Prevention in social care: where are we now?

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Skills for Care is the employer-led, strategic body for workforce development in social care for adults in England. It's part of the sector skills council, Skills for Care and Development.

This work was draws heavily on a review of existing evidence by Wavehill Ltd, a specialist research agency.

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Introduction

There is growing interest in the role of social care in the prevention agenda, outlined in health and care policy. However, it remains unknown how social care providers interpret and deliver services to include the main aims of prevention.

In order to understand more about the current situation, Skills for Care commissioned research to:

- provide an overview of the published and unpublished literature relating to prevention in social care
- consult with stakeholders to understand more about engagement with the prevention agenda
- identify examples of practice in England to learn more about how prevention is working in social care.

The research was conducted by Wavehill Social and Economic Research (2019) under the guidance of Skills for Care. This short report draws together the main findings from the research.

We hope this report will stimulate debate and discussion in this area to further explore how the sector can build on and embed best practice.

Prevention in social care

Summary

A key rationale behind prevention and promoting wellbeing is its potential to reduce the demand for remedial and acute services and improve the outcomes of people who need care and support.

However, there's a lack of common understanding and consistency in the approach to prevention and wellbeing within the social care sector.

Whilst policy reflects primary, secondary and tertiary levels of prevention, in practice, mapping and measuring delivery in social care is hampered by this lack of consistent understanding and application.

What does the sector say?

Prevention is a well-used term across many sectors, including health and social care. However, there's no clear definition or consensus of what prevention means in practice in social care (Wavehill 2019). This lack of consensus presents a clear challenge on many levels, for example, how do you measure the impact of social care on the prevention agenda or how can you synthesise good practice when you have no common basis of understanding?

There's disagreement as to the extent to which social care can or should be involved in the prevention and wellbeing agenda. This was illustrated in a recent consultation with stakeholders in social care (Wavehill, 2019), who described different ways in which prevention is viewed in the sector, for example:

- social care, by its very nature, is all about prevention with a focus on delaying and reducing the need for care
- social care is not currently supported to deliver a prevention role as this would require a change in commissioning to focus more on prevention activities and less on task-based outcomes
- social care does not have a primary role in prevention, but in working with others e.g. public health, to support their work
- social care has a very clear role in prevention given the close contact and relationships with individuals
- social care should have a much clearer role in social prescribing, care navigating and other local approaches which tackle prevention.

There's also limited evidence on the impact of social care in prevention, which offers no direction for travel.

Nonetheless, given the role and contact that social care staff have with people who need care and support, there are lots of opportunities for involvement and a growing interest in the potential of the social care workforce by health bodies such as Public Health England, Health Education England and the Royal Society for Public Health.

What does policy say?

At a national level, prevention is firmly on the policy agenda for health and social care with the aim of tackling causes, rather than the symptoms, of particular issues. This reflects ongoing concerns over sustainability, as services stretch to meet the needs of an increasing ageing population and people living with long term conditions.

The Department of Health and Social Care (2018) vision, '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 from arising in the first place and, when they do, supporting people to manage them as effectively as possible. Prevention is as important at seventy years old as it is at age seven*."

There are three levels of prevention dominant in policy.

Whole population Selected groups	Selected individuals at risk	People using services
Primary prevention Reduce risk factors to prevent likelihood of health and wellbeing issues. Ongoing public health messaging and programmes	**Secondary prevention** Identify population at risk and early detection of health and wellbeing issues. Targeted programme	**Tertiary prevention** Support and manage existing condition to prevent deterioration. Specific support – reablement and self-care

The vision highlights the need to use new technology and build workplace strategies and local communities, to support people with health conditions and prevent worsening health. There is a clear role for the social care sector in this vision.

The Care Act 2014 placed statutory requirement on local government to provide preventative services. It states that local authorities must provide or arrange services that help to prevent people needing care and support services, or delay people deteriorating to a point where they need ongoing care and support.

Policy is being supported by initiatives such as the Better Care Fund (BCF) which joins up working between health and social care. To date, their work has focused on secondary and tertiary level prevention with the aim of reducing referral/transition to more intense service options (Forder 2018).

Supporting policy implementation, there's a growing trend towards measuring the outcomes of prevention in health and social care:

- the Care Quality Commission (CQC) Key Lines of Enquiry (KLOEs) set out factors that inspectors assess, include examining how providers support people to live healthier lives (KLOE E4, CQC, 2017)
- the Adult Social Care Outcomes Framework (ASCOF), a tool used to set priorities for care, now also measures delayed or reduced need for services.

What are key prevention outcomes?

The prevention agenda aims to improve peoples' outcomes and reduce the strain facing social care and other public services.

The key prevention outcomes can be categorised into:

- individual
- staff
- organisation/system.

