Gloucestershire's

Prevention and Self-Care Plan

'Scaling up prevention through empowering individuals and enabling active communities'

Contents

1.0 Introduction

Prevention and self-care need to be at the heart of a sustainable future that requires us to look at innovative approaches to address the health inequalities across our county whilst responding to the projected prevalence increase in long term conditions (including those with multi-morbidity).

The NHS Five Year Forward View[1] set out a central ambition for the NHS to become better at helping people to manage their own health: 'staying healthy, making informed choices of treatment, managing conditions and avoiding complications. One of the key requirements of the Sustainability and Transformation Plan (STP) is to develop a cross-partner prevention plan, with particular action on obesity and diabetes and locally identified priorities to reduce demand and improve the health of local people. This aim of this plan is twofold; firstly it provides a framework on how Gloucestershire will fulfil the requirements of the STP; secondly it outlines our ambitions to 'scale up prevention' through a whole-system approach.

Much work has already been undertaken to formulate policies and strategies for prevention throughout Gloucestershire. Prevention is currently co-ordinated across a number of organisations and strategic partnerships (see appendix 1). The Gloucestershire Health and Wellbeing Board is currently responsible for bringing together bodies from the NHS, public health and local government, including Healthwatch to jointly to plan how best to meet local health and care needs, and to commission services accordingly. The joint health and wellbeing strategy has identified a number of local priorities for which to improve the health of the population. These include:

- Healthy Ageing
- Mental wellbeing
- Healthy weight
- Reducing alcohol related harm
- Health Inequalities

As part of the Health and Care Communities 5-year strategy 'Joining Up Your Care', prevention and self-care has been identified as a key priority to help realise its vision:

"To improve health and wellbeing, we believe that by all working better together - in a more joined up way - and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people".

Its ambitions are to ensure that:
- People are provided with support to enable them to take more control of their own health and wellbeing. Those that are particularly vulnerable will benefit from additional support;
- People are provided with more support in their homes and local communities where safe and appropriate to do so, thus moving away from the traditional focus on hospital-based care;
- When people need care that can only be provided in a hospital setting, it is delivered in a timely and effective way.

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[1] NHS. Five Year Forward View. October 2014. https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

1.1 Progress to date

Gloucestershire has already made good progress in working towards this vision and has developed a range of programmes that demonstrate the breadth of activity and how we are integrating self-care and prevention across the system. These include:

- A comprehensive **social prescribing service that** supports approximately 1000 individuals annually to self-care and connect to community based support.
- A nationally acclaimed **cultural commissioning programme** seeking to explore how public sector commissioning of arts and culture can be developed and embedded in order to support health and wellbeing.
- Working with patients and GP's to support the management of **atrial fibrillation (AF)**, and related stroke prevention in primary care
- An innovative **community eye health service** that empowers patients to self-care and self-manage and know how and when to access appropriate services when needed.
- Developing our **Integrated Community Teams** by moving from a 'person-centred' approach to a 'person-led' approach. This involved implementing a comprehensive change management programme focusing on active listening, positive risk taking and using a strengths-based approach.
- Implementation of our **Living with and beyond Cancer Programme** in partnership Macmillan that aims to provide a holistic approach to support patients to live with and beyond cancer.
- GP practices offering opportunistic health checks (including mental health) to all registered **carers**. This includes prevention advice to avoid becoming a patient themselves.
- Development of an online **health professional information website (G-Care)** that provides information on local care pathways, training and support, clinical guidance, referral forms, patient and self-care information and local services
- Development of a countywide **[health inequalities plan](#)** based on the 'Marmot principles'
- A pioneering **online pupil survey** which captures the views of over 20,000 pupils on lifestyle issues over a range of ages on a bi annual basis. This has enabled us to target our work at emerging issues such as self-harm.
- A **dementia programme** focused on raising awareness among public and professionals and increase early diagnosis and intervention.
- Development of **seven locality plans** that respond to the local needs of their population and instigated a range of prevention initiatives working alongside district councils i.e. park runs
- A comprehensive **community weight management service** that has supported over 12,000 patients since 2013 losing over 64,500kg's,
- Midwifery Partnership Teams working with Health Visiting and other early years services to improve outcomes for vulnerable families and have **successfully reduced the number of women smoking** at the time of giving birth.
- Working in partnership with Gloucestershire Fire Service delivering Safe and Well Home checks including key falls messages and eye health screening
- A multiagency approach **to reducing under-18 contraception** which combines health interventions from community pharmacy, general practice, acute trust

specialist midwives and specialist sexual health providers with social workers, youth support, children's centre and education teams. The combined work has seen under 18 conceptions fall by over 50% over the last 15 years.

- Joint working between **drug and alcohol service** and children's social services. Services co-located and sharing expertise to improve reduce harm to families

We recognise that there is still more to be done to increase prevention activity and patient activation. Given the number of strategies and policies already working to improve population health and wellbeing and preventing ill health, this plan will not seek to duplicate this work but will be the cross-partner plan that underpins the STP and will drive forward key overarching issues that can be implemented at pace and at scale. It will also look to identify gaps in service provision and ensure that we work with individuals and communities to meet local need.

2.0 Why do we need a prevention and self-care plan?

The current social care and health system is unsustainable and will buckle under the weight of demand unless we re-engineer our planning and service provision to promote healthy choices, protect health, prevent sickness and intervene early to minimise the need for costly hospital treatment. Trying to fix this by focusing on treatment alone is not the answer. We need preventative strategies that mitigate or defer the need for costly interventions and at the same time deliver better outcomes for individuals.

The NHS as a whole is undergoing unprecedented challenges in terms of long term sustainability which is driven by demographic changes, complex illnesses and higher levels of expectations, all of which are operating in the context of a funding gap. This is also at a time when the Local Authority Public Health budget has been reduced. The specific issues around the 'health and wellbeing', 'quality and finance' and 'efficiency' gaps are well highlighted in the Five Year Forward View[2]. Though currently in financial balance as a system, Gloucestershire is not immune from these challenges with particular issues for us around our ageing population, more people living with multiple long-term conditions. safeguarding issues and attendant demand for social and other care and support services for children and adults. For example, the 2% most complex patients (1,724) are responsible for 15.3% (£34,724,000) of the total CCG spend. This is compounded by national data which suggests around 70% of the total health and care spend in England is attributed to caring for people with long term conditions. We therefore need to take a fresh look at our system as a whole in order to address our collective challenge, using different innovative approaches and engaging new partners in the process.

3.0 What do we mean by prevention and self-care?

Prevention and self-care have a number of definitions and it is therefore important to define these terms so that we have a collective understanding across our STP footprint.

3.1 Prevention
The term "prevention" or "preventative measures" can cover many different types of support, services, facilities or other resources. There is no one definition for what constitutes

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[2] NHS. Five Year Forward View. October 2014. https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

preventative activity and this can range from whole-population measures aimed at promoting health, to more targeted, individual interventions aimed at improving behaviour knowledge or skills for one person or a particular group.

Prevention is often broken down into three general approaches – primary, secondary and tertiary prevention, with these three levels informing our approach:

1. **Primary prevention**
   Primary prevention aims to protect healthy people from developing a disease in the first place, through such measures as good nutrition, regular exercise, avoiding tobacco and alcohol, and receiving regular medical check-ups. Primary prevention may also extend to population-wide measures and social determinants of health, such as improving air and water quality, mass immunisation, and strengthening family and community ties to promote good mental health.

