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What role can local and national supportive services play in supporting independent and healthy living in individuals 65 and over?

Future of an ageing population: evidence review

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What role can local and national supportive services play in supporting independent and healthy living in individuals 65 and over?

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Contents

Executive summary

The UK population is ageing rapidly and the extent of comorbidities will continue to increase. This greater demand for support and care will need to be met within an environment of continued economic restraint. One policy response to mitigate such demand has been the reinvigorated focus on prevention and early intervention in health, social and third sector care. Prevention is broadly defined to include a wide range of services that promote independence; prevent or delay the deterioration of health and well-being resulting from ageing, illness or disability; and delay the need for more costly and intensive services. In exploring the existing evidence base around effective and cost-effective preventative services, our typology of prevention includes the accepted discourse of primary, second and tertiary prevention, while placing those 'upstream' well-being interventions at the core of any prevention strategy.

Well-being preventative services across the continuum

- In mitigating social isolation and loneliness, there is relatively good evidence that befriending interventions, social prescribing services, group activities and volunteer schemes can reduce loneliness and depressive symptomology, improve physical health, and result in differences in mortality.

- A range of exercise provision is able to improve balance, cognition, well-being, mobility, core strength and cardio-metabolic health, and reduce fall or fracture risk, depressive symptomology and cognitive decline. Physical activity can be supported through community-based interventions (e.g. walking for health groups, peer-supported exercise programmes), resulting in improved health-related quality of life and reductions in the use of secondary health care.

- Information, advice and signposting are seen as fundamental by individuals, as well as their families or carers, who need (or in the future may need), care and support to maintain independence. However, few studies concentrate on what works for older people, or whether timely and appropriate advice is able to maintain independence or improve quality of life. There is emerging evidence that care navigators (CNs) can provide effective practical and social support to older people, ensuring timely signposting to interventions and acting as a 'link' between community and statutory services.

- There is a range of low-level practical interventions that can support older people to remain at home, e.g. minor housing repairs, assisted gardening and shopping. While the link between such services and the use of higher-intensity provision is little discussed in the literature, a timely and trusted response can improve quality of life and reduce service use. Gardening has been shown to improve physical strength, fitness and cognitive ability and to reduce depression and anxiety.

Primary, secondary and tertiary prevention

Available primary and secondary preventative services (e.g. health screening, vaccinations, care management, day services, reablement) should be delivered holistically, i.e. 'making every contact count'.

- Two national population health screening programmes – breast and bowel screening – demonstrate efficacy. In contrast, the level of uptake of the NHS Health Check has been

lower than expected. While older people are more likely to attend, older individuals most likely to benefit (e.g. smokers, minority ethnic groups and those living in more deprived areas) seem less keen to engage.

- Day services for older people are a contested area, often perceived as part of the 'one-size-fits-all' welfarist agenda. Where the evidence is available, day services improve social care and quality of life for users and carers, reduce social isolation, may delay institutionalisation for people with dementia, and provide a sense of purpose for the individual, but are unlikely to reduce health service use.

- Care management, essential in supporting the individual to 'age in place', can reduce hospital admissions, lengths of stay and Accident and Emergency (A&E) attendances, although outcomes are dependent on the structure and processes adopted. Improved outcomes can be achieved by delivering well-being services alongside statutory provision.

- While reablement improves independence, health-related quality of life and service use, there are continuing process difficulties in appropriately involving or transferring older people to further service provision.

- In exploring tertiary prevention (minimising disability and deterioration from established diseases), the evidence base remains fragmented, with little clarity on the processes, structures or outcomes of, for example, rapid response teams (RRTs) or ambulatory emergency care (AEC) units.

Fragmented evidence base?

There is a wide range of available and effective well-being preventative services that can support older people to live independent and healthy lives. However, there are still gaps in the evidence base. Few evaluations explore whether reported changes in quality of life, service use, morbidity or mortality are maintained long term, with even fewer reporting cost-effectiveness. There is also little evidence that identifies the types of package of early interventions that should be provided, when these need to be offered, and to whom they would make the most difference. The evidence is non-existent on the structures and processes of effective preventative pathways.

