

Adult Social Care Prevention First Strategy

2026 – 2031



Contents

01 Foreword	3
02 Our Vision	4
03 Drivers of adult social care	5
04 What we mean by ‘prevention’	8
05 Guiding principles	12
06 Preventing social care need	16
07 Reducing and managing demand	21
08 Delaying and avoiding long-term demand	30
09 Delivery, governance and monitoring	38
10 Partnering with us	39

Foreword

Welcome to our Adult Social Care Prevention First Strategy for 2026–2031. It sets out our strengthened commitment to embedding prevention across everything we do.

This strategy renews our commitment to proactive, preventative interventions that help people in Hampshire live long, healthy and independent lives, while delaying or reducing the need for adult social care.

Changes in national direction, technology, demography and demand create opportunities to work differently with partners and communities. This will require changes in professional leadership and practice, how we use data and share information, how we work together and commission services across disciplinary and organisational boundaries.

The role of Adult Social Care and Occupational Therapy is central to achieving the health and care outcomes that residents want to see, and our public services require. Our staff work at the most local level, supporting people in their homes in the context of their family, community and neighbourhoods. Social care has as much of an influence over health prevention as health and housing have in reducing demand for adult social care.

We invite statutory partners, Voluntary, Community and Social Enterprise Sector organisations and residents to put prevention first and take action that improves outcomes, reduces inequalities, restores dignity and strengthens communities.

This Strategy is a flag in the ground – a marker of our commitment to doing ‘our sizeable bit’ to stem demand, prevent health deterioration and maximise independence. It is equally a call to action – an ask of you to do your bit, too.

Cllr Zoe Huggins BEM

Executive Lead Member for Adult Social Care and Public Health

Our Vision

Our vision is for every person in Hampshire to live a long, healthy and independent life, in the place they call home, with the people and things that they love, belonging to safe and thriving communities.

We want to prevent, reduce and delay the need for social care through earlier intervention and a strong focus on the people and communities who make up the greatest demand for care and support, and experience the poorest health and wellbeing.

By implementing this Strategy in partnership, we aim to create positive change:

- More people will live independently at home for longer
- Fewer people will move into long-term residential or nursing care
- Risk and deterioration will be identified earlier
- Our front door and information offer will be stronger
- Unpaid carers will receive better support
- More people will be supported through community solutions
- Agencies will work differently together in neighbourhoods
- Inequalities will reduce.
- Avoidable admissions due to falls and frailty will be fewer.



The following 'I' statements from the Think Local Act Personal Making It Real framework reflect what success will feel like for people.

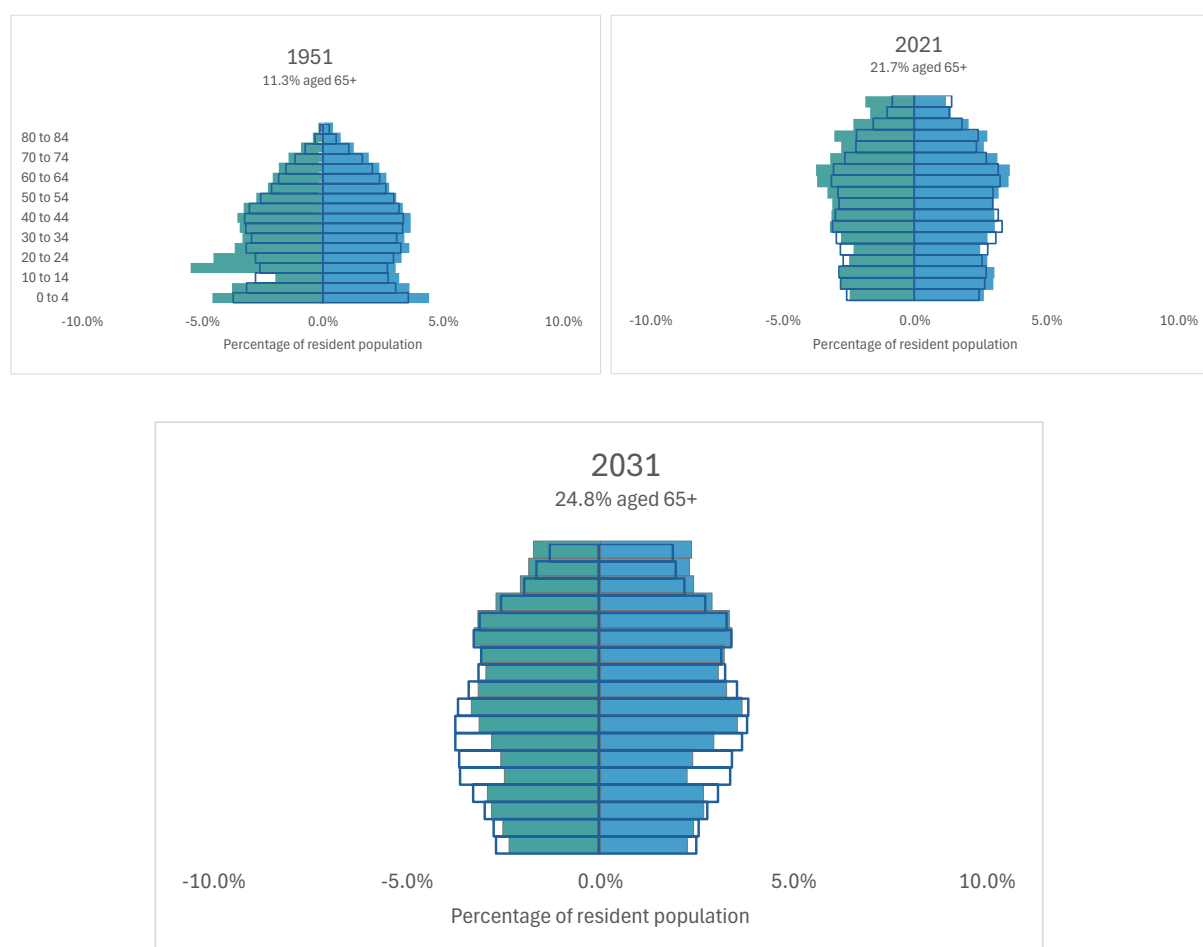
- I am supported by people who see me as a unique person with strengths, abilities and aspirations.
- I can live the life I want and do the things that are important to me as independently as possible.
- I feel safe and am supported to understand and manage any risks.
- I can get information and advice that is accurate, up to date and provided in a way that I can understand.
- I have people who support me, such as family, friends and people in my community.
- I am supported to plan ahead for important changes in life that I can anticipate.
- I live in a home which is accessible and designed so that I can be as independent as possible.
- I can plan ahead and stay in control in emergencies.
- When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place before change happens.