Outcomes for individuals

Wavehill (2019) identified a range of key outcomes of the prevention agenda for individuals, including:

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

Outcomes for staff

There's potential for positive outcomes for staff delivering the prevention agenda through spill-over effects from improved knowledge and awareness of their own lifestyle, health, wellbeing and risk factors.

In addition, employer initiatives and interventions directly aimed at staff are becoming increasingly popular and focus on improving staff wellbeing.

The key outcomes of the prevention agenda on staff include:

- increased job satisfaction
- reduced employee stress and burnout
- improved relationships at work
- higher levels of staff engagement.

Outcomes for organisations and systems

As a sector, there are two main potential benefits for engaging in prevention work:

- reduced demand on services
- increased staff retention.

The social care sector is facing a range of workforce challenges, including recruitment and retention and relatively high rates of turnover (Skills for Care, 2017).

Service innovations through the prevention agenda could offer part of the solution to these challenges, through improving the wellbeing of staff and the attraction of new job roles within the sector.

Key approaches in prevention

Summary

The literature identified five key approaches to prevention.

Advice and guidance: evidence from health is promising but there's no evidence from the social care sector, although uptake of training in this area is growing.

Physical activity promotion: there's strong evidence of the impact of promoting exercise and movement, and the role of social care in this work should be further explored.

Social prescribing: the evidence for social prescribing is inconclusive, however, the number of these schemes is likely to increase which will give a better evidence base for assessing their effectiveness.

Reablement: there's evidence to support that reablement improves health-related quality of life and improved service outcomes. Research is ongoing to consider the cost effectiveness of the approach.

Asset-based approaches: the complexity of this approach makes evidence synthesis difficult, but there is potential in developing this approach and our knowledge on the role and impact of social care.

The adoption of preventative approaches is patchy and variable. The evidence available (Wavehill, 2019) highlights five approaches to prevention in social care:

- advice and guidance
- physical activity promotion
- social prescribing
- reablement
- asset-based approaches.

Advice and guidance

This approach focuses on giving advice and guidance to increase people's knowledge about the potential risks surrounding health and to share information on promoting wellbeing. This could relate to a range of potentially harmful behaviours, including sedentary lifestyles, smoking, alcohol intake or poor diet.

Consultations with several domiciliary care providers indicated that their workforce is already engaged in promoting healthy lifestyles in this way (Wavehill 2019).

For example, a number of providers talked about *Making Every Contact Count* (MECC), a national approach to changing peoples' behaviour by providing advice and guidance about health and wellbeing at every opportunity. Whilst still limited, social care providers are increasingly accessing training and support offered through MECC and embedding the approach in practice.

As part of the approach, staff training focuses on equipping them with the confidence, skills and knowledge to raise discussions around lifestyle in conversation with individuals at every opportunity. The objective is to embed this approach into every day work duties, rather than changing peoples' job roles. MECC also has support for organisations to help them embed the approach.

MECC in social care: Dorset County Council

Dorset County Council is rolling out MECC training to upskill their workforce in having healthy conversations with their teams and clients.

They worked with Livewell Dorset to develop a training offer for health and social care teams. This training is split over training for 'self', which includes 5 ways to wellbeing and resilience, and training to enable staff to support 'others', which includes healthy conversations and motivational interviewing.

MECC in social care: Kent and Medway STP

Kent and Medway Sustainable Transformation Partnership (STP), Kent County Council and Medway Council are working together to develop free training and practical resources for health and social care staff.

They did a survey with staff to understand their current confidence and knowledge around the principles and concepts of MECC, their confidence in having conversations with clients about a range of lifestyle areas (for example, smoking, mental health, alcohol and obesity), their time or capacity to have conversations about lifestyle issues and whether they're currently delivering brief interventions about unhealthy lifestyle choices and behaviours.

They used learning from the survey to develop the resources, which include bitesize learning and training in counselling techniques such as motivational interviewing, Cognitive Behaviour Therapy and solution-focused brief therapy.

There are practical limits that affect the extent to which this type of activity could take place during care visits, given the limited time that staff spend with people.

Nonetheless, pilot evaluations of MECC initiatives in health care services have found training to be effective in changing cultures of practice within health (Patten and Crutchfield, 2016).

There's no current evidence available for the social care sector, an issue that was highlighted by a number of stakeholders during recent consultations (Wavehill 2019).

Promotion of physical activity

There's a strong body of evidence around the impact of delivering physical activity and movement interventions, that focuses mainly on its' role in fall prevention and mobility maintenance.

Care About Physical Activity (CAPA)

This programme focuses on improving activity levels and movement for people using adult social care services. The model provides resources to help services move away from specific activities that are led by an activity coordinator, towards the whole workforce taking steps to encourage people to move more through everyday tasks such as putting away equipment, helping with food preparation and moving between rooms.

Evaluation has reported significant increases in participant wellbeing, reduced anxiety, increased happiness and improvements in self-efficacy to exercise. Following training, staff also report increased confidence in encouraging older people to move, greater self-efficacy delivering activities and had become more active themselves (UK Active Research Institute 2018).