2. **Secondary prevention**
   After risk factors have been found to be present, and/or signs of an illness have actually appeared, secondary intervention consists of screening for illnesses, particularly when risk factors are present, and early intervention measures to slow the progress of the disease while it is still in its early stages i.e. pre-diabetes

3. **Tertiary prevention**
   For patients who already have illnesses such as diabetes, heart disease, cancer or chronic musculoskeletal pain. Tertiary prevention consists of measures to slow down physical deterioration and is particularly relevant for patients with complex needs and focuses on their recovery, rehabilitation and re-ablement after acute exacerbation of their chronic illness i.e. self-management programmes
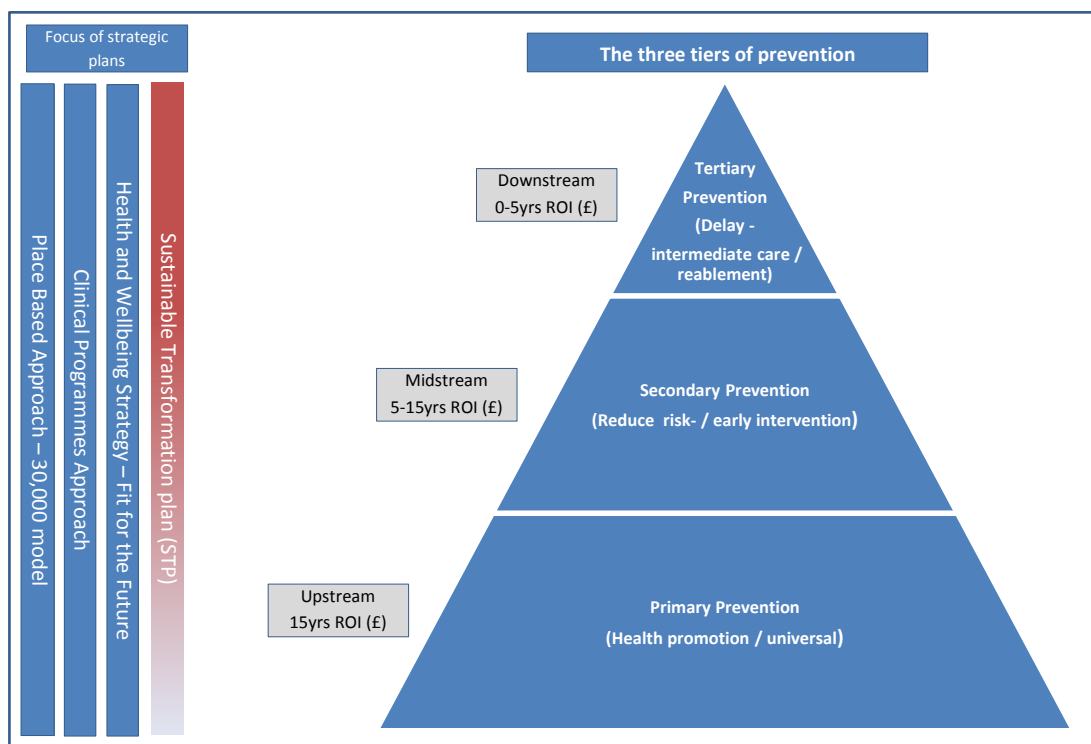

Figure 1. The three tiers of prevention and likely gestation times for return on investment

Understanding these three levels are important as it recognises that each of these approaches has a critical role to play in disease prevention. Our placed based approach outlined within the STP provides a unique opportunity to collaborate and focus our attention on these levels through co-ordinated care and integrated working across health and social care, for example to deliver care across a pathway or invest in proactive case management.

3.2 Self-Care

Self-care encompasses the things individuals can do to protect their health and manage illness. The Department of Health define self-care as:

"the actions people take for themselves, their children and their families to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital"[3]

This broad definition allows for a spectrum of self-care strategies which can be depicted on a continuum (see figure 2). These range from the daily choices we make – such as brushing our teeth, eating well, and exercising – to interventions aimed at managing long term conditions like asthma and diabetes. A key component of self-care is about individuals taking responsibility for their own health and well-being.
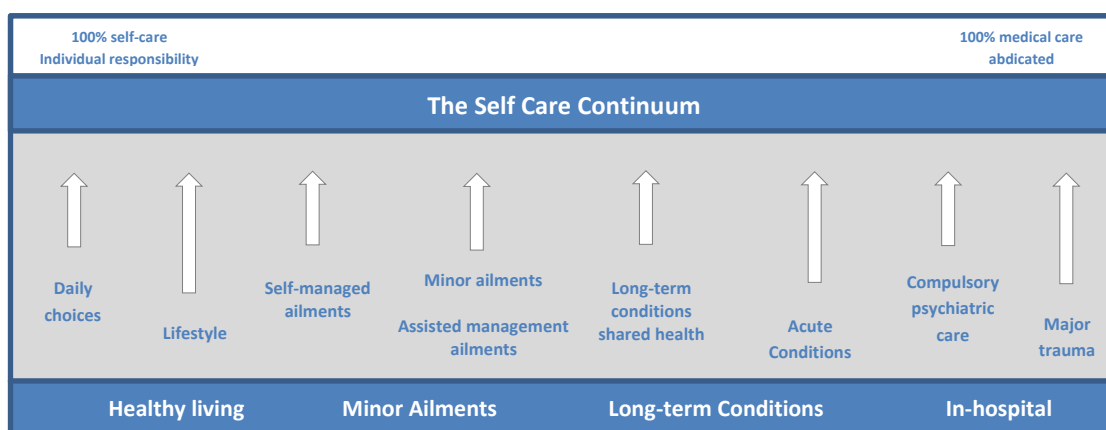
Figure 2. The self-care continuum (Self Care Forum, 2013)

Although much of the focus on self-care is on individual behaviour, self-care can also be viewed as basic skills and health promotion through to shared and social activities. Self-care is therefore related to broader issues of public engagement, social capita and community empowerment.

4.0 Our vision

Our vision focuses on individuals and communities having greater control of their health and wellbeing:

"Individuals have the knowledge, skills and confidence to self-care and live in well-connected, resilient and empowered communities"

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[3] Department of Health (2005) Self Care – A real choice. London. Department of Health

Whilst our vision focuses on the importance of self-care, we recognise that we need to create the right culture, environment and conditions to enable people to look after themselves i.e. supported self-care, influencing the wider determinants of health. We therefore intend to create a 'social movement' with the public that promotes personal responsibility and the importance of good health and wellbeing.

4.1 Our Aim

The overarching aim of the plan is to ensure that prevention is everybody's business and provides a high level overview of Gloucestershire's approach to radically upgrading our work on prevention. The prevention plan must not been seen as a standalone document, as prevention and self-care will run across all of our STP and partner plans. The intention of the plan will be to provide a framework and action plan to deliver measureable improved outcomes around prevention and self-care including improved life expectancy, enhanced quality of life for those with a long term condition and their carers, and a reduction in health inequalities.

The Gloucestershire Prevention Plan aims to deliver £20 million cashable savings over the next five years by engaging all parts of the local system in the prevention agenda. However in order to meet this ambition we recognise that the plan will need to focus on secondary and tertiary prevention activities that have a gestation period of less than five years.

We intend to develop our prevention and self-care plan in two stages. Our initial plan detailed in this document (see section 9) aims to meet the key priorities and deliverables identified with the Five Year Forward View. The second stage will involve further developing our ideas and long term vision with all our partners throughout 16/17 to include a greater emphasis on primary prevention and the wider determinants of health. Such approaches have a longer gestation period and involve working with a broader range of partners.
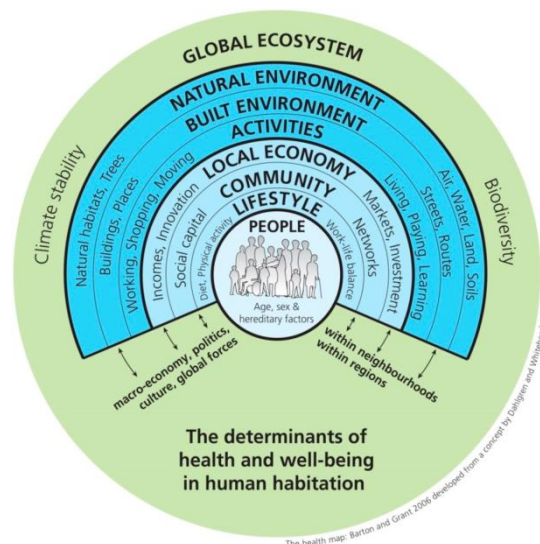

Figure 3 Diagram illustrating the social, economic and environmental determinants of health[4]

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[4] Barton, H. and Grant, M. (2006) A health map for the local human habitat. The Journal for the Royal Society for the Promotion of Health, 126 (6). pp. 252-253. ISSN 1466-4240 Available from: http://eprints.uwe.ac.uk/7863

The second stage will also enable us to focus our efforts on health inequalities and support the implementation the county's new [health inequalities plan](#) building on the recommendations of the Marmot Review of Health Inequalities in England[5].