Drivers of adult social care demand

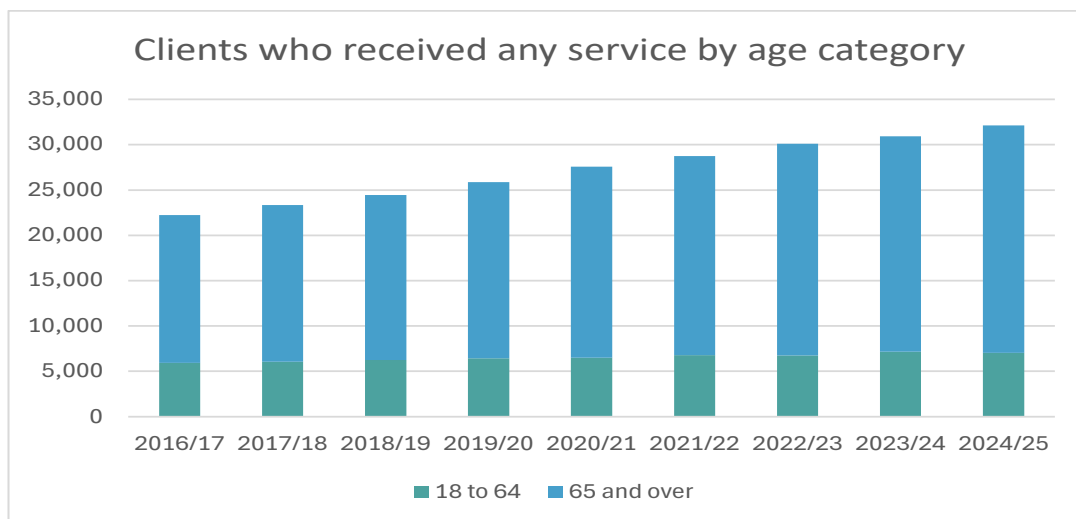
Demographic change

Hampshire has a growing and ageing population, with a higher proportion of older adults than the national average. As people live longer, they are more likely to be older and live alone, experience reduced mobility and increased risk of falls, have multiple and complex health needs, and live with dementia or cognitive decline. These factors increase both the likelihood and duration of care and support needs.

Hampshire's changing and ageing population structure is placing increasing and different demands on health and social care services. Demand for adult social care is increasing in scale, complexity and cost, driven by demographic change, inequality and rising levels of need. Without a shift in how demand is managed, these pressures will continue to grow and become harder to sustain.



The number of people receiving services continues to rise, with the greatest increase in the numbers of older adults



Inequality and developing needs earlier

Demand for care is not evenly distributed across the population. The highest rates of need relative to population size are often found in areas of greater deprivation where fewer people can pay for their own care privately and more are reliant on state funding and support. People living in more deprived communities are more likely to enter care earlier, have more complex needs and live longer in poor health.

Increasing complexity of need

Many individuals accessing support are living with multiple long-term health conditions, including frailty, dementia, mental health needs and physical disability. These needs often interact, resulting in higher levels of risk and more intensive support requirements.

Demand is also increasing among younger adults. Although people with learning disabilities in the UK continue to have a lower life expectancy than the general population, there is evidence that some individuals are living longer than in previous years. This is a positive development, but it also brings new challenges. These can include the loss of a parent or family carer, as well as the increasing impact of age-related health conditions, which may mean spending more years living with complex health needs.

Demand is also growing amongst people with complex mental health needs where there are also inequalities. People with Serious Mental Illness die around 10-15 years younger than the wider population. Individuals often present at a point of crisis, requiring high-cost interventions and long-term support.

Importantly, many people who go on to require long-term care have had previous contact with services. This indicates an opportunity to intervene earlier, address risk factors and prevent escalation.

Rising cost and system pressure

Prevention is first and foremost about improving people's lives. If we are to sustain high-quality adult social care in the face of demographic and financial pressures, we must also change the trajectory of future demand and expenditure.

Rising numbers of people requiring support, combined with increasing complexity, are driving higher costs across all areas of provision. A targeted and systematic approach to prevention can delay when people enter the system, slow down the escalation of need, and reduce higher-cost, long-term care. This can reduce resource pressures and help agencies to focus on people with the greatest need.



What we mean by 'prevention'



Prevention is central to the Care Act 2014, which places a statutory duty on the upper tier councils to prevent, reduce and delay the need for care and support.

In line with the Care Act, prevention is a continuous process which requires a consistent approach applied at each stage of a person's journey.

This means:

- **Preventing people from developing care and support needs** (sometimes known as 'primary prevention') - we will act earlier to prevent demand from arising by supporting people to remain healthy, connected and independent within their communities

Mandy lives alone and has been identified through council systems as being at increased risk due to social isolation following the loss of her partner. Her family live some distance away and are concerned about her wellbeing but want to help her to remain independent. A proactive call from Technology Enabled Care partner Argenti Advice explores how everyday technology could help Mandy stay connected, reduce isolation and give her family greater reassurance. Community Wellbeing Workers support Mandy to access a local charity which provides bereavement support and financial advice.

- **Reducing the level of need where it exists** (sometimes called 'secondary prevention') - Where risks begin to emerge, we will intervene sooner to reduce escalation and prevent crisis.

Mandy experiences a fall which requires admission to hospital. During her time in hospital, she is supported to move which prevents muscle deterioration and supports her motivation to get better. When she leaves hospital, she continues to be supported to move through a short period of enabling care at home to help her regain her strength. A strengths-based, person-centred assessment of Mandy's needs is undertaken. Mandy is given an Argenti falls detection aid and is supported to access a local community group close to where she lives where she can build friendships and stay active. Minor adaptations are made to Mandy's home to remove hazards and prevent future falls.

- **Delaying the progression to more complex or costly support** (sometimes referred to as 'tertiary prevention') – Where individuals already require support, we will focus on delaying or reducing long-term and high-cost demand by promoting independence and avoiding unnecessary reliance on formal care.

Mandy starts to experience more frequent falls, and this pattern is picked up through Argenti data analytics. Local partners have shared that Mandy has withdrawn from local support groups and there has been contact from her family raising concerns about Mandy feeling disorientated at times. This information is considered holistically, and Mandy is supported to access health services to explore early signs of dementia. Mandy's care and support needs are reassessed, and her care and support plan updated. She is allocated a dedicated worker. Mandy agrees to Argenti ADL (Activities of Daily Living) sensors on a short-term basis to monitor movement in the home. This helps to reassure Mandy's family that Mandy can continue to be safely supported at home.

Acting across these stages helps us influence the trajectory of demand rather than simply respond to it.

Summary of our ambitions

In line with the Care Act 2014, prevention is a continuous process which requires a consistent approach applied at each stage of a person's journey.

