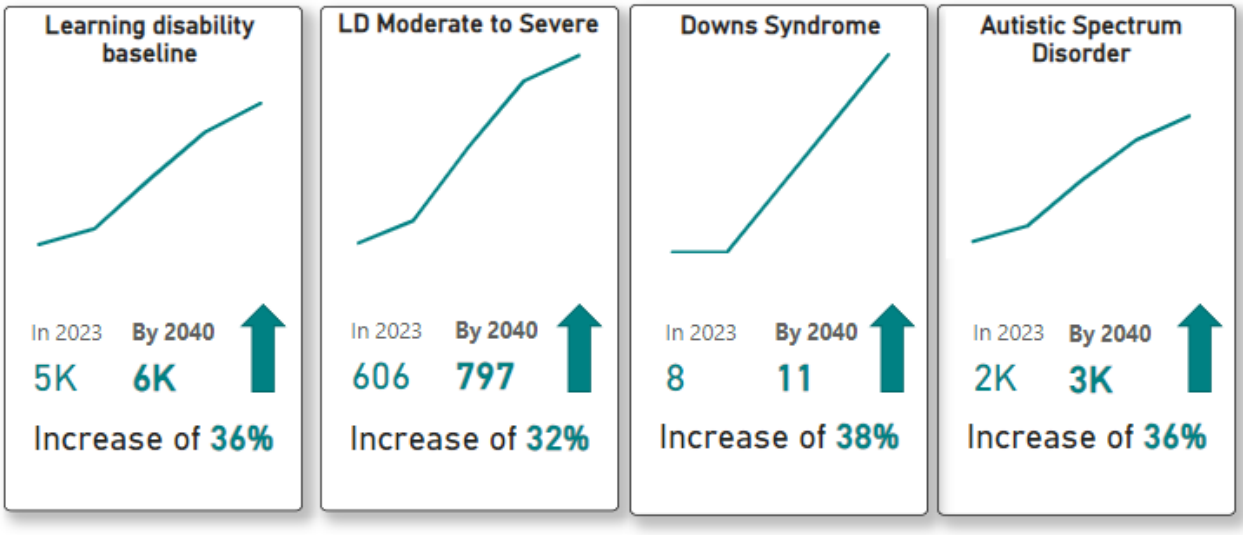
Trends, counts and % change for 60 years+ in Devon for sensory impairment





*Some indicators have been merged to provide overall total. Count has been rounded

Trends, counts and % increase for over 65 years + in Devon with learning difficulties and disabilities



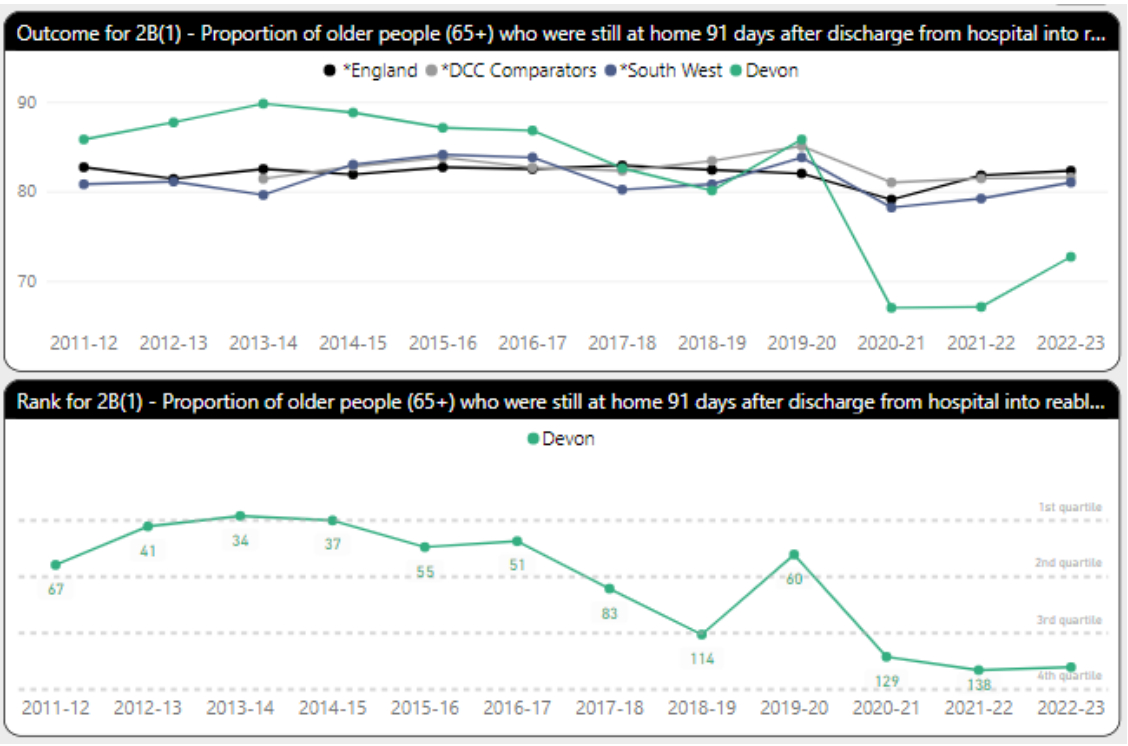
*Some indicators have been merged to provide overall total. Count has been rounded