There's strong and consistent evidence that supporting and promoting exercise, movement and staying active is effective for different groups of people, across primary, secondary and tertiary areas of prevention.

In social care, there's evidence to suggest that exercise and activity programmes:

- significantly reduce the risks associated with falling and reduce the rate of falls (Gillespie et al. 2015)
- increase mobility function and independence for older adults (Liubicich et al. 2012)
- improve physical activity for those receiving advice (Campbell et al 2012)
- are cost effective, especially where direct supervision or instruction is not required e.g. walking groups (Garrett et al. 2011).

Social prescribing

Social prescribing is a way of linking patients in primary care with sources of support in the community. It's being widely supported as a way of managing some of the pressures on general practice and is likely to increase following targeted investment in the voluntary sector through NHS England's 'Health and Wellbeing Fund' (Gov.uk, 2018).

The main outcomes associated with social prescribing include:

- health and wellbeing outcomes (e.g. around mental health and general health)
- healthcare usage outcomes (e.g. reduction in reliance on healthcare)
- patient experience (e.g. satisfaction with approach and increase in knowledge).

Wavehill (2019) identified a range of examples where people were referred to activities provided by local or national voluntary and community sector organisations. These activities included exercise and other physical activities, signposting to housing, welfare and debt advice, adult education and literacy, befriending, counselling, self-help support groups, lunch clubs and art activities.

Social prescribing is delivered in the community in lots of different ways, and we don't know the extent to which social care is involved. However, stakeholders involved in the Wavehill consultation indicated that there was a role for the social care workforce in supporting people to navigate local services.

Wellbeing advisor (social prescriber), Tandridge District Council

Tandridge District Council has recruited several wellbeing advisors to deliver their wellbeing prescription (social prescribing) service in East Surrey, that works to promote lifestyle change and prevent ill-health.

Wellbeing advisors work one-to-one with people in GP surgeries and/or in their own home. They use behaviour change techniques to help people to identify their health and social needs, encourage change and signpost them to services that can help them to live a healthier lifestyle.

People may be referred to the service for a variety of reasons including loneliness, anxiety, obesity and an inactive lifestyle.

The evidence is limited but there are some common factors that contribute to the success of social prescribing (Wavehill 2019, Pescheny et al. 2018), including:

- resources and training to support coordinators and enable networking with the voluntary and community sector
- good communication between GPs, link workers and participants
- good organisation and management of introduction to social prescribing
- shared attitudes and understanding between clinical and non-clinical staff involved
- good relationships and communication between partners
- organisational readiness before introduction, including staff training
- good support and supervision from senior management.

Pescheny et al. (2018) highlighted that some of the barriers to success include poor economic climate and funding, high staff turnover and low patient engagement.

Bickerdike et al. (2017) concluded that the available evidence base is limited by poor design and reporting, and, therefore, remains inconclusive about the role and potential of social prescribing as an approach to prevention and promoting wellbeing.

Reablement

Reablement aims to help people to regain their skills and confidence, enabling them to live independently, and is focused on their individual outcomes. Reablement services can support an individual to:

- remain at home with minimum support from domiciliary/community services where there's evidence of declining independence or ability to cope with everyday living
- return home from hospital or other in-patient care settings following an acute episode
- enable independence for longer and reduce the demand for residential care.

The recent increase in reablement services has led to a range of service models and differences between approaches, in terms of their functions and objectives. While reablement may include elements of rehabilitation, a key objective in their development was to provide clinical oversight in settings other than acute hospitals, and predominantly in peoples' own homes (Parker, 2014).

Depending on the particular approach, reablement services may be delivered by a range of professionals, including volunteers, care workers, care managers, community nurses, occupational therapists, and physiotherapists. Some reablement teams employ occupational therapists to deliver training to care workers, especially in the areas of assessment and goal setting. The roles and responsibilities are also diverse, from befriending and offering social support, to intensive instrumental support. This presents challenges in understanding and mapping practice and evidence.

Kent Enablement at Home Teams (KEAH)

In Kent, nine KEAH teams empower support workers to make reasoned and insightful decisions and help them to understand how to work with people to create personalised goals.

They use weekly reviews and structured paperwork to regularly review a person's progress and ensure the right support is provided at the right time.

Improvements are driven by analysis of the recorded data, which ensures issues that could prevent people achieving their best outcome are reviewed at an area and county-wide level.

Evaluation indicates that 83% of people who go through KEAH leave the service able to live independently at home and the number of care packages required has been reduced. The service has recorded year on year increases in the number of people who leave the service fully independent. In addition, the average amount of weekly support for those leaving the service with a care package has reduced by 40 minutes due to improved outcomes.

There's also an estimated saving of £3.2 million on long term support.