4.2 Principles

The purpose of the plan is to provide a collaborative framework for the health and social care community to agree the best outcomes for the population, within the resources available.

The plan will work to following principles:

1. Prevention will be considered across whole pathways by each Clinical Programme Group (CPG). The CPGs will take a strategic and integrated approach to the whole pathway and will consider the wider determinants of health and behaviour change to minimise the impact of risk factors for premature mortality and morbidity. Pathways will build on the principle of 'making every contact count' which makes the most of opportunities to empower healthier lifestyle choices.

2. The approach taken by the CPGs to prevention will be tailored and targeted, with self-care and self-management being central themes. The focus for associated actions will be on the whole self-care continuum from promoting wellbeing and primary prevention through to acute trauma. The emphasis will be on a) the practice of health and social care professionals in their consultations with patients, and b) the offer to patients.

3. Reduction of inequalities will be a central driver to any work commissioned to prevent ill health. Tackling the wider determinants will be important as these are known to strongly influence people's resistance to illness and disease, as well as their ability to self-care. There is a risk that without easily accessible support and advice, the advantages of self-care and strength based approaches may only be felt by higher socio-economic groups and therefore widen health inequalities.

4. Ensure that the Joint Enabling Active Communities Policy and strength based approaches becomes an integral part of mainstream service delivery by
   - Drawing upon the diverse range of assets within each local community;
   - Stimulate the provision of the diverse range of assets within each local community.

   This will involve working with communities as equal partners that bring strengths and assets to the table, rather than seeing them as places of need and deficiency. It will also involve mobilising all the resources in areas to promote and protect sustainable health and wellbeing.

5. This plan has been developed to align with other key local strategies and policies listed below:
   - Gloucestershire's Health and Wellbeing Strategy – Fit for the Future and its delivery plans for health inequalities, healthy weight, healthy ageing, reducing alcohol related harm and mental well-being
   - Enabling Active Communities policy and action plan

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[5] Marmot (2010) Fair Society, Healthy Lives

- Gloucestershire's Future in Mind 5 year transformation plan for children and young people's mental health
- Mental Health Strategy and action plan
- Crisis Care Concordat and action plan
- Building Better Lives Strategy
- Primary Care Strategy 2016-21
- Children and Young People Partnership Plan

6. Prevention will be embedded systematically through the work of all partner organisations

7. The Commissioning for Prevention 5 steps[6] should be taken into account within the strategies, action plans and service specifications. This includes: analysing key health problems, prioritising and setting goals, identifying high impact programmes, resource planning and measuring impact.

8. Ensure parity of esteem for our local population.

5.0 Governance

In order to achieve the intentions set out in this plan it is necessary to review and amend the governance structure overseeing health and wellbeing activities in Gloucestershire. It is proposed that the membership of the Health and Wellbeing Board (HWB) will be extended to include the Chairs of the three local health providers and the Chief Constable. A review will be carried out to determine how the work of the Health and Wellbeing Provider Forum can be extended to support the Prevention and Self-Care plan and the wider STP. Changes to the function of the HWB are also being proposed in order to position the Board as the system leader for health, wellbeing, prevention and self-care.

A Prevention and Self-Care Board will be created. This will report to the HWB and the STP Delivery Board (see figure 4). The purpose of the P&SCB is to oversee all the prevention activities within Gloucestershire. It will provide the strategic planning framework for all prevention activities. The group will also encompass the functions previously delivered by the Health and Wellbeing Board's Strategy Implementation Group and the CCG's Healthy Individuals Clinical Programme Group. It will have senior level representation from commissioner and provider organisations (including voluntary and community sector).
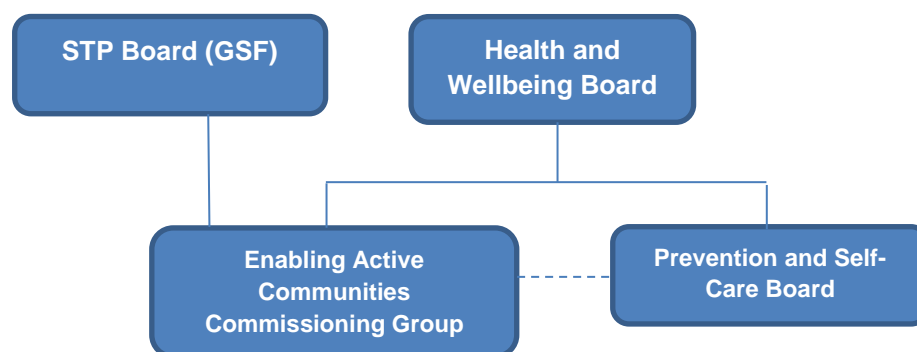

Figure 4 – Overview of the governance for the Prevention and Self-Care Plan

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[6] NHS England and Public Health England (2013) A call to action: Commissioning for Prevention

6.0 What we plan to do

The cross-partner prevention plan will underpin the STP and will provide a 'proportionate approach' that involves balancing investment and preventative activity across the three levels of prevention as illustrated in Figure 1. This recognises that whilst targeted approaches in at-risk patients with specific long-term disorders can yield the greatest short term results, we know that greater return on investment will be achieved by investing in primary prevention and tackling the wider determinants of health.

Our delivery plan focuses on the following four priorities that are inextricably linked to Gloucestershire's transformation and placed based approach:

1. **Supporting pathways**
   Utilising our transformational approach to service redesign, we will ensure that prevention (Primary, secondary and tertiary) is integrated across all pathways using the clinical programme approach. The aim will be to maximise the opportunities for prevention within community, primary and secondary care.

2. **Supporting our workforce**
   We will support our workforce to enable a shift in the clinician/patient relationship to increase patient confidence, decision making, compliance and lifestyle change to improve health outcomes and reduce health care costs. This will involve supporting the whole of Gloucestershire's workforce to ensure that they have the skills and competences to become co-producers in health and promote self-care.

3. **Supporting places and community centred approaches**
   We will develop place based and community-centred approaches aligned with the system wide 30,000 model. Our pioneering Enabling Active Communities Programme will co-ordinate action across the system by employing asset and strength based approaches to build stronger and more resilient communities. Our work streams will involve focusing on creating knowledgeable communities, developing local solutions and creating a culture of utilising opportunities (see appendix 2).

4. **Supporting people**
   We will ensure that people have the knowledge, skills and confidence to lead healthy lifestyles and self-care. Patient activation will be a core enabler for this priority and aims to significantly influence the way in which people in Gloucestershire are supported to manage their long-term conditions. We will also ensure that appropriate support is provided for carers to enable good health and wellbeing.

These four priorities align with our whole system approach to supporting people with long term conditions through adopting NHS England's House of Care framework[7] and the six principles to empowering people and communities[8]. This will require the following interdependent components to be embedded across the four priorities to ensure that we achieve person-led care and activated individuals:

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[7] Coulter et al (2013) Delivering better services for people with long-term conditions building the house of care. Kings Fund
[8] NHS England (2015) New Care Models: empowering patients and communities A call to action for a directory of support

- **Commissioning** – a range of organisations driving quality improvement.
- **Engaged, informed individuals and carers** – enabling individuals to self-manage and know how to access the services they need when and where they need them.
- **Organisational and clinical processes** – structured around the needs of patients and carers using the best evidence available, co-designed with service users where possible.
- **Health and care professionals working in partnership** – listening, supporting, and collaborating for continuity of care.