Guiding Principles				
Reduce inequalities in access to care and support services.	Take data-driven and evidence-informed action.	Strengthen co-production and community empowerment.	Work as a whole system partner in delivering neighbourhood health and care	Develop a skilled and confident workforce
Preventing Social Care Need				
Enhance our information and advice offer, making it even more accessible.				
Embed prevention within front door activity.				
Improve the quality of referrals into the Multi Agency Safeguarding Hub				
Strengthen the system-wide approach to falls and encouraging people to move more.				
Influence local plans and planning policy so that housing development maximises independence.				
Support disabled people or people with social care and health needs into good work, volunteering or education and training.				
Reducing and Managing Demand				
Reduce smoking and alcohol intake amongst those in receipt of adult care and support services.				
Support nutrition, healthy weight, hydration and continence.				
Prevent suicide and harm arising from domestic abuse, neglect and self-neglect.				
Prevent and slow the progression of cognitive decline and dementia, ensuring people receive timely support and intervention.				
Expand the proactive and preventative use of Technology Enabled Care across key pathways.				
Strengthen support for carers and reduce carer breakdown.				
Strengthen community-based reablement and ensure enabling approaches are consistently applied.				
Improve the identification of, and support for, people affected by hearing and sight loss known to Adults' Services.				
Improve continence outcomes and support people to maintain independence.				
Delaying and Avoiding Long Term Demand				
Reduce use of residential care and support access to community-based solutions.				

Improve choice and control by increasing uptake of Direct Payments and strengthening the Personal Assistants market.
Delaying and Avoiding Long Term Demand (continued)
Enable people to plan for their future health and care needs and reduce unplanned demand from capital depletion.
Enable individuals with long-term or lifelong needs, their families, and carers to transition well into older age.
Increase young people experiencing successful transition into adulthood accessing community-based settings with maximum independence and minimum restriction.
Increase the number of people who are supported to return home from hospital quickly and safely, with a focus on recovery, independence and avoiding long-term care where possible.
Improve ability to identify early signs of deterioration so that we can intervene earlier, stabilise need and prevent avoidable escalation.

Guiding Principles

Our approach to embedding prevention as a core part of demand management will be guided by key principles.

Reduce inequalities in access to care and support services

We focus action where need is greatest, improving access to services for under-represented groups at greater risk of unmet needs and poorer outcomes. We engage through trusted, community-based networks so that support is accessible, culturally appropriate and responsive to need.

Take data-driven and evidence-informed action

We use data, evidence and insight to guide decisions, target action and improve what we do. We focus action on the risk factors that drive demand and escalate need, such as frailty, falls, reduced mobility, incontinence, cognitive decline, social isolation and carer breakdown. We take a population health management approach, working with residents, health partners, councils, Voluntary, Community and Social Enterprise Sector organisations and communities to identify risks earlier and intervene before needs escalate.

Strengthen co-production and community empowerment

We work with people with lived experience, unpaid carers and communities as partners, using local insight and strengths to shape services and interventions that people trust and use.

We strengthen connections between local authorities, wider statutory services and Hampshire's thriving Voluntary, Community and Social Enterprise Sector. Many needs can be effectively met through this network of local provision, which plays a vital role in preventing escalation of need, supporting wellbeing, reducing isolation and building resilience.

Work as a whole system partner in delivering neighbourhood health and care

We take a coordinated, whole-system approach, recognising that many factors influencing adult social care needs sit beyond our direct control. This includes raising awareness of how health, housing, wider councils and the Voluntary, Community and Social Enterprise Sector can deliver interventions that affect social care demand.

In return, we recognise the vital contribution that adult social care makes to preventing illness and dependency and easing pressure on health services. Working with other councils, wider statutory partners, the Voluntary, Community and Social Enterprise Sector and residents, we want to maximise adult social care's contribution to delivering an integrated approach to neighbourhood health. Our central role in preventing health needs and delivering holistic support to individuals in the context of their family and community networks, makes us integral to delivering accessible and integrated care within local neighbourhoods, close to home.

As local government reorganisation develops, we will use this strategy to maintain a clear and consistent focus on prevention, independence and demand management. We will work with partners to ensure that future changes to local government structures strengthen local collaboration, support earlier intervention and continuity of care and protect place-based approaches to improving outcomes for residents.

Develop a skilled and confident workforce

We embed prevention in everyday practice and through a skilled and confident workforce – both our own and, with partners, supporting and influencing the external workforce where we can. Every contact is an opportunity to identify risk, support independence and promote wellbeing.

The following table summarise the ambitions, actions and success measures that support this strategy's guiding principles and delivery priorities.

Guiding Principle	How it will guide our approach	What success looks like
Reduce inequalities in access to care and support services	• Develop understanding of under-represented groups and demand to enable equitable access to preventative services. • Improve access to information, advice and early support.	• Higher prevalence of under-represented groups accessing preventative support.
Take data-driven and evidence-informed action	• Strengthen use of population health intelligence and demand modelling, alongside local insight and community engagement to understand demand and co-design interventions. • Adopt a 'test and learn' approach and pilot new approaches, enabling continuous improvement. • Develop a systematic approach to evaluation; strengthen links with academia so that research is more consistently applied to practice and supports independent evaluation.	• Interventions are focused where they are known to have greatest impact based on better understanding of need, risk and outcomes. • Data is used to stratify risk, anticipate emerging needs and reduce inequalities, leading to more proactive and preventative interventions. • Prevention activity is linked to measurable outcomes supporting better decision-making. • We know what works and can scale approaches that deliver meaningful impact.
Strengthen co-production and community empowerment	• Strengthen connections between statutory services and community-based support. • Enable the growth of community capacity and early help. • Recommission an expanded Community Wellbeing Service and align with wider community navigator roles.	• Individuals are connected to appropriate local support at the earliest opportunity. • People benefit from increased resilience and independence. • Reduced referrals into statutory services and reduced repeat contact. • Increased diversion from formal care pathways.

Guiding Principle	How it will guide our approach	What success looks like
Work as a whole system partner in delivering neighbourhood health and care	• Seek to play a full and active role in neighbourhood health so that people receive integrated care. • Shape and implement neighbourhood and place-based initiatives which bring services closer together, shaped by the people who use them. • Raise awareness of how partners can deliver targeted interventions which prevent social care demand. • Upskill staff in Asset Based Community Development approaches and strengthen community connectedness. • Influence Best Start in Life so that families and carers receive holistic support. • Understand the role and activity of system partners so that we can develop more effective local pathways and maximise opportunities for joint preventative action.	• People consistently benefit from timely, joined up and effective preventative support in their communities. • Professionals work together across disciplinary and organisational boundaries in multi-disciplinary teams which offer holistic, joined-up care. • Duplication is reduced and demand is managed more effectively across organisational boundaries.
Develop a skilled and confident workforce	• Develop the workforce so that staff are confident and able to take action to reduce the progression of adult social care need within assessment, care planning and review, and to identify and respond to risk. • Refresh training, tools, guidance and resources and equip staff in behavioural change approaches. • Collaborate with Public Health to give staff confidence in promoting health protection activities, including vaccinations, hydration, continence and Infection Prevention and Control.	• Staff understand what prevention means for their roles and are confident in behavioural change approaches and promoting health protection activities. • Prevention is evidenced in assessment, support planning and review and reflected in supervision, quality assurance and professional leadership.