Research and evaluation into reablement is limited due to the complexity and diversity of delivery. However, there's some evidence (Beresford et al. 2019, Tessier et al. 2016, SCIE 2013, IRISS 2011) to suggest that the key factors that contribute to success include:

- a shift in commissioning practice from 'time and task' to individualised outcomes
- specific training for care workers to understand the principles of reablement, that's underpinned by a commitment to the approach
- clarity around role and input across different professions
- user engagement and goal-orientated interventions established with individuals, families and carers, with flexibility to respond to circumstances
- understanding of who might benefit most from reablement services
- inclusion of psychosocial and social support as well as attention to physical needs
- ongoing support from management
- involvement of specialist support and multi-disciplinary working
- provision of support by a single team rather than separate assessment and reablement staff.

The research base is limited, but there is some evidence from the UK and abroad (Beresford et al. 2019, Tessier et al. 2016, SCIE 2013, IRISS 2011, Windle et al. 2009) that the implementation of reablement can improve:

- service outcomes, specifically prolonged ability to live at home and reduced need for home care services
- health related quality of life
- job satisfaction for care workers
- outcomes for individuals linked to increased functioning and independence.

Asset-based approaches

The fundamental question underpinning an asset-based approach is ‘what will make us healthy?’ rather than ‘what will make us ill?’ The aim of this approach is to promote and strengthen factors that support good health, and build communities and networks to sustain this.

There is some evidence to suggest that health and social care staff are encouraged to focus on what can improve health and wellbeing and reduce preventable inequalities (Rippon and Hopkins 2015). Specific services offered within an asset-based approach seek to draw on a person’s skills, networks and community resources in order to improve the care and support they receive, and the third sector plays a crucial role in this.

The key steps in this process involve identifying assets, mobilising assets and measuring assets. There’s also growing knowledge around the importance of individuals, associations, institutions, place-based assets and connections.

EveryDay Wellbeing Centres, Age UK North Tyneside

Age UK North Tyneside, trading as EveryDay, runs EveryDay Wellbeing Centres that provide mini wellbeing checks, including measuring weight, height, body mass index (BMI), blood pressure, lifestyle and self-care advice, Hospital Anxiety and Depression Score (HADS) and 6 item Cognitive Impairment Score (6CIT).

The centres are available to everyone - older people can pay privately or access the services via direct referral from their GP or social worker.

They also provide an ‘exercise snacking’ programme, which offers structured bouts of exercise, twice a day, to increase wellbeing, power, muscle and strength in older people, including those living with dementia and living independently. The programme is based on research from the University of Bath and Department of Health.

In a recent review, Blickhem et al. (2018) concluded that asset-based community development appears to be a promising way to support people with long term health conditions, but there’s a lack of evidence to support this approach – this view is also reflected by broader reviews (e.g. Rippon and Hopkins 2015).

The evidence around this approach is often generated locally which makes it challenging to synthesise findings into transferable learning.

There is some learning from broader community development approaches which suggests potential for this approach, and discussion continues around developing a clearer framework for evaluation and indicators, specifically for asset-based approaches.

There’s some evidence that focuses on what helps with successful asset-based community development (McNeish et al. 2016, Morgan 2014, Foot 2012), including:

- prioritising theoretically-based positive paradigms for wellbeing

- involving individuals and local communities effectively and appropriately
- connecting individuals with their community and broader society
- facilitating decision-focused, multi-professional and multi-disciplinary working
- securing investment through multi-method, evidence-based approaches
- focusing on development within the community, based on systems that reflect their need, not organisational needs
- including social, economic and environmental factors in the approach.

Prevention and the integration agenda

Summary

Prevention and the integration agenda are closely linked. New job roles with a remit for preventative action continue to emerge across health and social care, and the social care workforce needs to work effectively within new multi-disciplinary integrated models. These roles tend to focus on co-ordinating services, community connections and raising the profile of the strengths of the individual, with the intended benefit of improved choice and control, independence and increased access to the local community.

The prevention and wellbeing agenda overlaps significantly with integration and the policy drive for closer collaboration between health and social care organisations. This way of working includes strong links with the voluntary and community sector. There are various routes to facilitate closer working relationships:

- new care models
- wellbeing teams
- new and emerging job roles.

New care models

In 2015, NHS England and partners established the 'New Care Models Programme' to develop and test new ways of delivering health and care services. The programme spanned three initiatives including: Integrated Care Pioneers; Vanguard sites and the primary care home model. Social care providers and their workforce need to work effectively within these integrated care models to achieve strong outcomes for people who need care and support.

Five case studies from the Vanguard sites tested preventative approaches to improving health, wellbeing and experience of care (NHS Confederation, 2016). A key feature of these was their focus on using multi-disciplinary teams and the use of holistic, person-centred approaches.

There was one case study about enhanced health care in care homes, that was designed to reduce demands on secondary care, in particular through the work of multi-disciplinary teams. Evaluation found evidence to support this approach with a reduction in ambulance call-outs and total bed days.