The aim will be to balance investment between population and individual level interventions and shift our emphasis toward prevention, self-care and community empowerment. This will result in a move away from a reactive, disease-focused fragmented model of care towards one that is more proactive, holistic and preventative.

6.1 Our initial focus for 2016/17

We recognise that prevention will need to be scaled-up through a combinatorial approach involving a range of interventions, structural and cultural change shifting the emphasis to self-care and community empowerment. We have identified several programmes to focus on for 16/17 that would enable us to make progress at pace and at scale. These Include:

1. **Implementation of Healthier You: National Diabetes Prevention Programme (pending successful application to NHSE)**
   Gloucestershire has approximately 59,000 individuals with non-diabetic hyperglycaemia. Identifying these individuals and providing support before full symptoms develop is one of our key priorities. We will undertake two clinical audits in 2016 (July and Sept) across all 81 practices to identify and recruit eligible patients through data received through our NHS Health Checks Programme and the annual Diabetes Enhanced Service Audit. This will be supported through active engagement with primary care teams, clinicians, public health and local councils. We will also look to negotiate a pre-diabetes register as part of the Diabetes Local Enhanced Service. The Diabetes Clinical Programme Group will take a central role in the implementation of this programme to ensure that it aligns with our transformation approach to service redesign and embedded clearly within the diabetes clinical care pathway. This will be complemented through our work on the NHSE Diabetes Digital Test Bed that supports self-management and the new countywide integrated healthy lifestyle service commissioned by Public Health. We would look to build on the learning from the first wave sites and ensure put in place robust plans to overcome common barriers to implementation.

2. **Health Coaching**
   Patients and communities need to play a greater role in their health and care, as current management approaches are not working. Our priority to increase patient activation and support our workforce will be delivered through a comprehensive health coaching programme adopting a train the trainer model across our 21 integrated community teams (including nurses, GP', occupational therapists, physiotherapists and mental health practitioners). This will build on the learning from the NHS Innovation Accelerator Programme and utilise the recently acquired Patient Activation Measure (PAM). This will help embed the principles of person-led care and

tailor interventions to meet individual need through personalised care planning. This will be aligned to PHE's and NHSE's framework for personalised care and population health – 'All our Health'[9]. The project would form part of a countywide plan to harness the capacity of the health and care workforce and embed health improvement and prevention across the system i.e. Making Every Contact Count.

3. **Whole Systems Approach to Obesity – PHE and Leeds Beckett Pilot**

   Gloucestershire is one of four areas working with Leeds Beckett University on a national programme to co-develop a whole system approach to addressing obesity. To support this we will work with our partners to undertake a comprehensive review of our children and adult obesity care pathways ensuring that we maximise our investment in weight management services. We will be looking to increase investment across our maternal and child obesity pathways, particularly for Tier 2 and Tier 3 support. This will be supported through a range of school-based interventions including the 'daily mile', Facts4Life' and further development of the county's Gloucestershire Healthy Living and Learning' Programme.

4. **Social Prescribing and Cultural Commissioning**

   Gloucestershire currently has one of the largest social prescribing programmes in the country with over 1400 individuals accessing the service each year. Our scheme is open to all 81 GP Practices in the county and accepts referrals from system partners, such as community nurses and social workers. We will further develop our social prescribing programme and establish an enhanced social prescribing offer (Social Prescribing Plus) that builds on the work of our innovative Cultural Commissioning Programme. This will look to develop capacity within the VCSE to support individuals across the spectrum of self-care i.e. from universal health and wellbeing to supporting individuals with long term conditions. This will be supported through a new 'innovation grants programme' that will look to develop bespoke programmes to address persistent health and wellbeing problems or to support individuals and communities to take a proactive approach to health and wellbeing.

5. **Implementation of the National Workplace Wellbeing Charter**

   Gloucestershire has commissioned Health@work to support and accredit 40 organisations against the national workplace wellbeing charter standards. We are aiming for at least eight of these being our large public sector organisations (i.e. LA's, NHS Providers). This has the potential to reach 17,000 employees from the public sector alone. Each organisation will receive a bespoke support package including resources, action planning and expert advice from an experienced health@work consultant who will be hosted by the Local Enterprise Partnership. Our intention will be to continue investment beyond 2017 to support more employers and target SME's. The National Workplace Charter will support the priorities set out within NHS England's Healthy Workforce Programme[10]. This will ensure that we improve the health and wellbeing for staff in order to help reduce sickness absence, improve patient and staff experience and provide best practice examples for employer's role in promoting health and wellbeing.

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[9] NHS England (2016) Framework for personalised care and population health
[10] NHS Healthy Workforce Programme (2016) NHS staff health & wellbeing: CQUIN Supplementary guidance

6. **Implementation of a social investment bond for increasing physical activity (subject to outcome of feasibility study)**

   The evidence of physical activity on health and wellbeing and the health and social care system is substantial. Gloucestershire are currently in the process of being one of the first areas in the country to develop a social investment bond model for increasing population levels of physical activity. The aim is to create a lasting societal change on activity levels through working in partnership with Active Gloucestershire and Sport England. This will be achieved through a multi-component whole system and community wide approach that targets individuals who are inactive and those with chronic conditions or at risk of developing one.

7. **Developing a place based approach to preventing poor mental health**

   We will undertake a focused piece of work looking to support individuals who have poor mental health within Gloucester City. This will involve:
   - An analysis of need and current baselines
   - Investment in service gaps around perinatal mental health and personality disorder
   - Opening a crisis house and crisis Café
   - Analysis of case studies of regular ED attendees/acute admissions and working to develop bespoke plans for those individuals
   - Deployment of integrated personal budgets and development of social prescribing models to provide greater support for this with poor mental health

8. **Integrated Personalised Commissioning**

   Gloucestershire is part of the regional South West IPC demonstrator site, and has committed to embedding the principles of IPC in commissioning of care, including:
   - Giving people with complex needs and their carers a better quality of life, allowing them to achieve outcomes which are chosen by them and their families through greater involvement in their care;
   - Preventing crises in people's lives that lead to unplanned hospital or institutional admissions by keeping them well and supporting self-management;
   - Ensuring that our commissioning arrangements with the County Council are integrated and lead to outcome based personalised plans helping individuals to maximise their wellbeing (particularly: Children and Young people with complex needs, people with multiple Long Term Conditions, people with Learning Disabilities and people with Mental Health needs);

   This will be achieved by initial small scale implementation to cover a broad spectrum of conditions and support needs, followed by learning from our network partners and developing a systems change programme that will enable scaling up of IPC.

7.0 How will we measure impact?

Measuring the impact of the Prevention and Self-care plan will be challenging, given that it will be measuring interventions that have not occurred, e.g. avoided admissions, visits and appointments and it must be acknowledged that these benefits are in the main, cost avoidance and productivity gains as opposed to cashable savings. Nevertheless these are significant, allowing services to deliver care for increased numbers of patients, whilst increasing quality, self-care and compliance.

Due to the breadth and scope of self-care, a range of indicators and outcome measures will be adopted to assess the effectiveness of the programme of work (i.e. Public Health Outcomes framework, CCG Improvement and Assessment Framework). In terms of long term conditions, we will look to utilise NHS England's LTC dashboard that provides a summary of metrics that can be used to support commissioning for long term conditions across health and social care.

Each activity has an outcome/output measure and key performance indicator. Performance reports will be made to the Prevention and Self-Care Board on a quarterly basis and reported through to the STP Programme Board.