Preventing social care need

We will focus where there is strong evidence that timely intervention and access to universal services can support health and wellbeing and prevent the need for adult social care.

Social care need is driven by a combination of demographic change, complexity of need and wider determinants of health, such as deprivation, isolation, access to quality housing and employment. Many of the health conditions which drive care needs, such as dementia, strokes, heart failure, chronic lung disease and diabetes amongst others, are preventable.

We will play our part in influencing the preventable underlying causes of poor health and wellbeing, identifying risks earlier, supporting equal access to universal information and advice, and connecting people into evidence-based, preventative support in their communities. This will reduce unnecessary referrals, avoid escalation of risk and support more people to remain healthy and independent.

Housing and employment

Housing, employment and transport all influence health and independence. We will work with District and Borough Councils, registered providers and partners to support the development of accessible homes, housing adaptations, Disabled Facilities Grants, Supported Housing Strategies and employment opportunities that enable people to remain independent and connected to their communities.



Falls and physical activity

Falls are a major contributor to loss of independence, hospital admission and the need for social care. Increasing frailty, reduced mobility, and long-term health conditions contribute to a higher risk of falls, particularly among older adults. Falls are both predictable and largely preventable. Even relatively small increases in physical activity can contribute to increased independence, better health and quality of life and help to prevent chronic disease, functional decline and frailty.

Falls prevention features prominently in sector-wide initiatives and there are established programmes across Hampshire to support physical activity and social connection, such as *Live Longer Better*, jointly led by Public Health, Adult Services and Energise Me, and the Hampshire Steady and Strong programme. By working in partnership and developing a more joined-up approach, we can help more people to maintain mobility and confidence and achieve better health and care outcomes.



Access to information and advice

Access to clear, timely and accessible information is empowering and should be available at any point that a person needs it, with partners ready to signpost and support access.

Connect to Support Hampshire is an established resource for all residents seeking information and advice about care and support, with around 400,000 online sessions each year. Content is co-produced in response to feedback, fully accessible to people with different cognitive or visual impairments, and available in 200 different languages, as well as via a printed and widely distributed guide. By working with our partners, we want to ensure these guides reach the places that residents routinely go to find information.

Residents also receive accessible information through our webpages, the **Upfront Information Process**, which ensures residents receive information in accessible formats prior to their care needs assessment, and the **Family Plan**, which supports individuals to consider how they will maintain their health and wellbeing with support from family, friends and access to community resources.

These resources form part of Adults' Services 'pre front door' offer. Partners are encouraged to use this as their first 'port of call' for people seeking support and recognise when more than simple signposting is needed to help people access the help that they need – for example, through 'warm handovers' or Community Connectors.

The front door to adult social care

Preventing demand from arising begins at the earliest point of contact. The front door to Adults' Services acts both as a point of access and a key gateway for managing demand through advice, signposting, timely intervention and early resolution.

We are rapidly transforming the front door to adult social care to help people access support more quickly and reduce unnecessary contact and referrals. Every contact is an opportunity to identify risk and provide appropriate, timely support. This will be enabled by getting the right balance of self-service and human contact, enabled by technology and a skilled frontline.

The Multi-Agency Safeguarding Hub sits as part of the front door to Adults' Services and is the point of contact for safeguarding concerns to be raised across the system. We will work with partners to support referrals which meet the definition within the multi-agency Safeguarding Concerns Framework, enabling demand to be managed and resources to be focused where needed most.

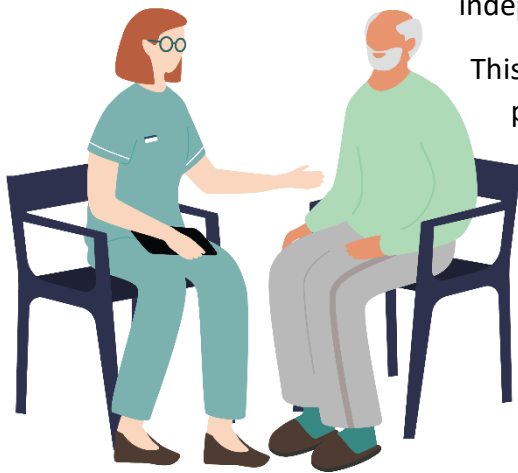
Our ambitions	What we'll do	What success looks like
Enhance our 'pre front door' information and advice offer, making it even more accessible	• Promote our 'pre front door' offer to partners as the first port of call for information and advice. • Align Public Health campaigns and information, such as on vaccinations, with Connect to Support Hampshire. • Develop self-service options, alongside non-digital contact channels. • Work collaboratively with the Voluntary, Community and Social Enterprise Sector to enhance accessibility and develop our non-digital information offer. • Ensure staff are confident in our information and advice offer, including accessible formats.	• More people can find and access the information and advice they need, when they need it. • Partners play an active role in signposting and supporting people to access the information and support that they need. • More people can 'self-serve' and find the support they need within their community. • Feedback is routinely used to ensure our pre front door offer remains relevant. • Referrals into Adults' Services are reduced.
Embed prevention within front door activity	• Strengthen triage and early resolution. • Integrate preventative services into front door pathways, starting with the Community Wellbeing Service. • Use data to improve demand management. • Expand self-service and digital options.	• More people can 'self-serve' and find the support they need within their community. • Referrals into Adults' Services are reduced. • Contact at the front door to Adults' Services is reduced. • A mature understanding of demand data informs the development of services.
Improve the quality of referrals into the Multi-Agency Safeguarding Hub	• Work with partners to raise awareness of the Multi-Agency Safeguarding Concerns Framework. • Provide feedback on safeguarding concerns.	• The proportion of safeguarding concerns that meet the multi-agency definition is increased. • Wider professionals and providers understand why a concern is or is not progressed.