Wellbeing teams

Wellbeing teams are based on the Buurtzorg model from Holland and are characterised by the creation of self-managing, values-led, neighbourhood-based care teams. A number of wellbeing teams have been established in England, including Thurrock Council, Oxfordshire County Council, Stockport MBC, Trafford Council and Wigan Council.

Wellbeing teams differ from traditional models of care in the following ways.

- Wellbeing teams are self-managing.
- The teams know what matters to each person and use this to co-produce a service that will help them to achieve their outcomes.
- Wellbeing teams work to outcomes, not just to deliver tasks.
- Wellbeing teams use the Support Sequence to deliver outcomes.
- Wellbeing teams are neighbourhood-based.
- The lengths of the visits vary according to what the person needs and wants.
- Wellbeing team workers know where they can use creativity and judgment.
- Wellbeing teams are small and close-knit.
- Wellbeing teams set their own rotas.
- Wellbeing team workers give and get feedback to and from each other (compassionate communication).
- The approach includes supporting the wellbeing of team members.

A Wellbeing team will typically include the following roles.

Wellbeing worker	Focus on ensuring people can do what matters to them at home and in the community
Community circle connectors	Connect people and teams to local communities
Practice coaches	Support wellbeing workers and ensure delivery of compassionate, person-centred care and support. They also support staff learning and development
Team coaches	Help the team to keep learning and developing, while focusing on wellbeing and self-organising

Research has shown that people working in self-managed teams are more satisfied than those working in traditional teams, and, as such, the model has potential benefits for the wellbeing of the social care workforce.

New and emerging job roles

New job roles, with a remit for preventative action, are continuing to emerge across health and social care, for example, trusted assessors, care navigators, care coordinators, local area coordinators, wellbeing advisors and lifestyle coaches.

These new roles tend to focus on coordinating support and services for people who need care and support, as well as raising the profile of prevention and promoting wellbeing amongst staff.

There are some common characteristics of this approach (Skills for Care and NHS Health Education England 2018), including:

- holistic and person-centred approach rather than task focused
- effective multi-disciplinary working
- influencing behaviour change and motivation towards healthy lifestyles
- providing information and guidance on healthy lifestyles
- signpost to local services and community support
- strong communication
- good information management.

Care coordinators, South Derbyshire

Care coordinators work to support and enhance integrated care delivery in the community. The main aim of the care coordinator is to help to avoid unplanned and inappropriate hospital admissions. They do this by liaising with colleagues and other health and social care professionals to support and coordinate the care of patients within a GP practice who are identified as being at ‘high risk' of their current situation deteriorating, and who may benefit from a multi-agency approach either through referrals and/or analysis of available data (e.g. frequent attendees to A&E or out of hours services).

Whilst it’s difficult to quantify the extent and effectiveness of these new and emerging job roles, benefits for individuals can include user involvement, improved choice and control, focus on independence and strengths of individuals and increased access to community and local organisations. For staff, the benefits focus on improving person-centred care to improve health and wellbeing, enhanced job role and increased job satisfaction.

How can we develop capacity in social care?

Summary

The social care workforce will need to develop their skills, knowledge and expertise to deliver effective prevention and wellbeing activities. There's a range of training resources available and some examples of social care workers accessing training through existing initiatives, for example, Making Every Contact Count (MECC), however there's limited evidence of take up across the sector.

The use of technology has the potential to develop capacity and learning to deliver prevention.

Commissioning for prevention and wellbeing will require a focus on co-production, working in partnership with local citizens and increased use of technology.

Wavehill (2019) highlighted that different approaches to prevention will place different demands on staff in terms of skills, knowledge and expertise. Workforce development needs to be a key feature in any move towards a more preventative approach. Social care staff will need to develop new skills, knowledge and capabilities to deliver effective prevention and wellbeing activities, for example, to be involved in:

- providing information of local services and support
- offering advice and guidance relating to self-care
- recognising common signs of poor health
- identifying health and other risks in a person's home or through their behaviour or presentation.

Staff may also need to develop persuasion, motivational and effective communication skills to discuss new and potentially difficult topics, support people to set goals and have follow up conversations.

This Sutton Vanguard Service Model provides an example of how staff are learning new skills and receiving additional training to support with hydration and nutrition.

Sutton Vanguard Service Model

The objective of the model is to empower care staff to make decisions and have conversations with other staff about improving hydration and nutrition.

They developed a comprehensive approach to support staff in developing and implementing effective practice. For example, nurses who work with care homes deliver training and support on hydration and nutrition for care workers.

Nurses and care workers are encouraged to attend annual study days around continence and bowel management. Staff are also offered 'quick guides' about preventing urinary tract infections.

Resources for workforce development

The learning and development materials that are currently available have mostly been published by health agencies such as Health Education England, the Royal Society for Public Health and Public Health England. These resources tend to have a health focus, making it more challenging for social care providers to apply in practice.