8.0 Financial position

We aim to deliver £20 million cashable savings over the next five years through the implementation of this plan. A summary of the potential areas for investment and identified savings are summarised in table 1. We will continue to explore the costs and benefits though further enquiry and the development of scenario assumptions modelling which would demonstrate relationship of investment and savings over time. We have allocated £1.7 million of non-recurrent investment to support preventative activity in 2016/17. The new Prevention and Self-care Board will decide how this money is allocated against the priorities detailed in the plan.

Area for investment	Net savings Over 5 years (approx.)
Diabetes (inc pre-diabetes)	£1.08 million
Respiratory	£1.5 million
Falls Prevention	£1.36 million
Physical Inactivity	£2.5 million
Smoking	£4.7 million
Obesity / Weight management	£0.13 million
Substance Misuse Drugs and Alcohol	£1 million
Workplace Health	£2.5 million
Social Prescribing	£0.6 million
Self-Management Education	£0.5 million
Total	£15.87 million

Table 1. Summary of how savings will be made against programme areas

9.0 Prevention and Self-Care Plan

9.1 Supporting pathways
• **Ensuring prevention (primary, secondary and tertiary) is embedded across all of our clinical pathways using the clinical programmes approach**

Priority Area	Actions	Outcomes	Measure/s	Timescale	Lead name / organisation
Diabetes	1.1 Implement NHSE's National -Diabetes Prevention Programme (pending successful application)	Reduction in the number of people developing type 2 diabetes Reduction in the number of patients with non-diabetic hyper glycaemia	Number of patients completing programme Hb1aC	2017-2021	Matt Pearce (CCG) Sue Weaver (GCC)
	1.2 Delivery of NHS England Digital Test Bed for Diabetes including mHealth Challenge	Increase knowledge and skills for people with diabetes to better self-manage Increase proportion of people attending structured education	Number of patients activated PAM	2016-20	Adele Jones (CCG)
Respiratory	1.3 Increase utilisation of the smoking cessation service for patients prior to an elective operation (Stop B4 the Op)	Reduced risk of heart disease, cancer and premature death for the patient	Reduced length of hospital stay Reduction in risk of complications	2017	Matt Pearce (CCG)
	1.4 Awareness and education campaign for Respiratory Tract Infections (RTI's) for adults and children	Better health care service utilisation Reduction in consulting primary care Reduce Anti-microbial resistance:	Reduction in admissions related to RTI's	2019	Kelly Matthews (CCG)
	1.5 Pilot an incentivisation scheme for Pregnant smokers and other household members	Reduced complications during labour Reduced stillbirths Reduced babies with lbw Reduction in childhood RTI admissions	Reduction in the number of pregnant women who smoke	2016/2018	Sue Weaver (GCC)
	1.6 Develop a place-based mental health prevention strategy focusing on Gloucester City	Improved outcomes for those with poor perinatal mental health and personality disorder	Change in health service usage	Apr 2017	Karl Gluck (GCC)

Priority Area	Actions	Outcomes	Measure/s	Timescale	Lead name / organisation
Mental Health	1.7 Commission an integrated arts and culture health and wellbeing service	People in Gloucestershire are able to access early help for mental and physical health problems through arts and culture interventions	Number of users Number of users who are referred on to statutory/other services	Apr 2017	Karl Gluck (GCC) Jules Ford (CCG)
Alcohol	1.8 Ensure sufficient capacity within the specialist alcohol services for patients in secondary care	improving quality and efficiency of care reducing mortality related to the misuse of alcohol by systematically identifying alcohol-related conditions	Reducing admissions and length of stay reduction in A&E attendances reducing the duration of detoxifications in hospital	TBC	Jennifer Taylor (GCC) Steve O'Neil (GCC)

9.2 Supporting our workforce					
• **Supporting the whole of Gloucestershire's workforce to ensure that they have the skills and competences to become co-producers in health and promote self-care.**					
Priority Area	**Actions**	**Outcomes**	**Measure/s**	**Timescale**	**Lead name / organisation**
Health Coaching	2.1 Implementation of train the train health coaching model across 21 ICT's	Patients are motivated to self-care. Improved patient experience and satisfaction. Increased patient activation	Number of activated patients	Jan 2017	Candace Plouffe (GCS) / Matt Pearce (CCG)
	2.2 Ensure uptake of brief intervention training (MECC) across the health and social care system as part of the Integrated Healthy Lifestyles Service	Staff provide brief interventions to patients and individuals that lead to healthy living Targeted advice tackling unhealthy behaviours provided at the point of care	Patients offered brief intervention Improved health and wellbeing	Jan 2017	Tracy Marshall (GCC)
	2.3 Embed the Patient Activation Measure (PAM) across all appropriate pathways and services	Improve patient engagement and outcomes Better population segmentation and risk stratification to target interventions	Number of PAM licenses used Number of activated patients	June 2016	Caitlin Lord (CCG)
Person-led	2.4 Develop a consistent and	Improve empowerment, support effective	Number of	Aug 2017	Caitlin Lord (CCG)

care	systematic approach to personal care planning in line with our integrated personalised commissioning pilot	behaviour change, and lead to improved patient experience and a reduced demand for high-intensity acute services	individuals having personal care plans (GP clinical systems)		

9.3 Supporting places and community centred approaches
• **Supporting a place based and community based approaches aligned with the system wide 30,000 model**

Priority Area	Actions	Outcomes	Measure/s	Timescale	Lead name / organisation
Workplace Health	3.1 Roll out of National Workplace Wellbeing Charter across the county	Improve the health and wellbeing of the workforce Increased productivity Reduced staff absenteeism	Number of organisations achieving accreditation	June 16 - June 17	Matt Pearce (CCG) Di Billingham (GCC)
	3.2 Developing a suite of workplace initiatives focused on physical activity i.e. CSP workplace challenge, physical activity champions	Increase staff morale Increased physical activity levels	Number of organisations taking part	June 16 - June 17	Deborah Potts (Active Glos)
Obesity	3.3 Co-develop a whole system approach to obesity as part of the Leeds Beckett and PHE pilot.	Reduction in the prevalence of obesity across the life course	PHOF / HSE NCMP	Jan 16 – Jan 19	Sue Weaver (GCC)
	3.4 Complete the feasibility phase of Gloucestershire Moves – social investment model	Increase in the proportion of adults being physically active	Active People Survey	Jan 17 – Jan 22	Deborah Potts (Active Glos)
	3.5 Undertake a comprehensive review of our adult and childhood obesity pathways using the transformation and redesign approach	Reduction in the prevalence of obesity across the life course Improvements in health and wellbeing and weight status among obese adults and children	PHOF / HSE NCMP Number of participants in weight management interventions and weight loss	June 16-June17	Sue Weaver (GCC) Matt Pearce (CCG)