Our ambitions	What we'll do	What success looks like
Strengthen the system-wide approach to falls and encouraging people to move more.	• Strengthen early identification of frailty and falls risk. • Expand access to strength and balance interventions • Embed falls prevention into frontline practice and care planning by increasing strength and balance and supporting home hazards assessment. • Consider how to influence the external market to support falls prevention, e.g. via training.	• Reduced hospital admissions and readmissions linked to falls, frailty and dementia. • Delayed entry into long-term care. • Reduced new referrals and repeat contact into Adult Services following crisis. • Delayed progression of need, reflected in care package size and cost.
Influence local plans and planning policy so that housing development maximises independence.	• Raise awareness of the links between health, housing and social care and strengthen the role of Occupational Therapy in preventative housing interventions. • Influence Supported Housing Strategies so that these support independence whilst reducing homelessness. • Influence the development of supported and specialist accommodation to ensure accessible design standards, with development matched to demand. • Influence transport strategy and plans to take account of the needs of older adults living in areas of deprivation.	• There is sufficient availability of quality supported accommodation to meet need. • Housing and transport strategies support independence and reduce inequalities in health and care. • Occupational Therapists routinely contribute to preventative housing interventions. Professionals understand the importance of suitable housing and transport links to prevention and how this is relevant to their roles.
Support disabled people or people with social care and health needs into good work, volunteering or education and training	• Successfully deliver the Government's Connect to Work initiative. • Encourage the replication of local initiatives which connect people with care and support needs to volunteering, training and employment opportunities.	• More people with a disability or with health conditions and complex barriers are supported to access and sustain volunteering, training and employment opportunities.

Reducing and managing demand

We will reduce and manage demand within adult social care by providing timely support where people are at risk of their needs escalating, or they are already in receipt of care and support.

For individuals already known to Adult Social Care, prevention focuses on slowing, stabilising or reversing the escalation of need through identifying risks early, providing timely support and focusing on enabling people to retain or regain independence.



This will be achieved through strengthening preventative practice across existing services and ensuring that support is proactive rather than reactive. This may include earlier use of strength-based conversations, timely referral into community or therapy-based support, preventing infections by promoting vaccination take-up, and practical interventions that maintain mobility and confidence.

Risk factors

Several key risky behaviours or wider risk factors contribute to health deterioration and escalating care needs. These factors disproportionately affect those living in more deprived communities and cause inequality in health and care outcomes:

- **Smoking** – There are many benefits to stopping smoking including physical and mental health, fire safety, prevention of harm to others through second-hand smoking, and being better off financially. Smoking rates are significantly higher among people with mental health conditions, who often face barriers to accessing cessation services and support. Other groups at greater risk include people living in low-income households and people with complex needs, such as those experiencing homelessness, substance misuse and Gypsy, Roma and Traveller communities.

Smoking is often viewed as a lifestyle choice – however, it is a physiological addiction from which most people who smoke want to be free. In line with our duty under the Care Act 2014 to promote wellbeing, we want to support people with care and support needs to stop smoking and protect our staff from second-hand smoking.

- **Alcohol and drug misuse** – The vast majority of people who are dependent on alcohol in Hampshire are not receiving treatment. Drug and alcohol use is higher in areas of greater deprivation. We want to contribute to reduced levels of alcohol use and drug misuse by identifying risks, issues and opportunities to offer advice and support earlier.

- **Nutrition and healthy weight** - Nutrition plays an important role in the development of age-related diseases. Malnutrition, or deficiencies in vitamins and minerals, particularly in older people, is associated with faster functional and cognitive decline, falls, infections, disability, more hospital admissions, longer hospital stays and loss of independence. Risk is increased amongst those living alone or in areas of social deprivation. We want to strengthen the role of adult social care in supporting people to maintain a healthy diet and reduce the risk of malnutrition.



Public Health commissioned services provide weight management support for people with Serious Mental Illness and Learning Disabilities, helping residents experiencing the greatest inequalities to improve their health and wellbeing.

We will collaborate with Public Health to support appropriate referral into weight management support for people with care and support needs.

- **Hydration and Continence** – Alongside nutrition, adequate daily fluid intake is critical to good health and wellbeing, preventing urinary tract infections, dizziness, falls and hospital admissions. Hydration also supports continence and reduces the risk of poor bladder and bowel health. For many people, continence issues are treatable, manageable or can be improved through early intervention, advice, rehabilitation and appropriate support. We want our staff to be knowledgeable and confident in promoting continence so that care plans include effective measures which also uphold individuals' dignity and independence.

We have identified a further **three areas of safeguarding risk** where action is needed across the system to prevent abuse and neglect and keep people safe. These are **suicide prevention, preventing domestic abuse and acts of neglect and omission and self-neglect**. We want our staff and partners to feel confident and equipped to identify risks associated with these three areas and take timely, effective and joined up action to prevent risk escalation and keep people safe and well.

Cognitive decline and dementia

Cognitive decline is a significant driver of increasing need, particularly when combined with physical health issues or social isolation. Early signs of memory loss, confusion or changes in behaviour can indicate rising risk and, if unaddressed, can lead to crisis and increased dependence on services.

Distinct from age-related cognitive decline, dementia is a major cause of death and a significant driver of demand for social care, often associated with increasing complexity of need, crisis presentations and longer-term care. Nationally, the number of people living with dementia is set to rise to 1.4 million by 2040. Up to 45% of dementia cases are linked to modifiable risk factors, which means they have the potential to be prevented.

We will work in partnership to create a more proactive and coordinated approach to cognitive decline and dementia, ensuring that individuals and carers are connected to appropriate services, including dementia pathways, community support and Technology Enabled Care in a timely way. Through early identification and action, including with respect to early onset dementia within younger adult cohorts, we can delay progression, reduce crisis presentations and support individuals to remain safe at home for longer.

Technology Enabled Care

Technology Enabled Care (TEC) will play an increasingly central role in reducing escalation and managing risk. TEC is already embedded as a mainstream offer supporting over 15,000 active users, a quarter of which have had their technology in place for five years or more.



Through monitoring, alerting and data insights, TEC enables early identification of changes in an individual's condition, allowing timely intervention before needs escalate. TEC also upskills individuals and supports self-management and independence by enabling individuals to manage risks within their own homes and providing reassurance to carers. Through TEC, some support may be delivered remotely, reducing reliance on fixed service models whilst supporting positive outcomes.

We will continue to expand the proactive and preventative use of TEC across key pathways, including frailty, falls and dementia and ensuring that it is consistently considered as part of assessment, care planning and review.

Unpaid carers

When carers are well supported, they are more able to sustain their caring role, reducing the likelihood of crisis and the need for replacement care.

The Hampshire Joint Carers Strategy sets out a shared aspiration for all carers to enjoy good physical and mental health, and to feel supported as carers. The system should work to identify carers in a timely way and support them to sustain their caring role while maintaining their own health and wellbeing. This applies to all carers, including young and parent carers and those from seldom heard groups. Proactive, timely support reduces the likelihood of crisis-driven escalation, which can rapidly increase demand for statutory services with limited opportunity for planned intervention.