In their research, Wavehill (2019) found that there is a need for a resource which fully integrates the social care perspective, and there could be merit in developing core principles or a common holistic skillset for social care, to sit alongside existing prevention work.

In the absence of a social care framework, providers seem to be increasingly accessing training and support offered through MECC (Wavehill 2019).

West Midlands e-learning for MECC

These training tools have been developed for social care staff across the West Midlands and are split into three sessions.

Brief encounters: this first eLearning session is suitable for *all frontline staff* and is based on a simple 'Ask, Advise, Assist' conversation framework. This framework supports frontline staff to have brief conversations that raise awareness of wellbeing and lifestyle behaviours, say something encouraging and supportive of making changes, and signpost to trusted sources of information and support. The focus is on all aspects of wellbeing.

Motivating change: this eLearning session focuses on the behaviour change model and person-centred conversation framework. It's suitable for staff *working with people who are either at high risk of lifestyle-related health conditions or already have one or more health conditions* or *who care for people with health conditions*. By using a person-centred conversation framework, staff can encourage people to consider the personal outcomes that are important to them, and to identify their first steps towards achieving them, as well as the support they need to take those initial steps. This session also introduces a health-coaching conversation framework for staff who support people to make and maintain their desired behaviour changes.

MECC plus for integrated care: these additional resources support the workforce to implement MECC based on integrated care principles and practice. They include case studies, PowerPoint presentations and example MECC pathways, illustrating how brief person-centred conversations can support the holistic assessment of a person's needs, as well as enable them to make changes to improve their self-care management.

There's also a 'MECC Plus Manual' that suggests bite-sized learning opportunities for managers and trainers to use with their teams, and a 'MECC Plus Pocketbook' that provides an aide memoire for all frontline staff.

There are some other examples of workforce development to support prevention.

For example, Coventry and Warwickshire STP has developed training on nutrition, mental health, health coaching and health championing for social care providers. Health Education England Hertfordshire and Worcestershire is working with domiciliary care providers to develop learning and development around prevention. Some specialist charities and training providers, such as Community Catalysts, offer training courses around community-based approaches with a focus on prevention.

Despite the availability of opportunities, there remains limited evidence of the take up and engagement from social care providers. Reasons could include a lack of awareness around the prevention agenda, lack of understanding, lack of funding for training, time to release staff and staff motivation to take on what can be perceived as new and additional responsibilities (Wavehill 2019). These issues need to be taken into consideration when encouraging providers to engage with prevention work.

Use of technology

Technology has the potential to develop capacity in the social care workforce to deliver prevention and wellbeing activities. This could include:

- predictive analytics: use of environmental indicator data collected through electronic technology to help determine needs
- diagnostic technology: use of personal diagnostic technology to promote self-care to avoid potential health crises
- learning and development: use of technology to facilitate learning and development e.g. eLearning and bite-sized learning.

Nottinghamshire County Council

Nottinghamshire County Council has developed a demonstration project exploring the potential of data analytics to inform an 'early warning system' for proactive referrals into adult social care. The decision support tool seeks to identify those at risk to prevent or minimise crisis, provide short-term reablement, assistive technology and effective signposting to delay the need for longer term social care, and provide care at home to prevent the need for residential care.

The system uses data from health and social care systems about residents of Nottinghamshire aged 65 and over, and highlights those residents whose combination of health, social and environmental indicators mean that they're at higher risk of losing their independence, even if they're not aware of it themselves or have not asked for support. The platform has proved to be a useful basis for strategy, commissioning and operational practice.

Care City – Test Bed Programme

As part of the Test Bed programme, Care City is working with domiciliary and residential care providers in the London Borough of Havering, to increase confidence in self-care and build the digital skills, confidence and productivity of the workforce. The aim is to improve management of long-term conditions, and therefore reduce pressure on health services.

Staff use digital technology to spot deterioration early in people with a long-term condition including:

- digital measurement of vital signs such as temperature, blood pressure and heart rate. Care workers are then able to take baseline observations and an algorithm is used to empower the care worker to decide when to involve the GP

- digital urine testing using a digital camera to identify the colour of urine and help care workers predict any potential issues.

Commissioning and contracting

Commissioning for prevention and wellbeing requires commissioners to focus on how they work in partnership with local citizens and how they co-produce new models of support.

Skills for Care launched the 'Commissioning for Wellbeing' qualification in 2017 and early findings suggest that when commissioners focus on outcomes, actively apply legislation and work in co-production with their local citizens, it's possible to begin to change local models of support.

'Stabilise and make safe'

'Stabilise and make safe' is a short-term reablement model designed to increase people's chance of long-term independence, which is accessed following hospitalisation or via a community referral.