	3.6 Commission Tier 2 and Tier 3 weight management services for children and their families.	Reduction in the prevalence of obesity across the life course Improvements in health and wellbeing and weight status among obese children	PHOF / HSE NCMP Number of participants and weight loss	Apr 18	Sue Weaver (GCC) Heike Fanelsa (CCG)
	3.7 Pilot a bespoke weight management programmes to increase uptake for men	Reduction in obesity prevalence in men Improvements in health and wellbeing and weight status among men	Number of participants Weight loss	2017	Sue Weaver (GCC)
Children	3.8 Implement at scale the Facts4Life programme to enable children and their families to take responsibility for their health	Positive impact on children's health related attitudes, beliefs and behaviour Reduced demands on the health service.	UWE Evaluation	2015-2018	Helen Ford (CCG/GCC)
	3.9 Roll out the 'daily mile' across schools in Gloucestershire	Increase in activity levels School attainment Reduction in child obesity prevalence	Number of schools signed up to Mile a day	June 16 - Mar 17	Deborah Potts (Active Glos)
	3.10 Ready Steady Go - Transition programme for young people with a long term condition	Empowers young people to take ownership of their condition improving their health in the long term.	Programme embedded throughout the three main health Trusts in Glos	2015-2018	Helen Ford (CCG/GCC)
	3.11 Implementation of Gloucestershire's Future in Mind Strategy – Schools pilot	Building resilience and early identification of mental health issues in children and young people. Supporting and joining schools together with mental health services.	Evaluation of the schools pilot	2016-2017	Helen Ford (CCG/GCC)
	3.12 Ensure healthy lifestyle support is embedded to meet needs across maternity and early year services	Healthy lifestyle support is targeted to areas of greatest need and impact.	Reduction in smoking cessation levels for women at time of giving birth	2016-2018	Helen Ford (CCG/GCC) Sue Weaver (GCC)
	3.13 Continue to develop our approach Social Prescribing to connect individuals to non-medical interventions to improve health and	Improved mental wellbeing Reduced A&E attendances, emergency admissions and outpatient attendances	Number of patients WEMWS Health Care service utilisation	June 17	Helen Edwards (CCG)

	wellbeing				
	3.14 Implement a VCSE Innovation grant fund to support community-centred approaches and increase capacity within the VCSE sector	Increased capacity and resilience within communities Belter self-care support within communities	Number of grants awarded	Mar 17	Helen Edwards (CCG)
Supporting communities to become healthy and sustainable	3.15 Systemic review of current ways of working in order to improve health and social care outcomes for older people, focusing on prevention and early intervention and collaborative working with District partners i.e. housing	Better Care Fund (BCF) outcomes: • Reduce emergency admissions • Reduce numbers of older people in residential care • People are at home 91 days post discharge • Reduce delayed transfers of care • Improve patient experience • Improve quality of life for carers	BCF assurance process: outcomes measured on quarterly basis and reported via BCF Provider Forum, JCPE and Health and Wellbeing Board. Individual projects starting in 16/17 will have bespoke measurement outcomes related to BCF	2016-19	Mary Morgan (GCC/CCG)
	3.16 Sustainable Travel Transition Fund – Think travel Gloucestershire	To increase active travel participation by challenging perceived car use dependency. Focused on improving 'access for all', 'access to jobs', and 'access to education and skills'.	Workplace Engagement with approx. 5,000 employees within the M5 Growth Zone. Target 10% mode shift away from the private car within the targeted group. Increase levels of walking and cycling.	2016-17	Orlagh Stoner (GCC)

	3.17 Develop a systematic approach to healthy and sustainable communities through influencing the planning process and working with district council partners	Health and wellbeing outcomes Better connected communities	PHOF, Marmot indicators		TBC
	3.18 Increase the range of self-care information, advice and services within community pharmacies.	Increase in patients knowledge, skills and ability to self-care Patients able to optimally manage their condition	Number of healthy living pharmacies Public Health Pharmacy Campaigns	Mar 2017	Teresa Middleton (CCG)

9.4 Supporting people					
• **Ensuring that people have the knowledge, skills and confidence to lead healthy lifestyles and self-care**					
Priority Area	**Actions**	**Outcomes**	**Measure/s**	**Timescale**	**Lead name / organisation**
Supported Self-care (including self-management)	4.1 Develop and pilot an integrated self-management education programme that meets the needs of patients with one or more long term condition	Patients with a long term condition have increased their knowledge, skills and confidence	Number of individuals accessing service PAM	2016/17	Craig Robinson (CCG) Matt Pearce (CCG)
	4.2 Increase capacity within the falls prevention service and shift emphasis toward prevention and education	Reduction in the number of falls as a result of greater support and assessment for those at risk of a fall.	Reduction in admissions to secondary care related to a fall	2016-17	Carl Davies (CCG)
	4.3 Pilot an 'exercise and lifestyle' pilot for stroke patients in partnership with the Stroke Association (SA)	Increase patient knowledge and skills to self-manage	PAM	2016-2017	Craig Robinson (CCG)
	4.4 Develop a patient facing website to support people to self-manage and navigate the health system	Increased patient knowledge and skills to self-manage Better health service utilisation	Website developed Number of hits	Mar 17	Anthony Dallimore (CCG)
	4.5 Widely promote ASAP to	Patients access the right service at the	Health Service	Ongoing	Anthony Dallimore (CCG)

Increase patient knowledge on how to self-care and access services	encourage local people and staff to use the most appropriate healthcare options (self-care and services) to meet their needs	right time Awareness of ASAP amongst the public the HCP's	utilisation data Qualitative evaluation App download data / website hits		
	4.6 Develop a single online portal for Gloucestershire that brings all information to one place	Patients have easy access to information, advice and guidance to meet their needs	Health Service utilisation data Qualitative evaluation App download data / website hits	July 2018	Matt Pearce (CCG)
	4.7 Implement integrated healthy lifestyles service following tender process	Individuals have access to information and support to adopt healthier lifestyles Individuals make positive lifestyles changes (stop smoking, lose weight, reduce alcohol, increase activity)	Number of participants Lifestyle changes (e.g. weight loss, smoking quit)	From January 2017	Sue Weaver (GCC)
Integrated Personalised Commissioning	4.8 Ensure current jointly funded individual packages have a person led care and support plan. Pilot additional cohorts where person led care and support planning may improve patient outcomes.	Patients have better coordinated care, better outcomes, and are more able to manage their own conditions, with lower reliance on statutory services.	Numbers of individuals with a person led care and support plan	Mar 18	Kim Forey (CCG)

Appendix 1 - Matrix outlining how local need on prevention is being met across the system

Area	Population need and prevention opportunities	Relevant Strategy or Programme
Clinical Pathway Specific Prevention	Improving case finding and early management of **hypertension and CHD**	CVD Clinical Programme Group
	Improving **Cholesterol control** in adults with **diabetes**	Diabetes Clinical Programme Group
	Improving **Cholesterol control** in adults with **Coronary Heart Disease**	CVD Clinical Programme Group
	Improving **Anti-coagulation** in people with **Atrial Fibrillation** (CHADS$_2$ score greater than 1)	CVD Clinical Programme Group
	Improving management and self-care for **Asthma**	COPD Clinical Programme Group
	Improving proactive care and support in **primary care** and the **community** for **complex patients** aged 55 and over and for **babies and children** (and their mothers), and a particular focus on those with circulatory problems, cancer and gastrointestinal problems.	Children's Clinical Programme Group
	Improving support and management **of common mental health disorders** in the **community**	Mental Health Strategy Group
	Improving access to **diabetic retinopathy screening**	Diabetes Clinical Programme Group
Health Improvement	Reducing the **incidence and prevalence of cancer** (especially bowel cancer, breast cancer) through **healthy behaviours**	Cancer Clinical Programme Group
	Reducing the incidence of **Low Birth Weight babies**	Children's Clinical Programme Group
	Reducing **excess weight in 4-5 year olds**	HWB Obesity Action Plan / STP Prevention and Self-care Plan
	Preventing and reducing **overweight or obesity in children**	HWB Obesity Action Plan / STP Prevention and Self-care Plan
	Promoting optimal **physical activity** across the **life course**	HWB Obesity Action Plan / STP Prevention and Self-care Plan
	Promoting **breast feeding**	Children's Clinical Programme Group
	Reducing **smoking prevalence at age 15** – occasional smokers	Health Inequalities Plan
	Reducing **maternal smoking**	Health Inequalities Plan / STP Prevention and Self-care Plan
	Reducing **Diabetes prevalence**	Diabetes Clinical Programme Group / STP Prevention and Self-care Plan
	Improving and maintaining **health and wellbeing** through **engagement with workforce**	STP Prevention and Self-Care
	Improving successful completion of **drug treatment for opiate and non-opiate users**	Drug and alcohol commissioning framework
	Reducing **Admissions episodes for alcohol-related conditions**	Alcohol Harm Reduction Action Plan 2016-19