Appendix 4

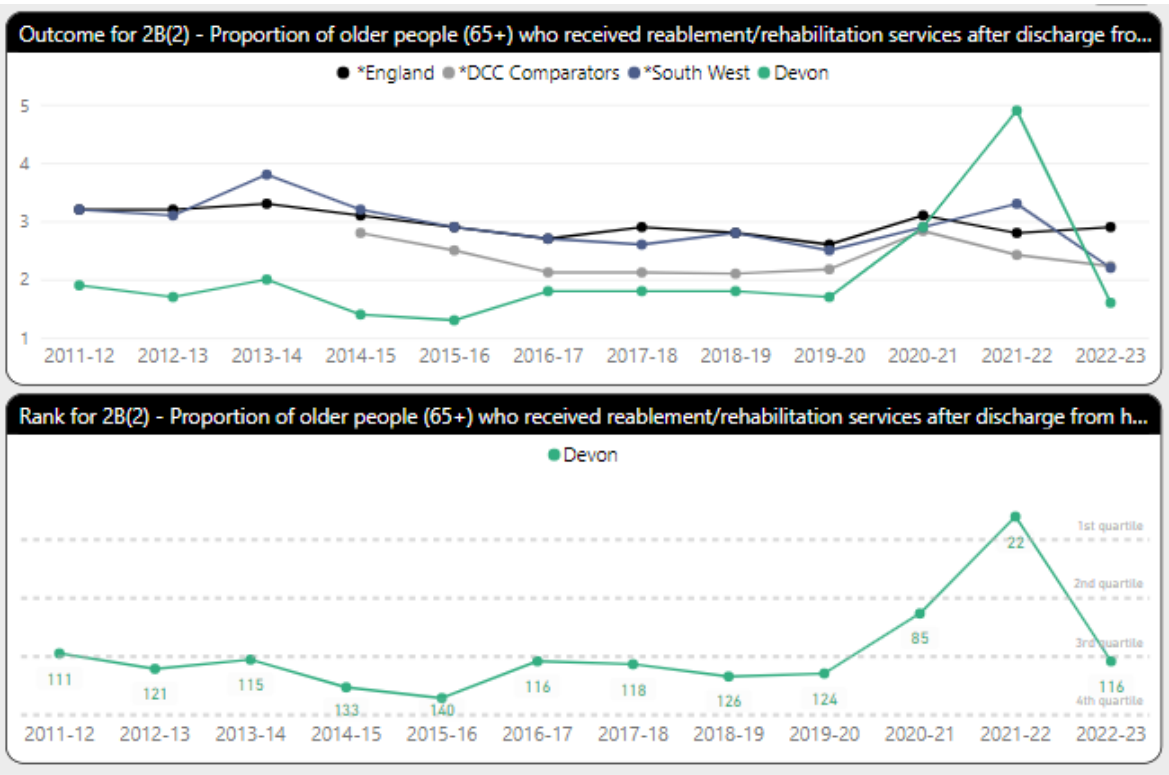
Comparative performance on prevention activity within the Adult Social Care Outcomes Framework (ASCOF) 2022-23, and within the Public Health Report 2024 dashboard:

Adult Social Care Outcomes Framework (ASCOF) 2022-23:

2B1 Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation - Proportion of successful reablement



2B2 Proportion of older people (65+) who received reablement/rehabilitation services after discharge from hospital - Coverage of reablement services



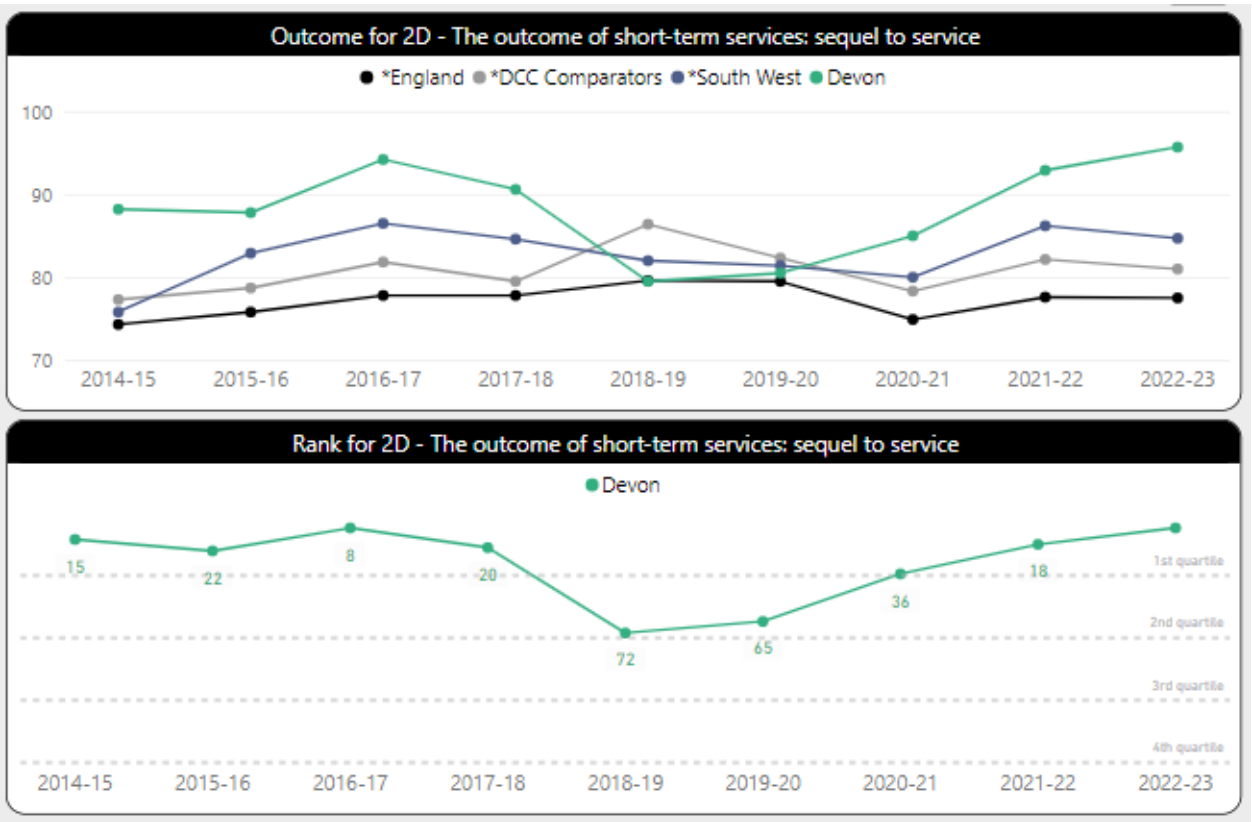
Narrative for 2B1 and 2B2:

When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence.

There is strong evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, in order to minimise their need for ongoing support and dependence on public services.

These measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. It captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement.