The business model is based on geographic areas to foster good understanding of local demand with a pricing model based on a fixed cost to the local authority, rather than an hourly rate, to incentivise providers and promote quality of care. Staff are expected to be high-calibre and subsequently receive enhanced rates of pay and training.

The following benefits have been reported:

- 70% of clients achieving full independence following six weeks of support
- reduced length of hospital stays
- reduced times from referral to assessment (one-three days following referral)
- estimated £1million net savings in the first year of the service
- return on investment of £7.78 for every £1 invested.

Source: SCIE (2017)

Implementing prevention in practice

Summary

Social care employers will need to take account of critical factors to effectively implement and embed changes to practice, with a variety of contributing factors to success.

Stakeholders expressed that change which aligns with staff values and beliefs, with clear benefits to people who need care and support, can be a key success factor, as well as strong leadership and the right workplace culture.

There are innovations in prevention practice that are embedded into existing service frameworks, as well as those that seek cultural shifts and service re-design.

Wavehill (2019) found that one of the critical factors influencing a successful move towards preventative approaches is the knowledge, attitudes and behaviours of staff. In the same study, stakeholders expressed a view that staff are more likely to be on board with change if it aligns with their values and beliefs and has benefits for people who need care and support.

The evidence (Wavehill 2019, Rabiee and Glendinning 2011) suggests that to be successful:

- staff should be aware of the underlying rationale for change, in addition to the practical details of forthcoming changes
- communication strategies for change should focus on the positive outcomes for people who need care and support as a higher priority, over and above cost savings
- adequate time and funding should be available to allow staff to integrate new approaches into practice, with sufficient time and attention including peer and professional support, guidance, and training.

Although limited, some information from stakeholders (Wavehill 2019) indicated the following could contribute to success:

- the right workplace culture supported by leadership and supervision
- good team working
- flexible and agile working
- well supported and developed staff
- regular communication and sharing of practice
- embedding the principles into everyday practice e.g. through conversation and supervision
- strong relationships between commissioners and providers, with a focus on long-term planning and provision
- a continued focus on the principles of prevention and promotion of wellbeing.

Stakeholders also felt that it was useful to link up the economic incentives when developing preventative approaches, for example:

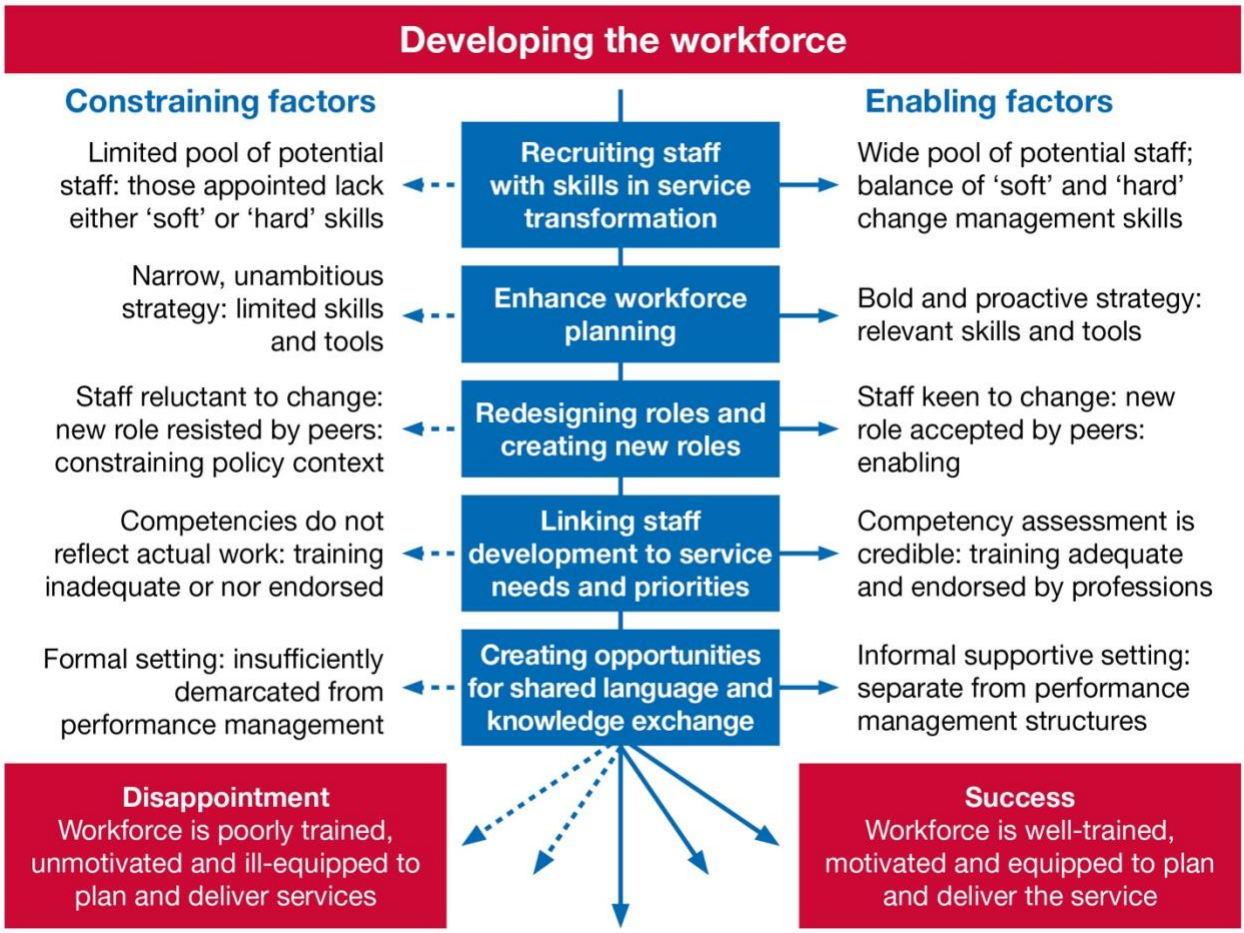
- the use of technological innovation to support better outcomes for people
- attracting and retaining staff through more fulfilling roles
- using social care budgets to achieve positive outcomes for people whilst developing community enterprise
- achieving savings which can be reinvested in social care.