We have strengthened the support available to carers through the Carers Support Service, delivered in partnership with the Princess Royal Trust for Carers. This includes delivery of carers' assessments and the provision of timely, proportionate and flexible support. We have also diversified respite options, invested in TEC pathways and are working to improve the experiences of young carers, young adult carers and parent carers. This is a strong example of the positive outcomes that can be achieved by working in partnership which we want to build upon.



Enabling support

Reablement and enabling services support individuals to regain independence following periods of illness, hospital admission, or deterioration. Use of Therapy Outcome Measures evidence the impact of reablement on individual independence.

We will strengthen community-based reablement, with Occupational Therapists contributing to prevention and early intervention. We will continue to share expertise in proportionate care, helping to embed Optimal Handling Care across social work practice, thereby reducing

over prescribing and supporting strengths-based approaches to maximise independence.

Working in partnership with District and Borough Councils and wider partners, we will continue to influence timely home adaptations and support access to equipment, Disabled Facilities Grant and Technology Enabled Care.

Our Sensory Services provide short-term, enabling support to people with sight or hearing loss. As the population ages, hearing loss will become more prevalent. If left unaddressed, hearing loss can lead to

poorer health outcomes. Drawing on the expertise of our Sensory Services, we will support the social care workforce to recognise signs of hearing loss and support effective management and access to services.



Our ambitions	What we'll do	What success looks like
Reduce smoking and alcohol intake amongst those in receipt of adult care and support services	• Equip staff to identify, record and respond to key risk factors and support behaviour change. • Target interventions towards high-risk populations. • Raise the profile of carers for people with drug misuse and mental health needs.	• The smoking status of people known to Adult Services will be consistently recorded and reflected within care assessments and support plans. • Staff feel confident talking about smoking behaviours and signposting to cessation services. • Policies and guidance protect staff from exposure to second hand smoking. • Staff can recognise alcohol issues and risks and refer to specialist services. • Carers' assessments reflect the needs of carers for people with substance misuse and mental health needs.
Support nutrition, healthy weight, hydration and continence.	• Train and upskill our staff to incorporate healthy diet, weight management, hydration and continence into care plans and know when and how to signpost to specialist services when needed.	• More people with care and support needs receive timely, person-centred support to develop healthy eating habits, maintain a healthy weight, stay hydrated and maintain continence, and this is evidenced in care records. • People receiving this support experience fewer health complications, falls and hospital admissions. • There is greater representation of people with care and support needs receiving commissioned weight management support.
Prevent suicide and harm arising from domestic	• Equip our staff to provide person-centred, holistic care which supports mental wellbeing and prevents suicide.	• Staff confidently and competently identify and respond to suicide risk factors.

Our ambitions	What we'll do	What success looks like
abuse, neglect and self-neglect	Equip staff to identify escalating risk factors and develop effective strategies to address these, including through domestic abuse awareness training.	Fewer people known to Adult Services die from suicide.
Prevent and slow the progression of cognitive decline and dementia, ensuring people receive timely support and intervention	- Work with system partners to co-produce and deliver a Dementia Strategy for Hampshire. - Improve the navigation and coordination of services at a neighbourhood level. - Introduce dedicated workers for people with dementia known to adult social care. - Integrate Technology Enabled Care into dementia support. - Work collaboratively with health partners to support people with learning disabilities to access a baseline cognitive assessment to support diagnosis of dementia later on in life.	- People with dementia receive coordinated, effective support within their communities which delays the need for formal care services and prevents crisis, unnecessary hospital admission and reliance on residential care. - When social care is needed, people are supported well to slow the progression of dementia and enable them to live with as much independence as possible for longer. - As a system, we are more effective in identifying early signs of cognitive decline and dementia.
Expand the proactive and preventative use of Technology Enabled Care across key pathways	- Expand preventative TEC pathways, including frailty, falls and dementia. - Consistently promote TEC at key points, e.g. first contact and after hospital discharge. - Increase access to TEC by self-funders and carers. - Improve use of TEC data to inform assessment and support planning. - Expand the Younger Adults TEC programme. - Develop staff confidence in promoting TEC solutions and upskill Trusted Assessors in	- Increased uptake for TEC, particularly within target cohorts, thereby reducing the escalation of need and delaying entry into wider care services. - More people benefit from increased independence and self-management, supporting better outcomes and reducing reliance on unpaid carers. - Reduced need for commissioned care and associated cost.

Our ambitions	What we'll do	What success looks like
	making requests for TEC when assessing for a Disabled Facilities Grant. • Systematically embed health advice into TEC pathways.	
Strengthen support for carers and reduce carer breakdown	• Improve the identification of carers, including those at risk of breakdown, and target support. • Expand access to assessments and support. • Provide flexible respite and TEC-based support for carers. • Improve the experiences of young carers, young adult carers and parent carers utilising the national 'No Wrong Doors' guidance and tools. • Engage older carers to support them through 'second transition' arrangements for younger adults over 50.	• Carers are satisfied with the support they receive. • More carers can sustain their caring role for longer, preventing carer breakdown, crisis and the need for replacement care. • Entry into formal, longer-term care services is reduced.
Strengthen community-based reablement and ensure enabling approaches are consistently applied	• Develop an OT Strategy detailing how the Service will be developed to enhance universal, targeted and specialist support. • Encourage District and Borough Councils to adopt a Trusted Assessor model to support timely home adaptations and offer discretionary grants • Work towards a unified referral mechanism into Reablement. • Upskill staff to deliver proportionate care and embed enabling approaches across care pathways; share learning with the independent market.	• More people have timely access to the home adaptations they need to support independence and prevent escalation of need. • There is evidence of proportionate care within social work practice and amongst independent providers. • More people supported through reablement and enabling services do not go on to receive ongoing support. This is demonstrated through improvement in Therapy Outcome Measure scores. • Therapy Outcome Measures for Proportionate Care are embedded across the Hampshire system.

Our ambitions	What we'll do	What success looks like
Improve the identification of, and support for, people affected by hearing and sight loss known to Adults' Services	• Equip all teams to identify and address simple sensory needs. • Improve recognition of hearing loss and effective management and access to services for those affected.	• The number of people known to Adults' Services identified as having hearing loss is increased. • There is evidence of appropriate, preventative support for people with hearing loss within assessment, care planning and reviews.
Improve continence outcomes and support people to maintain independence	• Improve awareness and early identification of continence needs across Adults' Health and Care. • Strengthen continence within assessment, review, reablement and falls prevention pathways and ensure this is a consistent feature. • Improve access to advice, equipment, adaptations and specialist support. • Work with partners to promote bladder and bowel health and maintain independence.	• More people receive timely support for continence-related needs. • Improved independence and ability to carry out activities of daily living. • Reduced escalation of need associated with unmanaged continence issues. • More people remain living independently at home for longer.