The future role of services to 2030

If appropriate management of future pressures on the health and social care environment is to be delivered, the system needs to be rebalanced toward well-being interventions, and primary, secondary and tertiary prevention. However, the budget for such care is continually under threat. There is an urgent need to apply a single health and social care budget, incorporating housing and transport and delivered through a single commissioning point. Perhaps the main challenge in reorienting provision toward preventative care is that there first needs to be an accepted clarity from all partners across the health and social care environment as to what is being prevented – unnecessary hospital admissions or morbidity (ill health). The rhetoric of prevention needs to be embedded into service provision with appropriate care strategies, processes and structures able to support the promotion of well-being and health, rather than the management of disease.

1. Introduction

It is a well-rehearsed argument that the UK population is ageing rapidly and that the extent of comorbidities will continue to increase. Over 50% more people in England are likely to have three or more long-term conditions by 2018, compared with 2008 (Select Committee on Public Service and Demographic Change, 2013). It is also recognised that such changes will need to be met within an environment of continued economic restraint (Barnett *et al*., 2012). Recent strategic health and social care documents have identified that even with efficiency savings, the likely funding gap will result in fewer people receiving quality health care or publically funded social care (Commission on the Future of Health and Social Care in England, 2014; New Economics Foundation, 2014; NHS England, 2014a).

One policy response for mitigating such demand has been the reinvigorated focus on prevention and early intervention in health, social and third sector care (e.g. Department of Health, 1998, 2010a; HM Government, 2007): "the nation [must] get serious about prevention" (NHS England, 2014a: 7). Interventions or services that promote prevention and deliver independence, good health, well-being and autonomy are now perceived as essential in delivering the wider agenda of healthy communities and efficiencies across the health and social care economy (Department of Health, 2010b). Prevention is broadly defined to include a wide range of services that promote independence; prevent or delay the deterioration of health and well-being resulting from ageing, illness or disability; and delay the need for more costly and intensive services (Department of Health, 2008). It also encompasses older people's inclusion in social and community life and the creation of healthy and supportive environments, i.e. healthy communities (Wistow *et al*., 2003).

In exploring the role local and national services can play in supporting older people's independence, health and well-being, definitions are first provided and a brief discussion of previous national preventative programmes highlighted. The existing evidence base of services across the continuum of preventative care is then discussed. The limited nature of this review dictates a concentration on those effective and cost-effective services that have demonstrably maintained independence or improved health and well-being. Throughout, there will be an assessment of whether the literature is still "fragmented and underdeveloped" (Allen and Glasby, 2013: 905) and continues to provide little (if no) information on, for example, primary preventative services that might support particular 'seldom heard' population groups, e.g. minority ethnic groups, deprived communities, travellers or older people from sexual minorities (Windle *et al*., 2011). Where relevant, the role of service integration will be discussed.

In the final section of this review, we explore how the "nation [can] get serious about prevention" (NHS England, 2014a: 7), identifying and locating the individual's role in preventative care as well as those care sectors that should continue or initiate preventative services. We will draw on the review of evidence to (where possible) isolate those barriers to the widespread implementation of preventative care and identify effective processes, techniques or structures that can appropriately identify those innovative and cost-effective services provided by the community or statutory provision that could be effective in supporting older people to be independent and healthy.

2. The preventative continuum

Preventative services represent a continuum of support (Hollander and Tessaro, 2001). *Primary prevention* is generally designed for people with few care needs or symptoms of illness, with the focus on maintaining independence, good health and well-being (Wistow and Lewis, 1997; Windle *et al*., 2009, 2010a; Walter *et al*., 2010). Interventions include those resources that can promote healthy lifestyles (e.g. healthy living advice, screening, vaccination, physical exercise) and maintain well-being (e.g. activities to reduce loneliness or social isolation such as befriending, and practical help with tasks like shopping or gardening). *Secondary prevention* is targeted toward those individuals 'at risk' of specific conditions or events, such as falls or stroke. Relevant provision may include case-finding and holistic assessments (Mallery and Rockwood, 1992). In delivering *tertiary prevention*, it is necessary to focus services toward relatively ill and frail older people, designing and implementing support that can minimise disability or deterioration from established diseases. Such services aim to maintain individuals at home and may include personal health or social care budgets, multidisciplinary or integrated case management, intermediate care or RRTs (Jones *et al*., 2013; Pearson *et al*., 2013; Bardsley *et al*., 2014).

