North Tyneside Council Adult Social Care Prevention Strategy

2024-2026

North Tyneside Council

Version Control

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Introduction

Prevention is one of the six key principles enshrined in the Care Act 2014 and Local Authorities have a legal duty to prevent, reduce and delay social care needs.

The Department of Health and Social Care in its 2018 policy document, 'Prevention is Better Than Cure' states that:

'Prevention is about helping people stay healthy happy and independent for as long as possible. This means reducing the chances of problems 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.'

It is a significant challenge for local authorities to maintain a focus on prevention when demands on social care services are so high. The demand on budgets to meet current needs leaves little spare funding for investment in upstream prevention yet being able to stem demand at an earlier stage is key to managing the increasing numbers of older people and rising demand within mental health services and services for people with learning disabilities and neurodivergence.

Despite the challenges we want to ensure that we make the most of every opportunity to prevent reduce and delay social care needs and support the residents of North Tyneside to live independent and fulfilling lives.

Strategy Aim

This strategy aims to ensure that the North Tyneside Adult Social Care service maintains its focus on prevention and has an improvement plan which maximises, within the finite resources available, the opportunities to embed and enhance prevention in all our contacts with the people we serve.

Scope of the Strategy and links with other Plans

There is no single definition for what constitutes preventative activity with the concept ranging from whole-population measures to promote general health to targeted individual interventions to improve functioning for one person.

North Tyneside Council, working with partners including the NHS, Police and Fire and Rescue in addition to many voluntary sector organisations, delivers a wide range of services with preventive impact.

The North Tyneside Health and Wellbeing Board has a strategy to improve Health inequalities 'Equally Well' and this sits alongside the North-East and North Cumbria Integrated Care Board's strategy for local health services, 'Better Health and Wellbeing for All'. These strategies outline a range of primary prevention initiatives across North Tyneside and in specific neighbourhoods. These include support around smoking, weight management, levels of physical activity, drug and alcohol misuse, and mental health and wellbeing. These population level initiatives are outside of the scope of this document.

This Adult Social Care Prevention Strategy focusses on adults and young people who already have care needs or are expected to have care needs in the foreseeable future.

Our Vision

- Helping people to live as healthily a life as possible; mentally and physically
- Supporting people to live as independently as possible
- Helping people live at home for longer
- Reducing use of health services including primary care, emergency services, and hospitals
- Preventing or reducing the escalation of health issues

Outcomes

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

What is Prevention?

Prevention is often described as falling into three categories

Prevent

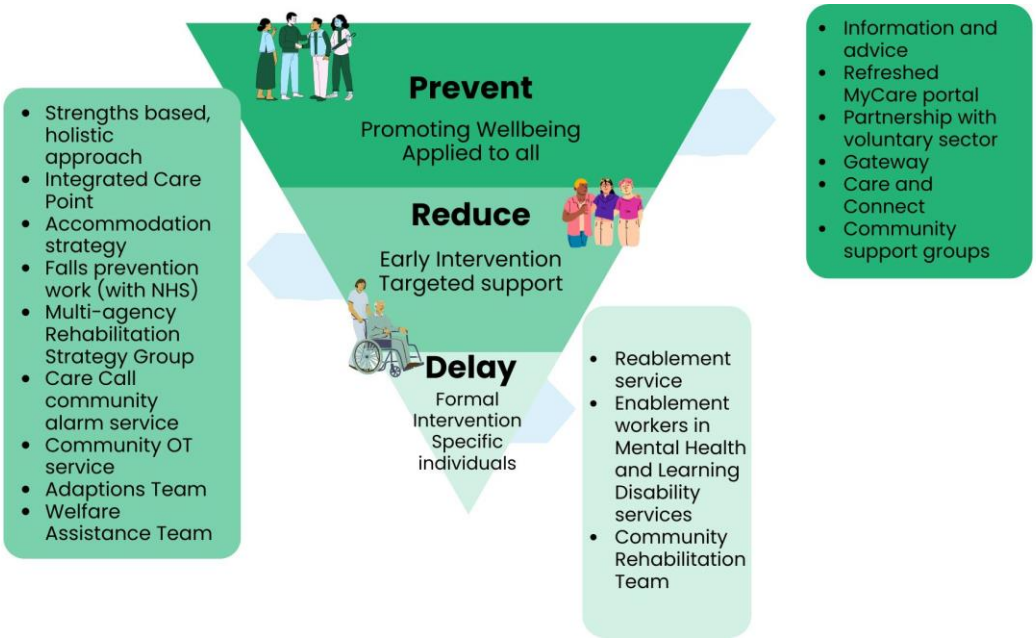
Promoting wellbeing – applied to all, range of services facilities and resources helping to avoid the need for care and support developing. Promoting healthy and active lifestyles, reducing loneliness and isolation. Our web-based support; Living Well North Tyneside, My Care, Care and Connect Team, Gateway signposting are examples of this kind of prevention.