Ensuring effective implementation

Macfarlane et al. (2011) developed a useful approach for mapping and understanding the success factors underpinning workforce redesign.

Figure 1: Enabling and constraining factors in workforce redesign

(Macfarlane et al, 2011), reproduced in Wavehill, (2019)



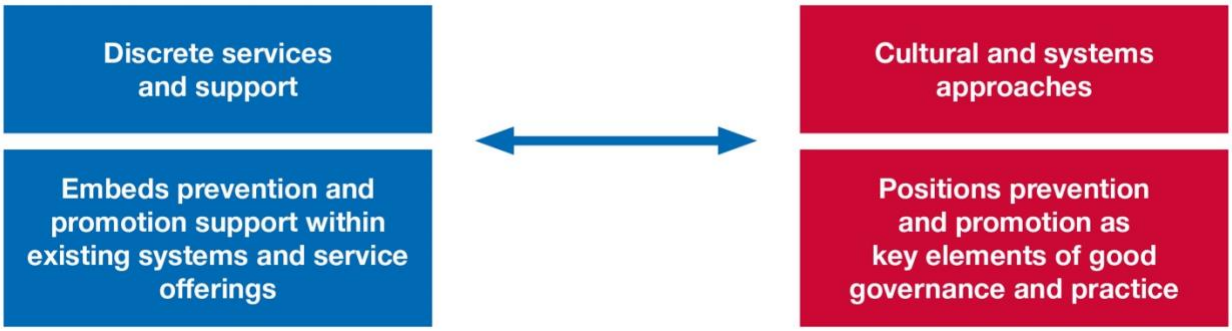
Wavehill (2019) also identified broader organisational level and influences, such as:

- strategic and operational leadership
- cultures of learning and practice
- the organisational context.

Embedding prevention and promoting wellbeing into practice

Wavehill (2019) identified a range of ways that prevention and wellbeing approaches are embedded in practice (see Figure 2) and found examples of innovations in practice that were implemented into existing service frameworks. Other approaches included cultural shifts in practice or significant service re-design. These seek to embed prevention into everyday practice and governance, where staff consciously apply principles of prevention in interactions with people who need care and support.

Figure 2: Achieving cultural shifts in practice (Wavehill, 2019)



Gaps in the evidence

Wavehill (2019) suggests that the focus of future primary research should seek to explore the role and potential of prevention and promoting wellbeing for under-represented groups within the research base. This includes people with disabilities, carers and people accessing domiciliary care services. Future research exploring the effectiveness of certain provision should seek, in the first instance, to improve the quality and rigor of the evidence base.

Another area where further research could be valuable relates to the impact of the prevention work delivery and the spill-over effect on the wellbeing of staff. This would advance our understanding of the role and potential of prevention and promoting wellbeing practice, whilst also deepening our understanding of the consequences and implications of practice more generally.

Next steps

The evidence has found a mixed and limited understanding of the definition of prevention in social care and the role of the workforce. We need to do more work to highlight how the social care workforce supports the prevention agenda.

The evidence demonstrated that the social care workforce has an important role to contribute to the prevention agenda, however we need to further understand the key elements of that role and the skills and knowledge that the workforce needs to be active and valued partners in any programme of prevention.

We plan to conduct further research with a range of employers to explore their experiences of implementing workforce development activity that significantly contributes to the prevention agenda. The aim will be to demonstrate what employers need to do to enable their workforce to be active and knowledgeable contributors to the prevention agenda.

As we move into the second phase of the work, we'll work with strategic partners, providers and commissioners in line with prevention policy and priorities.

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