2D Outcome of short-term services: sequel to service

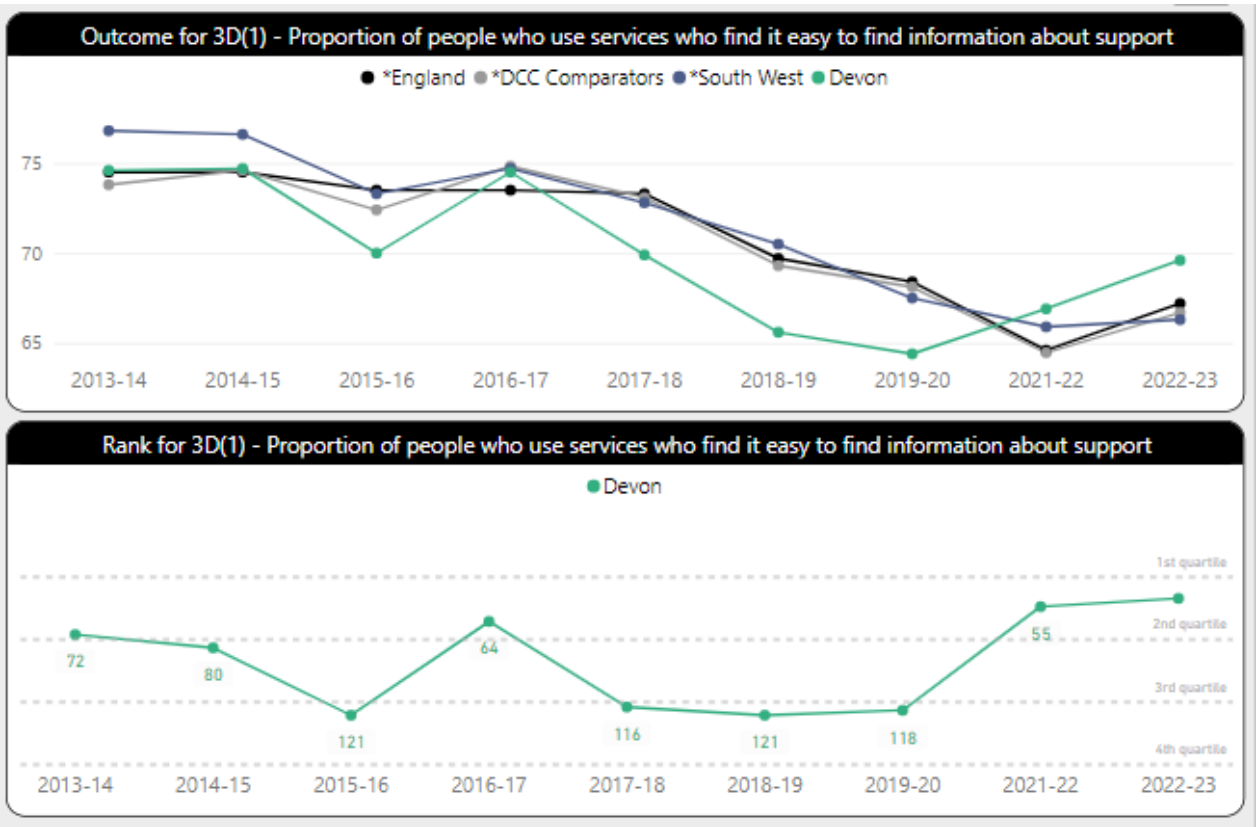


Narrative for 2D:

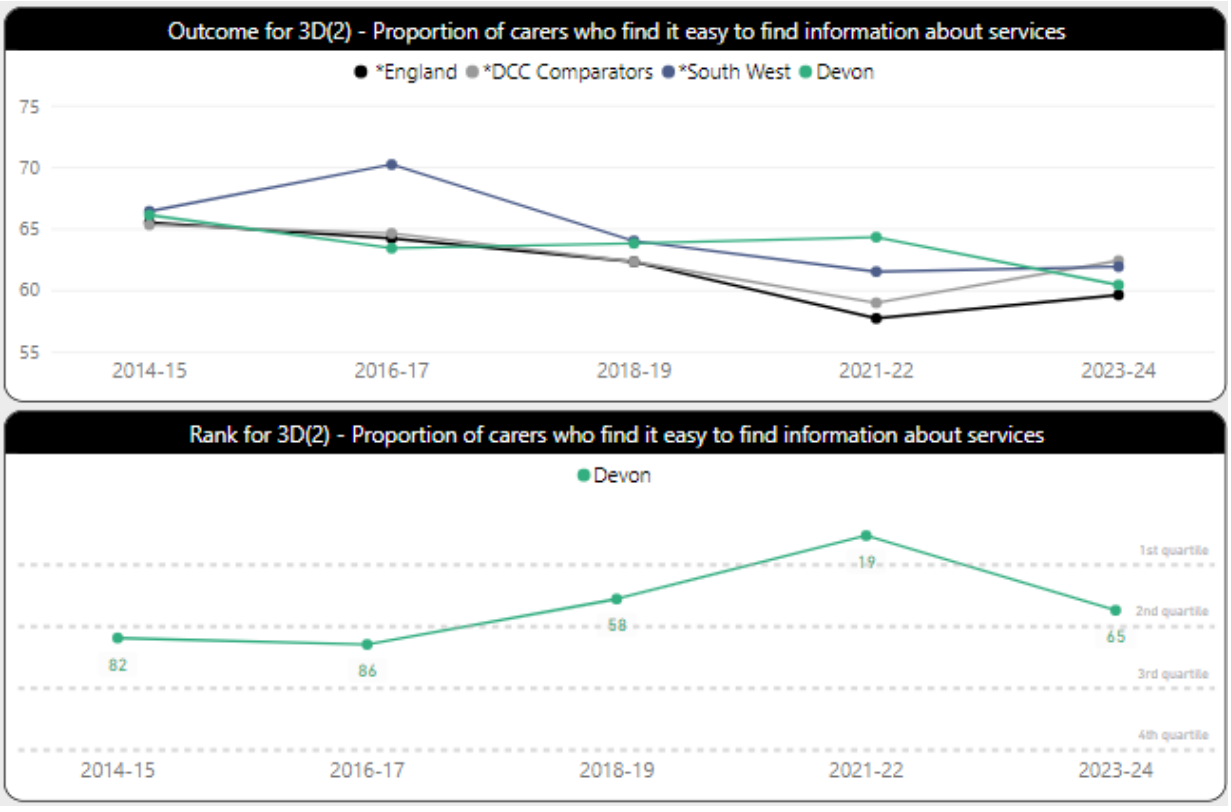
Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.

This measure will reflect the proportion of those new clients who received short-term services during the year, where no further request was made for ongoing support. Since short-term services aim to reable people and promote their independence, this measure will provide evidence of a good outcome in delaying dependency or supporting recovery – short-term support that results in no further need for services.

3D1 The proportion of people who use services who find it easy to find information about support



3D2 The proportion of carers who find it easy to find information about services



Narrative for 3D1 and 3D2:

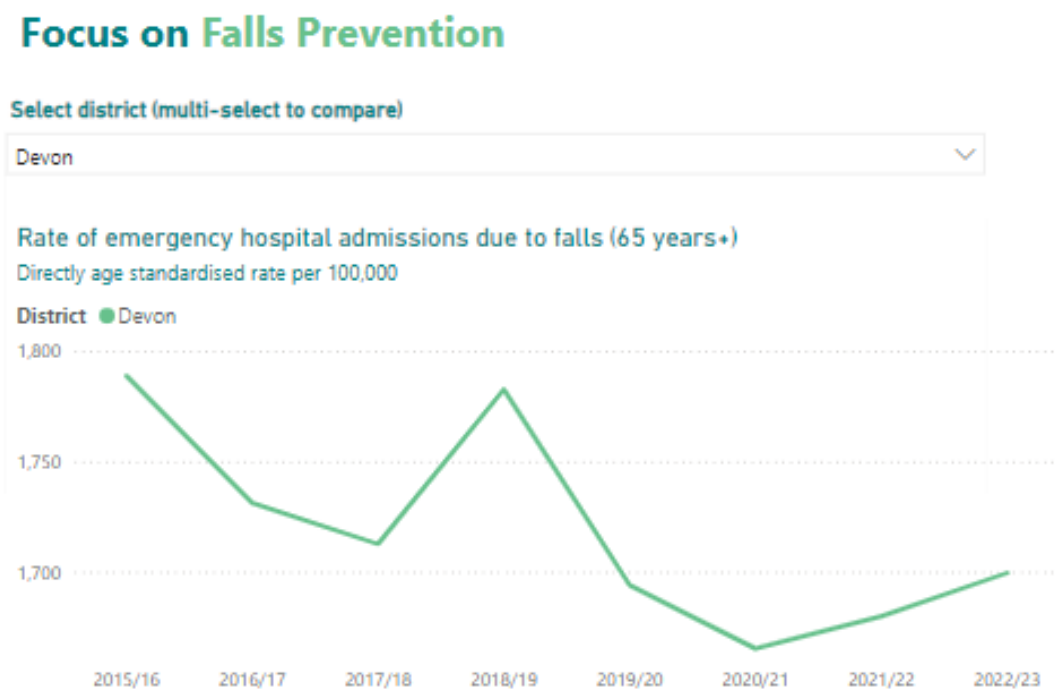
People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.