Delaying and avoiding long-term demand

We will delay and reshape long-term demand into adult social care, particularly where needs are complex, ongoing and high cost.

A relatively small number of individuals account for a disproportionate share of adult social care demand and expenditure. Many individuals move into long-term or higher-cost support following a period of increasing pressure, often linked to deteriorating health, insufficient support or breakdown in existing arrangements. By intervening earlier, supporting self-management and independence, and strengthening support around individuals and their networks, we can prevent or significantly delay this progression.

Expanding housing and community-based alternatives

Access to appropriate housing and flexible community-based support is essential to delaying long-term demand. Models such as Extra Care housing, Supported Living and Shared Lives enable individuals to remain independent within the community, reducing reliance on residential care and supporting more personalised approaches. We will continue to expand and promote these options, ensuring that individuals are supported to access alternatives to traditional care at an earlier stage.

We will maintain strong partnerships with District and Borough Councils and Registered Providers to support the provision of new supported housing, contributing evidence of demand and playing an active role in local Supported Housing Strategies.

We want as many younger adults as possible to be enabled to live at home, avoiding the need for residential care. Our ambition is to grow the number of Shared Lives carers with a focus on supporting individuals with more complex needs. We will also continue to develop Extra Care housing in strategic locations to meet demand.

Direct Payments

Direct Payments help people to design flexible, personalised arrangements that promote choice, control, independence and wellbeing. We will increase uptake of Direct Payments, making them easier to access and use, in line with our Direct Payments Strategy.

We will align Direct Payment activities across Adults' and Children's Services, ensuring a consistent pathway from early conversations through to adulthood. This includes embedding Direct Payments within early intervention pathways so that families can explore flexible options sooner, reducing crises and improving continuity of care.

The ways that Direct Payments can be used to support independence will be expanded, ensuring strong alignment with our Technology Enabled Care offer and support for unpaid carers.

Reducing future demand from capital depletion

An increasing proportion of individuals enter care as self-funders and subsequently become reliant on local authority support once their financial resources are depleted. These 'capital depleters' often move into residential or higher-cost care earlier than necessary, without fully exploring alternative options.

We will take a more proactive approach with partners and wider professionals to supporting individuals and families to make informed decisions about care, and to plan for their future 'wealth and health'. This includes improving access to information and advice on care options, housing and financial planning and having conversations at key points in their lives, such as retirement. By strengthening early conversations and promoting community-based alternatives, agencies can support more people to be financially better off and enjoy greater independence and quality of life, while reducing unplanned demand arising from capital depletion.

Supporting transitions

Transitions are the points in the system where demand is most likely to increase rapidly. At these moments, individuals experience changes in circumstances, support arrangements or health, which can lead to uncertainty, fragmentation and increased risk.

By identifying these transition points earlier and managing them more effectively through planning ahead, coordinating support and sharing responsibility, we can prevent escalation and crisis and achieve more stable, sustainable outcomes.

Second transition

Our proactive approach will include a focus on individuals with long-term or lifelong needs. This is especially important for people with a learning disability and their families, where the '**second transition**' into older age represents a significant point of risk and a challenging period for carers.

As people with learning disabilities age, they are more likely to experience the early onset of chronic health conditions such as early onset dementia, diabetes, or physical frailty. These can go unrecognised which increases the complexity of need, making it more difficult to source suitable, community-based support and accommodation. New or emerging health issues may be incorrectly attributed to the person's learning disability, leading to delays in appropriate diagnostic investigations and inaccurate conclusions.

As carers age or become unable to continue in their role, there is a risk of crisis-driven decisions and high-cost placements. Family carers can also find it challenging to make advanced transition plans due to lack of confidence in the available alternatives and the emotions and complex considerations associated with a family member leaving home.



Our focus will be on working with health partners to strengthen early identification and sustained engagement with individuals and families, supporting planning well in advance of these changes. This includes developing appropriate community-based housing options and enabling gradual, planned transitions that support stability and independence. This will be supported by a dedicated worker model, providing consistent professional involvement and enabling relationships that support ongoing planning.

Alongside this, we will continue to work with families and carers, taking a ‘whole family approach,’ to better understand the barriers to future planning. This insight will help to ensure that services are shaped by lived experience and support earlier, more effective intervention.

Transitions into adulthood

Transitions into adulthood for young people with complex needs also require earlier and coordinated planning. Over the past five years, complexity of need across all care groups has increased and notably among young people with mental health needs. Through the work of our Independent Futures team, we will continue to strengthen joint working with Children’s Services and partners to ensure that transitions are planned well in advance, with a clear focus on building independence, developing life skills and identifying sustainable, community-based support options.

We will continue to enable young people to access Younger Adults Supported Accommodation and Extra Care, supporting improved outcomes, security of tenure and greater choice in how support is delivered. The use of crisis support, strengths-based assessment and Technology Enabled Care will continue to increase young people’s independence.

Transition between care settings

Hospital discharge is one of the most significant transition points within the system. Without effective coordination and a clear focus on recovery and independence, individuals are at risk of deterioration, readmission or unnecessary entry into long-term care.

We will maintain a strong “home first” approach, ensuring that individuals are supported to return home wherever possible, with access to timely reablement and short-term support. Short Term Services will continue to provide time and space so that decisions about long-term support are based on an individual’s potential for recovery and independence. We use our in-house Care and Support Services to provide short-term bedded facilities enabling people to ‘step-down’ from acute settings to recover in a nursing-led setting, supported by a multi-disciplinary team including social workers and Occupational Therapists. A range of

step-up beds and bookable respite beds also support admission avoidance, enabling people to be supported for a short period before returning home.

Occupational Therapy is central to this approach, helping to identify what individuals can do with the right support, including the use of equipment, adaptations and alternative ways of completing everyday tasks.

For **younger adults transitioning from mental health inpatient settings**, early and coordinated planning is essential to prevent relapse, avoid crisis-driven interventions and support long-term independence. Younger Adults Services work alongside health, Children's Services, housing, education and community partners to develop strengths-based transition plans and connect people with community-based support. This includes working with the NHS to coordinate robust aftercare planning.



Identifying and responding to deterioration

Not all transitions are defined by a single event. Gradual deterioration in physical or mental health can also represent a significant transition point, where needs begin to change and risks increase. We will improve our ability to identify early signs of deterioration, including changes in frailty, mobility, cognitive function and overall wellbeing. By using data, professional insight and tools such as Technology Enabled Care – supported by system-wide demand management and prevention capability – we can intervene earlier, stabilise needs and prevent avoidable escalation.