3. Prior national preventative programmes

In response to the policy focus on prevention over the last two decades, a number of national pilot programmes have been funded by the Department of Health or the Department for Work and Pensions. Each programme has explored the feasibility and outcomes of a range of preventative interventions. For example, Health Action Zones focused on building community capacity or engagement to reduce health inequalities (Sullivan *et al*., 2002; Barnes *et al*., 2005; Bauld *et al*., 2005). The Innovation Forum – Improving the Future for Older People assessed whether collaborative or integrated preventative services could reduce emergency bed-days by 20% across 3 years (Henderson *et al*., 2010; Beech *et al*., 2013; Sheaff *et al*., 2014); LinkAge and LinkAge Plus brought local authorities together with their partners in health and voluntary care (VCOs) to explore new ways to improve local services for older people, promoting independence, well-being and an active old age (Davis and Ritter, 2009; Watt and Blair, 2009). Finally, perhaps the largest pilot programme, the Partnership for Older People Projects (POPP), tasked 29 local authorities, and their health and third sector partners, with developing services for older people that could promote health, well-being and independence and prevent or delay the need for higher-intensity or institutional care (Windle *et al*., 2009, 2010a, 2010b). The national evaluations of all these programmes found that low-level preventative services improved both the user's and carer's quality of life and (where measured) reduced secondary and primary care service use. The number of projects developed as part of these pilots and their differing focus constrained assessment of the counter-factual, i.e. what the outcomes would have been if the projects were not in place (Allen and Glasby, 2009). Nevertheless, where relevant we draw on their findings in discussing below the effectiveness and cost-effectiveness of different preventative projects.

4. The prevention environment

The sheer range and number of interventions that can support well-being and independence in older individuals can limit the extent to which a typology of prevention can be understood, developed and implemented (Godfrey, 2001; Allen and Glasby, 2010). There are local (and national) variations in the labels applied to each intervention, e.g. the terms ‘signposting service’, ‘community link worker’ and ‘way finder’ have all been used to describe a community navigator (CN) intervention. In contrast, interventions with the same name (e.g. mental health café) may have completely different structures, processes and eligibility criteria (Windle *et al*., 2009). The universally accepted health discourse of primary, secondary and tertiary prevention is not always successful in determining those ‘upstream’ interventions that develop from third sector or community innovation and are considered essential by older people (Clark *et al*., 1998; Curry, 2006). To ensure clarity around the evidence base and assist in identifying evidence gaps, this typology includes well-being services (along with primary, secondary and tertiary prevention) and concentrates on those preventative services for which we have (at least) emerging evidence.

5. Well-being preventative services across the continuum

A number of services should span primary, secondary and tertiary preventative care, albeit delivered by different organisations and encompassing disparate structures and processes. For example, provision of information, advice and advocacy is essential at all stages of the older person's journey, whether they wish to be signposted to a local 'Walking your Way to Health' group or need information on eligibility and funding for supported housing or residential care. The former may involve a simple one-off phone call or provision of a leaflet; the latter should necessitate a number of relatively lengthy face-to-face meetings to determine the wishes and needs of the older person and (where relevant) informal carers. To ensure older people can maintain healthy living, maintain independence and well-being, these interventions *need to be universally available* if appropriate primary, secondary and tertiary prevention is to be achieved.

5.1 Well-being – social inclusion/loneliness

Social isolation and loneliness impact on quality of life and well-being with demonstrable negative health effects: lonely individuals have higher blood pressure than their less lonely peers (Hawkley *et al*., 2010); are more likely to develop dementia than those without feelings of loneliness (Holwerda *et al*., 2012); have higher rates of depression and mortality (Greaves and Farbus, 2006; Ollonqvist *et al*., 2008; Mead *et al*., 2010); higher health and social care use and earlier admission to residential or nursing care (Pitkala *et al*., 2009; Holt-Lunstead *et al*., 2010). It is often reported that group interventions, e.g. day centre type services, self-help and self-support groups, are more effective than one-to-one services, e.g. befriending, mentoring (Findlay, 2003; Cattan *et al*., 2005; Oliver *et al*., 2014). However, there are differential outcomes: some group activities have no impact while there are specific one-to-one interventions that are seemingly effective.