Health Protection & Healthcare	Optimal uptake of **NHS Health Checks**	Health Inequalities Plan
	Public **Mental Health** (including **suicide and self-harm** prevention)	HWB Mental Health Strategy / Mental Health Strategy Implementation Plan / Suicide Prevention Action Plan 2015-20
	Optimal uptake of **breast, bowel and retinal screening**	Gloucestershire Bowel Screening Programme / National Breast Cancer Screening Programme / Gloucestershire Retinal Screening Programme
	Improving **Flu vaccine uptake** by pregnant women, at risk groups, older people and frontline staff	STP Prevention and Self-care Plan
	Optimising the uptake of **childhood immunisations**	
	Preventing **tooth decay** in children	Health Inequalities Plan
	Improving suicide rate (persons, males)	Gloucestershire HWBB Strategy / Suicide Prevention Action Plan 2015-20
	Reducing mortality rate from communicable diseases	Health Protection Assurance Framework
Wider Determinants	Improving **parenting** and **child care** support for **new mothers** and **at-risk families**	Children and Young People's Plan – 2015-18
	Improving **Early Years Education (school readiness)**	Children and Young People's Plan – 2015-18
	Reducing **Social Isolation**	HWB Older People's action Plan
	Improving **mental health and wellbeing of mothers**	Children and Young People's Plan – 2015-18
	Support early help for families experiencing mental health, **drug, alcohol** and **domestic violence** problems	Families First Phase 2 Outcomes Plan
		Children and Young People's Joint Strategic Commissioning Framework
		Domestic Abuse and Sexual Violence Commissioning Strategy & Outcomes Framework 2014-2018
	Engagement with and support for **carers**	Joint Carers Commissioning Strategy
	Supporting and **keeping adults and older people in their homes** for as long as possible	Gloucestershire County Council Strategy 2015-18 / Care At Home Review 2016
	Supporting **Dementia** patients in their **homes and communities**	HWB Older People's action Plan
	Improving **employment** opportunities and support for **people with mental health problems and disabilities**	Building Better Lives Implementation Plan
	Improving provision of **life-long learning** including **extended schools,** training and **apprenticeships**	Gloucestershire HWBB Strategy

> **A JOINT POLICY FOR ENABLING ACTIVE COMMUNITIES IN GLOUCESTERSHIER – REALISING OUR SHARED VISION**

1   Purpose

1.1   This policy describes how the Gloucestershire Health and Wellbeing Board will work to enable local communities to become more active, stronger and more sustainable, and in turn improve the health and wellbeing of local people.

1.2   This joint policy is accompanied by a governance framework, as well as a joint action plan describing what collective steps we are going to take.

2   Introduction

2.1   During 2013/14, the key organisations within the Gloucestershire Health and Care Community developed a five-year strategic plan, which was based on a programme of extensive community-wide engagement, This plan - Joining Up Your Care - included a shared vision for the future of health and care services in Gloucestershire:

> To improve health and wellbeing, we believe that by all working better together - in a more joined up way - and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people.

Three key ambitions were stated as:

- People are provided with support to enable them to take more control of their own health and wellbeing. Those that are particularly vulnerable will benefit from additional support;
- People are provided with more support in their homes and local communities where safe and appropriate to do so, thus moving away from the traditional focus on hospital-based care;
- When people need care that can only be provided in a hospital setting, it is delivered in a timely and effective way.

2.2   For the purposes of this policy, we are defining 'communities' as a group of people with a common interest or identity or who share a common place.

2.3   A set of principles as the foundation for collaborative working were also agreed, including -

> To build stronger, more sustainable communities and in turn improve the health and wellbeing of local people, we will draw upon, and stimulate the provision of, the diverse range of assets within each local community.

3 Background

3.1 For some time, as individual organisations GCCG and GCC have been developing their thinking around how the community assets in the county can be used to improve the health and wellbeing of local people. Since 2014 a joint programme of work has been underway to ensure the strengths derived from aligned working are maximised. Other key agencies have also sought to build on and support community-based activity.

3.2 Later in 2014, flowing out of its 'Together We Can' consultation, GCC has been working to clarify its own thinking about community capacity building and people accessing information, advice, guidance and services (across all council activities). The feedback from the consultation is summarised below, and has been used to support the formation of a GCC 'Active Communities Policy' and an 'Active Individuals Policy':

- Strong support for GCC's aim to make it easier for people to make choices that help them to stay active and independent;
- The need to make it easier for people to access information, advice and services;
- People need a range of options when they require support or advice, using technology and face-to-face support;
- Support for the notion of the Council consolidating its buildings and land in order to free up money for frontline services, but with many commenting on the potential of buildings to act as a community resource or to generate income.
- Overwhelming support for the idea of communities taking on a bigger role;
- Active Communities is people about being supported and involved, with people coming together to work towards a common goal. Also, it is about developing a new relationship with GCC, with more power and decision-making going to the community so that they may develop their own solutions to issues that are important to them;
- People identified a number of activities that they felt GCC could assist in supporting Community Capacity Building, such as funding, support and training, advertising of examples of other communities that were active, supporting the provision of places for people to come together, and utilising the assets of the Council itself (including buildings, information sources, publicity mechanisms and a large workforce);
- Communities need time and support to take on more responsibility, recognising that not all communities will be equally ready and able to do this.

It is recognised that the above messages will resonate in different ways with all the partners – i.e. health, county council, district councils, the VCS Alliance, Gloucestershire Healthwatch, Gloucestershire Constabulary and the Police & Crime Commissioner.

4 Our Starting Point

4.1 For many people in Gloucestershire outcomes are good. However, there are significant health inequalities that remain and must be addressed. Some of the key challenges we face include:

- 19,000 people in Gloucestershire classifying themselves as socially isolated;

- Comparatively high numbers of older people living in Gloucestershire mean there is greater pressure on health and care services;
- Challenges in supporting families and individuals who have benefitted from intensive professional support and preventing re-referrals;
- The county covers a large geographical area, with some isolated rural areas and a widely distributed population with two main urban centres, posing a challenge for equality of access to health and care services, as well as leisure activities.

4.2 *What are we aiming to do?*

Our Shared Vision states we will:

- Draw upon the diverse range of assets within each local community;
- Stimulate the provision of the diverse range of assets within each local community.

… And for what purpose?

Discussions taken place to date have suggested that the purpose of doing these things is to:

- Improve individual and community health and wellbeing through a **range of measures to encourage and enable positive health behaviour**;
- **Reduce social isolation** and the associated negative impacts on health and wellbeing;
- **Improve outcomes for vulnerable people and families,** and reduce the risks they face.

Although these are the primary drivers, further areas include to:

- Reduce demand for services by enabling more people to receive help within their communities
- Enable people to live in their own homes safely as long as they are able/wish to;
- Encourage people to take more control of their own health and wellbeing, including self care/management;
- Be local centres for community activity, and connecting local people;
- Be a gateway into accessing other public services;
- Reduce the need for people requiring extra care;
- Enable protection of, and support for, vulnerable people in their communities;
- Strengthen local communities in an inclusive way.