Reduce

Early intervention targeted at individuals at risk of developing needs where support may slow down this process or prevent other needs from developing. In North Tyneside our carer support, Care Call, falls prevention activities, support to manage money including Welfare Assistance, peer groups providing emotional support and stress management, equipment and adaptations are all examples.

Delay

Formal intervention aimed at people with established complex health conditions to minimise the effects, support people to regain skills and reduce their needs wherever possible e.g. reablement or rehabilitation, meeting needs at home, providing respite care, equipment and adaptations can all delay increase of needs.



What we do now

Prevent

- Information and advice – a series of Factsheets covering all aspects of social care support have been recently rewritten with input from people experienced with care to ensure they are easy to understand and provide the information and advice that people require.
- Our refreshed care portal MyCare allows an individual to register and access more tailored advice. MyCare also can be used to facilitate a contact to Gateway.
- A partnership with the voluntary sector provides the Living Well North Tyneside website which offers information on a wide range of community

resources like support groups, activities and more formal resources like contact details for care providers.

- Gateway – our Advice and Information Response Officers (AIROs) are trained to take a preventative approach to identify the reason behind a contact and signpost to a resource which will encourage the individual to help themselves.
- Care and Connect within Gateway offers advice and information and signposting to community groups via Community Navigators who have detailed knowledge of their local areas. They work with local people to establish new special interest groups and can support individuals to go along to groups for the first time.
- Community groups like North Tyneside Carers Centre, Launch Pad (mental health) and Autism Better Together provide peer support and opportunities for people to influence service provision, raise awareness and have their say on issues that are affecting them.

Reduce

- Our strengths-based approach, through genuine conversations, establishes a holistic picture of a person's life. This looks at a person's strengths, ambitions and priorities, their support networks their needs and risks, the available community groups and resources answering the question, 'what does a good life look like for you and how can we work together to make that happen?'
- Our Integrated Care Point is provided jointly by North Tyneside Council and Northumbria Healthcare Trust. It provides safe and effective hospital admissions avoidance and discharge services through a range of disciplines including social workers, nurses, occupational therapists, physiotherapists and reablement workers. The team works together to support people to remain safely at home and to return home after a stay in hospital by preventing and reducing needs wherever possible.
- An Accommodation Strategy which facilitates prevention. North Tyneside has a well developed extra care offer and an extensive range of independent supported living arrangements for people with learning disabilities. Independent Supported Living for younger adults with Mental Health difficulties has also been developed recently. Other forms of supported housing are available for people who face exclusion from mainstream services or have difficulties associated with substance misuse and who struggle to maintain tenancies without support.
- Falls prevention work with NHS partners covering a range of initiatives overseen via a multi-agency Falls Group. A Falls Strategy has been in place in North Tyneside for a number of years and working groups are currently

developing a 5-year refreshed strategy. There is a multi-agency Falls Service in place covering 4 streams:
    - Safe and Well Checks (Fire Service)
    - Strength and Balance Classes (Age UK)
    - Falls First Responder Service (Care Call in partnership with North East Ambulance Service)
    - Falls Clinic (Secondary Care)
- A newly established multi-agency Rehabilitation Strategy Group is currently reviewing our joint intermediate care pathways against the new national framework and mapping services to ensure we have the right care in the right place at the right time to optimise flow
- Our Care Call community alarm service helps people to maintain and build confidence in their own homes, provides crisis response and a falls response service preventing admissions to hospital.
- We are currently trialling a '6 Week Review Team' within the Community Rehabilitation Team with a focus to review care packages at the 6 week point with a rehabilitation/functional perspective to ensure people receive an optimal care package and not 'over prescribed' care reducing dependence on care and preventing intrusive levels of care.
- The Community Occupational Therapy Service provides advice and information, assessment and rehabilitation to support people to regain or maintain their independence at home. This service assesses needs for equipment provided through the Authority's Loan Equipment Store or can advise people on private purchases of equipment.
- The Adaptations Team works closely with Occupational Therapy to identify ways to adapt a home to promote independence and reduce or delay needs. This can include the use of a Disabled Facilities Grant to provide adaptations like stair lifts or level access showers which can allow people to continue to live safely at home and avoid the need for residential care.
- Welfare Assistance Team provides financial assistance to individuals and families who are experiencing a financial crisis. They also provide advice guidance and signposting to other sources of support such as Citizens Advice and other voluntary groups.
- Gateway Team also provide more specialist forms of prevention relating to domestic violence, exploitation and preventing radicalisation and extremism.