There is good evidence that **befriending interventions** reduce loneliness (Butler, 2006) and depressive symptomology (Mead *et al*., 2010). **Social prescribing services (SPS)** are a relatively new intervention and ensure primary care (GPs or practice nurses) or VCOs (Keenaghan *et al*., 2012) are able to refer patients with social, emotional or practical needs to a variety of holistic, local non-clinical services, for example group activity or mobility sessions, drop-in reminiscence groups (Brandling and House, 2007; Horne *et al*., 2013). Drawing on the existing service evaluations, SPS can seemingly reduce secondary care service use, and improve self-efficacy and quality of life (Dayson *et al*., 2013). In contrast, evaluations of **mentoring** provision, an intervention that works with the older person to achieve individual goals, (often) on a short-term basis (e.g. 12 weeks), have yet to demonstrate effectiveness; a case-control trial reported that there were no improvements in depressive symptoms, physical health, social activities, social support or morbidity (Dickens *et al*., 2011). Similarly, there is as yet no conclusive empirical evidence that **computer or internet usage** impacts on loneliness, or physical or psychological outcomes (Slegers *et al*., 2008). Some evaluations have argued that such interventions are effective in reducing loneliness (Fokkema and Knipscheer, 2007; Windle *et al*., 2008). However, small samples and inadequate methods have led to unreliable results (Windle *et al*., 2011).

Of the group interventions, a 12-week **'closed' group** that aimed to develop 'self-efficacy' in terms of social integration found no change in loneliness (Kremers *et al*., 2006; Martina and Stevens, 2006). **Social group activities** (e.g. hobby or educational classes – art, singing,

therapeutic writing) seemingly report greater effectiveness, achieving reductions in loneliness, improved physical health, reductions in falls and, where measured, statistically significant differences in mortality (Cohen *et al*., 2006; Pitkala *et al*., 2009; Savikko *et al*., 2010).

Wider community engagement, **volunteer schemes** and **'time banks'** have long been demonstrated as effective in mitigating loneliness and social isolation, improving emotional well-being and supporting older volunteers to maintain independence and health (New Economics Foundation, 2002; Narushima, 2005; Trickey *et al*., 2008; Rushey Green Time Bank, 2009; Heaven *et al*., 2013). 'Time banks' that use hours of time rather than currency, with the type of support volunteers undertake dependent on their own skills (as well as the needs of the wider community), have proved to attract socially excluded groups, widening and strengthening community capacity (Seyfang and Smith, 2002; Knapp *et al*., 2013).

5.2 Well-being – physical health

There are clear benefits to older people in maintaining or starting **physical activity**; inactivity leads to around 37,000 premature deaths in England per annum (The Richmond Group of Charities, 2014). It is reported that levels of physical activity are low among people aged 40–79, and argued that health gains could be made if activity was increased (South West Public Health Observatory, 2013). Systematic reviews and randomised control trial evidence have consistently demonstrated that a range of exercise provision is able to improve balance (Johnson *et al*., 2003; Bean *et al*., 2004; Baker *et al*., 2007); cognition (Zlomanczuk *et al*., 2006); cognitive decline (Fratiglioni *et al*., 2004; Gregory *et al*., 2012; McLaren *et al*., 2013); well-being (Kelley *et al*., 2009); mobility (Carral and Pérez, 2007; Dionigi, 2007; de Vries *et al*., 2012); fall or fracture risk (Kemmler *et al*., 2010a, 2010b); depressive symptomology (Blake *et al*., 2009); core strength (Heath and Stuart, 2002); and cardio-metabolic health (Chu *et al*., 2014).

Care needs to be taken prior to transferring such seemingly effective interventions into the community. Many are 'laboratory' based, with older people transported to a specially set up gym environment (e.g. Bean *et al*., 2004; Carvalho *et al*., 2009; Opdenacker *et al*., 2011). A number of (expensive) techniques were also reported to be used in ensuring adherence – telephone follow-up if an older person missed a session, initiating transportation and the provision of one-to-one professional sports science or clinical support (e.g. Johnson *et al*., 2003; Baker *et al*., 2007). Similarly, many of the users who self-selected to take part in such trials reported long-term involvement in carrying out some form of physical activity (e.g. Carral and Pérez, 2007; Dionigi, 2007). These structures and processes could negate successful community implementation as well as requiring a budget that may not be available to localities.

Where the interventions are replicable (e.g. Walking for Health groups, dancing, yoga, chair-based or non-aerobic exercise), identified by older people as preferred activities, e.g. gardening, walking, golf (Legarth *et al*., 2005) and solely dependent on community or individual motivation, rather than professionally or clinically prescribed (Petrella *et al*., 2003; Pavey *et al*., 2011), the evidence base continues to be limited by weak methodology and this is discussed further below. Where such interventions have been robustly evaluated (a before and after study employing a quasi-comparison group), community-based physical activity interventions, e.g. peer-supported weekly exercise programmes in local village halls or chair-based exercise provision, have demonstrated improvement in health-related quality of life (5%) and reductions in the use of secondary health care (Windle *et al*., 2009).