Furthermore, the ambitions within the Shared Vision include the following purpose: *"People are provided with more support in their homes and local communities where safe and appropriate to do so."*
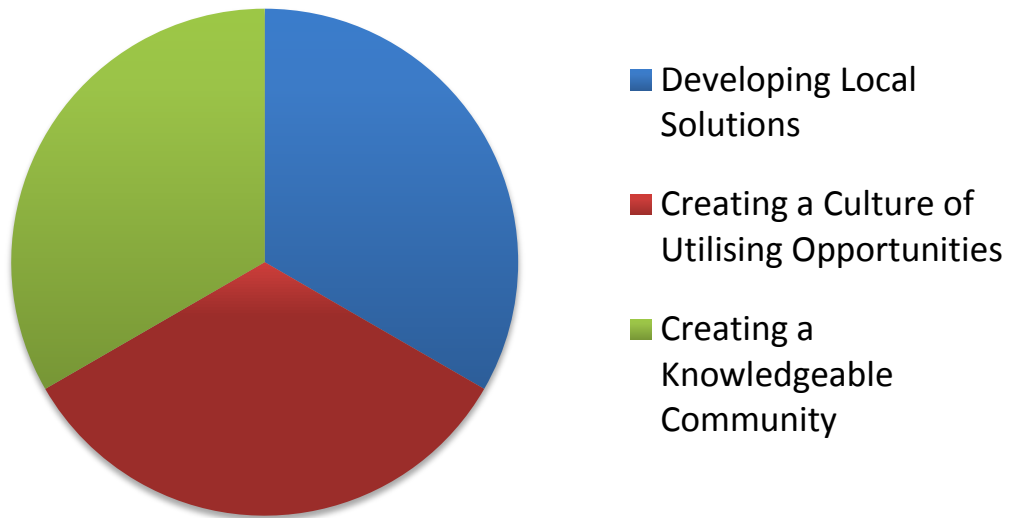
5 Our Approach

5.1 Building on the wide range of work already underway across the county,

our approach is to focus future work around three key strands in order to achieve our ambitions to:

- Draw upon the diverse range of assets within each local community;
- Stimulate the provision of the diverse range of assets within each local community.

Enabling Active Communities

Legend:
- Developing Local Solutions
- Creating a Culture of Utilising Opportunities
- Creating a Knowledgeable Community

6   Developing Local Solutions

6.1   In line with the well-documented Asset Based Community Development (ABCD) approach, we need to work **_with_** communities to identify what their needs are and how they might be better met. Where possible, the following steps are required to develop local solutions:

STEPS
Agree desired outcomes (see section 4.2 above)
Define the community you want to achieve the desired outcomes for, e.g. geographically, area of deprivation, age groups, health characteristics/condition
Define, <u>with the community</u>, **what are the right solutions (e.g. interventions/activities)** to meet the desired outcomes
Undertake a **baseline assessment of existing community resources** for the defined community
Evaluate success of existing community resources for the defined community to meet the desire outcomes
Identify gaps, if any
Formulate plan to address the gaps (using best practice/innovative approaches where possible). The plan is likely to include: • Expansion of existing community groups/services

> - Creation of new community groups/services

6.2 It is envisaged that there will be a range of triggers that could enact the above activities; for example, part of rolling-out good practice models to inspire others to take action; an approach requesting assistance from a community; and needs identified through another community based activity, for example social prescribing.

6.3 Over time, it is envisaged that communities themselves will continue to develop the above process further as part of an ongoing cycle, with the aim of commissioners being to draw upon and stimulate community assets by providing an initial 'helping hand'.

7 Creating a Knowledgeable Community

7.1 Most people want information and advice to point them in the right direction. Many will use online services to 'self serve'. There is little value in supporting community services and activities if no-one knows they are there and/or how to access them. Creating a knowledgeable community should:

- Enable people to resolve minor issues quickly and easily;
- Maximise access to, and utilisation of, appropriate services and activities;
- Help in the ongoing process of identifying issues where the community could 'step up' or where there is a real need for additional statutory services;
- Help deliver the aim of 'drawing upon community assets'.

7.2 As well as the individual needing help in some way, there are a wide range of people – from the public themselves, to community and voluntary groups, to the staff across the public sector - who need to be knowledgeable and have access to reliable advice and information, such as those shown in Annex One.

7.3 Aligning to the GCC Active Individuals Policy, the key question then is what can the health and care community in Gloucestershire (practically) do to support the creation of a knowledgeable community? There are three areas of focused work required to answer this question:

a) Raising awareness/interest/knowledge of staff about services and activities (building on considerable work already underway);
b) Access to, and promotion of, relevant information about what is available;
c) Public sector organisations working together to ensure their collective investment in advice and information is better managed for impact and reviewed.

8 Creating a Culture of Utilising Opportunities

8.1 There are already a wealth of health and care-related services and activities available in Gloucestershire to support local people. As well as ensuring communities have the knowledge about what is available, it is vital that existing opportunities are utilised and that the workforce is willing and able to build on community resources.

8.2 What do we mean by opportunities? They include:

a) **Workforce**: Annex One demonstrates diagrammatically that for many people in Gloucestershire, they already have 'connections' (possibly multiple) with health and care staff and services. These people/teams could support individuals by signposting other services/activities from which they would benefit;

b) **Buildings**: We cannot let ourselves focus entirely on services and buildings. However, we know that many buildings (public, private and VCS owned) are underutilised, such as community hospitals, GP surgeries, schools, churches, extra care housing, care homes, community centres, libraries etc, and we should be making the most of these valuable existing resources. We may also take opportunities to bring access to community services advice and information together;

c) **Existing services/centres/hubs**: There are already centres of community activity that can be used and developed, for example the GCC Older People's Community Hubs.

8.3 In summary, we need to utilise existing opportunities provided by the staff we employ and the connections they already have with people in local communities, spare capacity in buildings and maximise use of existing activities/community resources. We will align this work to the approach set out in GCC's Active Communities Policy.

8.4 As part of creating a culture of utilising opportunities, we also need to consider how new opportunities can be created.

- How will health and care staff be trained and supported in sharing knowledge and information with individuals and communities?
- How will people interested in setting up new community groups be enabled to do so (e.g. advice on fundraising, governance, marketing)?
- How will communities be stimulated to identify where there are buildings with spare space?

The joint action plan accompanying this policy will seek to tackle these issues.

9 Working Together

9.1 We recognise that each organisation (health, county council, or district councils, as well as partners such as the VCS Alliance, Gloucestershire Healthwatch and the Police & Crime Commissioner) cannot achieve all the above alone – we need communities to be willing and able to work with us. Similarly, we need to make sure that we are working in a joined-up, coherent way with other public sector partners to avoid making it unnecessarily complicated for communities to interact and work with us. We will therefore work together based on a clear set of principles, adopted from GCC's Active Communities Policy:

'Engaging with Communities' Principles

- **An asset based approach**: recognising and building on the strengths that exist within each local community including the people, facilities, places and environments
- **A needs-based approach**: The Council should prioritise *its* support for those communities where need is greatest
- **A shared approach**: Looking for shared priorities and co-producing shared solutions so that plans take account of what is important to and what works in each community

- **A local approach** that allows people to take control of the process, helps them to decide which outcomes matter most and finds solutions that suit the local circumstances. This means that solutions will look different in different communities
- **An empowering approach** that recognises the legitimacy of different voices within the community and give local people the opportunity to express their views, develop consensus and take action. As a council, we will be willing to participate without taking charge
- **A partnership approach**: We will work with other parts of the public sector, voluntary and community groups to develop common approaches to building capacity
- **An inclusive approach**: Ensuring that the voice of under-represented groups is heard within communities and that communities include all views and backgrounds.

9.2 We recognise that it is vital to have a shared/common language across all parties in order to simplify how we work together. We will adopt the definitions detailed in GCC's Active Communities Policy (see Annex Two below).

9.3 We have developed an overall governance framework to support work across partners to deliver the approach described in this policy and realise our collective ambitions. Our collective work is described in a joint action plan. The action plan is a starting point that will grow and evolve as communities identify their own strengths, weaknesses and opportunities to engage in active communities.

9.4 The challenge we have in taking forward this work is a considerable one. Statutory organisations can assume they know what is best for individuals and communities; this is often based on a professional view of the world. Delivering our ambitions will therefore inevitably be a very long-term process in order to change what has been decades of entrenched thinking. However, it's a journey that we must go on if we are to have a sustainable health and care system over the coming years, recognising though that the length and breadth of the journey for each community will differ. In considering the best way forward, we need to begin by collectively acknowledging this timeframe and challenge, but also recognise that there is significant collective interest in starting this journey, albeit one step at a time.