Our ambitions	What we'll do	What success looks like
Reduce use of residential care and support access to community-based solutions	• Influence the private retirement housing market to ensure residents are given choice of appropriate housing. • Grow the availability of Supported Living options and Extra Care. • Promote our Shared Lives scheme with a focus on recruiting younger carers who can support more complex needs. • Strengthen pathways that support people to transition to community-based settings.	• Fewer people will be admitted to residential and nursing care. • There will be a more sustainable use of council funds with reduced long-term care costs.
Improve choice and control by increasing uptake of Direct Payments and strengthening the Personal Assistants market	• Promote Direct Payments and support individuals and carers to manage them effectively, including through digital tools. • Strengthen our information offer and guidance on recruiting and employing Personal Assistants, whilst promoting PA roles within the local care market. • Align Direct Payment activities across Adults' and Children's Services • Enable Direct Payments to be used to purchase equipment or solutions that support safety and autonomy and reduce carer strain and escalation of need.	• People will benefit from greater choice and control over how their needs are met. • Families can explore flexible support options sooner, reducing crisis and improving continuity of care. • People have greater choice and access to aids and equipment that support their health and independence.

Our ambitions	What we'll do	What success looks like
Enable people to plan for their future health and care needs and reduce unplanned demand from capital depletion.	• Expand the reach and impact of <i>Planning for your Future</i> resources • Work with partners to promote earlier conversations about care options, cost and planning for the future.	• Greater independence and quality of life, positive financial outcomes for people. • Professionals equipped to have timely conversations about the range of community-based options available. • Reduced unplanned demand from capital depletion and delayed entry into local authority funded care.
Enable individuals with long-term or lifelong needs, their families, and carers to transition well into older age.	• Identify and support individuals experiencing second transition by strengthening early planning with individuals, families and carers. • Work with partners to identify and respond to changes in health and care needs, notably early onset of chronic conditions such as Dementia. • Influence the market to develop suitable community-based housing and support.	• Better long-term outcomes for individuals, families and carers. • Improved planning and stability of care arrangements. • Reduced crisis placements and reliance on high-cost residential care.
Increase young people experiencing successful transition into adulthood, accessing community-based settings, with maximum independence and minimum restriction.	• Work with partners in education, health and Children's social care to co-produce a joint transition Strategy for young people and their families. • Collaborate with the Integrated Care Board to improve transition pathways and enable timely decisions for people including for people with mental health needs.	• More young people receive earlier transition support, including earlier referral and involvement from Adults' Services. • More young people access community-based settings with the minimum level of restriction. • More young people benefit from technology solutions which support

Our ambitions	What we'll do	What success looks like
	• Expand the use of community-based and supported accommodation. • Give young people access to Technology Enabled Care which supports independence and wellbeing.	their independence and quality of life. • Reduced crisis demand and high-cost placements.
Increase the number of people who are supported to return home from hospital quickly and safely, with a focus on recovery, independence and avoiding long-term care where possible.	• Strengthen 'home first' approaches. • Improve access to short-term and community-based support post discharge. • Work in partnership to reduce delays and improve system flow. • Collaborate with health partners and the wider Voluntary, Community and Social Enterprise Sector to prevent hospital admission and develop discharge plans for individuals and carers which support recovery and independence.	• Reduce the amount of long-term care packages post hospital discharge. • Reduced unnecessary admissions and readmissions. • More people supported home with improved outcomes.
Improve ability to identify early signs of deterioration so that we can intervene earlier, stabilise need and prevent avoidable escalation.	• Test approaches to identifying deterioration and predicting future demand.	• More people receive timely, targeted support which supports positive outcomes and prevents escalation of need.

Delivery governance and monitoring

Hampshire County Council Adults' Health and Care will lead delivery of this strategy, working with partners across the Voluntary, Community and Social Enterprise Sector, Health, District and Borough Councils and wider statutory agencies.

Progress will be overseen by the Adults' Health and Care Directorate Management Team, with independent challenge and ongoing co-production through multi-agency partnership forums. Progress will also be reported to Members annually.

An action plan will underpin the strategy and set out the activity, ownership and milestones needed to deliver these ambitions.

The Strategy and Plan will be monitored using a proportionate set of core metrics which focus on outcomes and demand. These will include:

- Measures from the Adult Social Care Outcomes Framework – for example, new clients receiving reablement where no further request was made for ongoing support, discharge from hospital into reablement, permanent care home admissions.
- Locally agreed indicators which measure impact on demand and cost – for example, reduction in new referrals and repeat contact, delayed entry into long-term care, reduced care package size and cost, reduced hospital admissions linked to falls, frailty and dementia.

Where possible, we will align measures with system partners to demonstrate whole-system impact.

Partnering with us: how we can work together

Adults' Services cannot achieve this Strategy alone. Prevention requires collective action across local government, health, housing, communities, employers, residents and the Voluntary, Community and Social Enterprise Sector.

These ten steps have been developed in partnership and reflect our call to action:

1. **Support healthy, independent ageing** – Help people prepare for later life by promoting strength, balance, social connection and age-friendly places and reducing the risk of falls, frailty and isolation.
2. **Support equity in access to services and outcomes** - Connect professionals with under-represented communities. Enable the voices of seldom heard groups to be heard so that preventative action takes account of their views and needs.
3. **Make every contact count** – Promote and contribute to preventative information and advice, support people to plan for their future 'health and wealth' and raise awareness of alternatives to long-term residential and nursing care. Support agencies to be better connected and people to navigate the system.
4. **Prevent health deterioration, protect health and reduce avoidable harm** – Work together to maintain health and wellbeing during key transition points. Share information to prevent abuse and harm and protect vulnerable people, raising safeguarding concerns in line with the Multi-Agency Safeguarding Concerns Framework.
5. **Test, learn and improve** – Pilot, test and learn from innovations, supporting evidence-led continuous improvement in prevention across the system.
6. **Maximise independence and least restrictive practice** – Championing proportionate care and focusing on delivering care 'close to home'.
7. **Work together and with us to deliver change** – Share local knowledge and insight into what works well and where services need to change and be part of the solution, helping to co-design and deliver change.
8. **Improve the health and wellbeing of unpaid carers** – Taking joint action to deliver the shared commitments in the Hampshire Carers Joint Strategy.

9. **Take joint action on Dementia** – Delivering the shared ambitions of the emerging Hampshire Dementia Strategy to improve the health and wellbeing of people with dementia and their families and carers.
10. **Strengthen volunteers** – Strengthen the infrastructure support that empowers and supports local volunteers so that their contribution to health, wellbeing and independence can be maximised.