Upstream **assistive living technology** (aids and adaptations) is central in enabling older people to remain healthy and independent and to successfully 'age in place'. Without timely or appropriate installation, older people may increase their risk of falling; will reduce their house-based activity owing to safety considerations with a consequent reduction in mobility; are unable to return home from hospital; or face unnecessary hospital and residential care admission. There is a paucity of empirical evidence that assesses the impact of aids or adaptations that could increase or maintain mobility (e.g. ramps, outside hand-rails, raised beds in gardens), or ensure reductions in risk of injury (e.g. walk-in shower, bath rail, non-slip flooring). Where such support is discussed, it has been identified that many of the provided aids or adaptations are delayed, poorly fitted, underused or faulty (George *et al*., 1988). What is not known is whether an early intervention programme (incorporating aids and adaptations) can prevent or delay ill health and the use of more intensive service provision.

5.3 Well-being – information, advice and signposting

Information, advice and signposting are seen as fundamental by individuals, their families and carers who need, or in the future may need, "services and support in order to lead their lives" (Williams *et al*., 2009). The necessity to provide appropriate and timely information has been prioritised in numerous Governmental policy documents (see, for example, Department for Work and Pensions, 2005; Department of Health, 2006). In particular, such services are perceived as central building blocks to achieve the envisaged focus on preventative services (Baxter *et al*., 2006; HM Government, 2007; Department of Health, 2014a; NHS England, 2014a). Those organisations that have played or will play a crucial role in supporting such policy change are, in the main, VCOs. It is estimated that among social care third sector organisations, 42% provide information, advice or advocacy, while in health care, such services are provided by 47% of organisations (Department of Health, 2007). Despite their acknowledged value and the range of good practice recommendations that have been published (e.g. Margiotta *et al*., 2003; Age UK, 2013), much of the research evidence only describes the structure and process of specific initiatives. Few studies concentrate on what works for older people, or whether timely and appropriate advice is able to maintain independence or improve quality of life (Godfrey and Johnson, 2009). Where longitudinal studies of effectiveness are available, these are concentrated in the field of welfare benefit advice (e.g. Campbell *et al*., 2007; Moffatt *et al*., 2010).

One intervention for delivering information, advice and signposting that has been evaluated as effective and cost-effective is that of the **community navigator (CN)**. These are usually volunteers who provide 'hard-to-reach' or vulnerable people with emotional, practical and social support, acting as an interface between the community and public services, signposting individuals to appropriate interventions (Windle *et al*., 2010a; Windle, 2012). The structure and processes of CN interventions vary and are dependent on population need. For example, those CNs working with frail older individuals may carry out a series of home-based face-to-face visits, working alongside the older person to discuss what statutory or community provision may be beneficial. For less frail populations a telephone conversation may be more appropriate, providing written information that the individual can access and take forward if they so choose. One particular model, implemented as part of the POPP programme, located six CNs across one particular county (Windle *et al*., 2010a). Each was employed by VCOs, but sat within an integrated team. They carried out up to six face-to-face visits with the older person, resulting in a unit cost of £42, a cost that compares favourably with that of an adult social worker (£213 per face-to-face visit) (Curtis, 2013). Health-related quality of life of users improved by 17%, they reported using fewer statutory services and overall the project was cost-effective (Windle *et al*.,

2009, 2010a; Windle, 2012). Further economic modelling has identified that the benefits of CNs would amount to around £900 per person per annum (Knapp *et al*., 2013).

5.4 Well-being – practical support

There is a range of practical interventions that can support the individual to remain at home, e.g. minor housing repairs, assisted gardening and shopping. The link between **minor housing repairs** and use of higher-intensity services is little discussed in the literature (Clark *et al*., 1998). Those interventions that have demonstrated effectiveness and cost-effectiveness are drawn from the POPP programme. Of the 29 local authorities, and their health and voluntary partners, 12 localities put in place volunteer programmes that could carry out minor housing repairs. Local evaluations demonstrated that a timely and trusted response improved quality of life for users and carers and reduced service use (see, for example, Netten *et al*., 2009). The National Evaluation similarly found that users of such projects reported a far higher change in the health-related quality of life than might be expected from such simple services – an improvement of 13% (Windle *et al*., 2009).