This measure reflects social services users' and carers' experience of access to information and advice about social care in the past year. Information is a core universal service and a key factor in early intervention and reducing dependency.

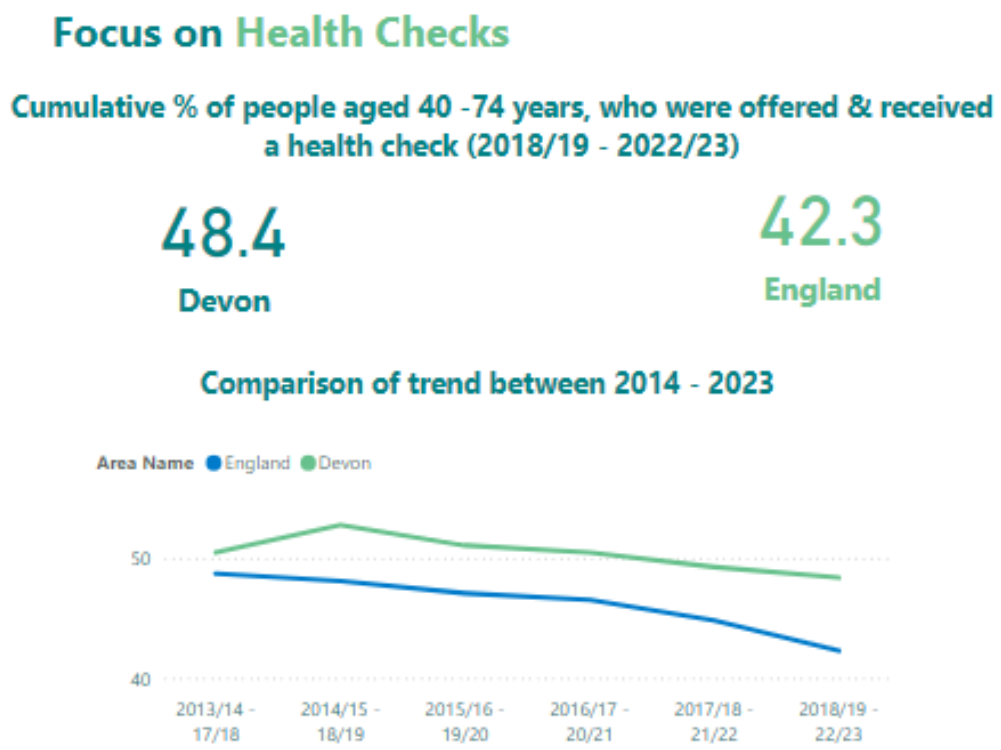
Improved and/or more information benefits carers and the people they support by helping them to have greater choice and control over their lives. This may help to sustain caring relationships through, for example, reduction in stress, improved welfare and physical health improvements. These benefits accrue only where information is accessed that would not otherwise have been accessed, or in those cases where the same information is obtained more easily.

Public Health Report 2024 dashboard data:

<u>Rate of emergency hospital admissions due to falls (65 years+)</u>



Cumulative % of people aged 40-74 years, who were offered and received a health check (2018/19 – 2022/23)



Estimated dementia diagnosis rate (aged 65 and older per 100. 2023)