Delay

- The Reablement service works mainly with older people who have been discharged from hospital to provide short term support of up to six weeks to maximise a person's level of independence to allow them to remain living at home safely with the minimum formal care.

- Enablement workers are part of our whole life disability service. These workers support individuals to learn key life skills for more independent living like independent travel, maintaining a home and managing money.
- Mental Health Reablement team promote a model of early intervention, using expertise to support independent and safe community living.
- Community Rehabilitation Team works to support people who have been discharged from hospital into one of our step down services before returning home, or who are at risk of admission to hospital. They work jointly with therapy staff from Northumbria NHS Trust to support people to maintain or regain skills of daily living. The team also works into residential care homes with people in short term placements to support a return home wherever possible. This work is focussed on delaying unnecessary admissions into long term care.

What we will do to improve

Prevent

- At a Strategic level continue to strengthen our relationships with partner organisations through existing structures like the Health and Wellbeing Board and its groups and committees, Safeguarding Adults Board, for example the Frailty Group, the Falls Group, Rehabilitation Strategy Group etc. This helps us to coordinate our efforts with key partners getting the best value from our interventions and making sure that Prevention is everybody's business.
- Develop even closer links with our colleagues within the Authority who work with the voluntary sector, deliver Housing and Leisure services, community safety and any other area where closer working can strengthen prevention of needs.
- Continue to develop our information and advice offer. Develop our own web-based support through MyCare to provide improved and more accessible information and advice including initial online supported self-assessment and financial assessment. Working with partners to broaden the ways our residents can find the support they need.
- Continue to work with our assessment staff to ensure that prevention is embedded in every contact they have with people and that the opportunity to prevent needs is taken. For example, fully embedding our Ways to Wellbeing approach in relation to Carers Assessments
- Improve Support for carers
- Carers improvement plan - delivering new training for assessment staff which focusses on the needs of carers and the whole family, development of respite facilities meeting specific needs including complex needs and

bookable respite for older people in extra care facility to improve availability of carer breaks.

    - Develop a new Carers' Strategy building on developments and improvements already undertaken, demonstrating a renewed strategic and operational commitment to supporting carers' wellbeing across the health, social care and voluntary sector in North Tyneside. This work will include co-design and production with people with lived experience of caring. It will set the objectives and pace for medium-long term improvement, supporting the achievement of Our North Tyneside Plan's aims, and the strategic objectives of the Health and Wellbeing Board
    - Be part of a regional pilot for a new web-based support platform for carers which provides resources to support Carers who do not normally approach local authorities or voluntary organisations for help

- Improved transition planning especially in relation to Mental Health where newly developed pathways are embedding
- Hospital discharge pathways are being reviewed and improved via the Rehabilitation Strategy Group to ensure optimal people receive the right support at the right time to recover after a stay in hospital.
- Commissioning developments, working with providers to ensure that prevention in embedded in commissioned care services.
- Continue to expand the range of accommodation options which meet different needs. We have identified a gap in availability of supported accommodation for younger adults with physical health needs.
- Development of the equipment and assistive technology offer. A new demonstration suite will help practitioners and residents understand how equipment and technology can support people to live safely at home for longer. Continue to explore the best ways to exploit new technology to support people to live at home safely building on knowledge gain through our lifestyle monitoring and 'Alexa' pilots.
- Improving processes within Adaptations to reduce waiting times for alterations to properties via Disabled Facilities Grant application or other funding routes. Where funds allow, consider how adaptations can be used to prevent further needs arising.

How do we measure the impact of our preventative approach?

791 people visited MyCare in Q3 of 2023/24 up 16% from the same period in 2022/23 with visits continuing to increase

Our Care and Connect service supports about 700 people with advice and information and to connect with their community.

Our loan equipment service issues about 2100 items of equipment each month with 95% routinely delivered within 7 days.

The North Tyneside Carers Centre supports about 6000 carers in their caring role each year.

Our Care Call service attends about 3500 incidents of people who have fallen each year and only 3% of those go on to attend A&E.

We support about 1400 people through Reablement each year.

The number of older people we support at home with homecare or extra care has increased in 2023/24 by 7% compared to 2022/23.

The number of older people who are admitted to long term residential care in North Tyneside is low compared to other local authority areas in the north-east and compared to the average in England.

The proportion of people with a learning disability supported to live at home is 94.3% and is above the national and regional averages.