Gardening by older adults has been demonstrated to improve physical strength, fitness, cognitive ability and socialisation and to reduce depression and anxiety (Brown *et al*., 2004; Larson and Meyer, 2006, Clatworthy *et al*., 2013, Thrive, 2013; Wang and Macmillan, 2013). Interventions that pair older people with younger volunteers have similarly proven effectiveness and cost-effectiveness. In one study, four out of five participants reported maintenance or improvement in physical activity, while 83% said it had made them more mobile. Exploring the service use of those individuals that reported an improvement, the estimated 'saving' to secondary and primary care was £113,748 per year. Such a figure rose when including those for whom the intervention prevented existing conditions from deteriorating, rising to £500,223 – a per person 'saving' of almost £10,900 (Jackson *et al*., 2012).

6. Primary and secondary prevention

Those interventions that support older people with increasing needs include, for example, health promotion (vaccinations), case or care management, reablement, intermediate care, telecare or telehealth, and falls prevention. In this review, primary and secondary preventative services have been deliberately grouped together. There is emerging evidence that if users or carers can be identified prior to emotional or physical deterioration (primary prevention) and at any crisis point, there is a far greater potential to improve outcomes (Windle *et al*., 2009; Ross *et al*., 2011). It should also be noted that the provision of preventative projects should not be limited to those aged 65 and over. For example, there is emerging evidence that primordial prevention (prevention throughout the life course) ensures the incidence of Alzheimer's disease may be reduced through improved education and physical activity (Norton *et al*., 2014). However, it is not possible in this review to describe the evidence base for all such interventions, although many directed toward older people are critically discussed in a recent strategy paper (Oliver *et al*., 2014). Here, there is a concentration on those demonstrably effective interventions that support older people to remain healthy or ensure independence through rehabilitation and include staff and services from across the health, social and third sector care environment.

6.1 Health screening, checks or assessment

The provision of population health screening, older people's health checks or assessments would seem to be a contested area, with an equivocal evidence base as to whether such actions improve outcomes for older people (see, for example, Thombs *et al*., 2013; Turner and Clegg, 2014).

Two national population health screening programmes – breast and bowel screening – demonstrate efficacy, with bowel screening reducing mortality by a quarter in those screened (Oliver *et al*., 2014: 8). A further population-wide primary prevention programme, the NHS Health Check, focuses on identifying individuals aged 40 to 74 who are at high risk of stroke, diabetes, heart disease or chronic kidney disease (Robson *et al*., 2015). Identified as having the *potential* to detect 20,000 cases per year of diabetes and kidney disease (Department of Health, 2014b), adults are invited to attend face-to-face consultations in GP surgeries or at contracted pharmacies. Family history is taken, lifestyle factors determined (e.g. smoking, alcohol use, diet and physical activity), blood pressure and cholesterol measured along with calculation of body mass index. Each is used to estimate the risk of cardiovascular disease (Public Health England, 2013). While consequent treatment with, for example, statins or antihypertensives, demonstrably improves outcomes (Robson *et al*., 2015), the level of uptake has been reported to be lower than expected (Dalton and Soljak, 2012, Department of Health, 2014b). Older people would seem to be more likely to attend (Robson *et al*., 2015), although older individuals most likely to benefit (for example smokers, individuals from 'seldom heard' groups, minority ethnic groups and those resident in more deprived areas) seem less keen to engage (Burgess *et al*., 2014). While the recent national strategy to reduce premature avoidable mortality (Department of Health, 2014b) exhorted local authorities to increase uptake from 48% nationally to 66% by March 2015, there is little guidance or evidence around best practice that would ensure accessibility, encourage the reluctant to attend or fully explain adverse effects such as distress, overtreatment of risk effects or increases in service use (Walker *et al*., 2005; Hill *et al*., 2013; Majeed and Banarsee, 2013). There are also recent indications that the cuts in health and social care have further affected widespread implementation (Majeed *et al*., 2012).

For those conditions or health problems perhaps undiagnosed or specific to older people, e.g. depression or frailty, there is less clarity. As discussed in Section 9.2, identification and treatment of depression and anxiety in older people continues to be often unrecognised or not addressed by health or social care providers (Collerton *et al*., 2009; Bosanquet *et al*., 2015). Yet there is limited evidence that any national screening programme would be of benefit to older patients (National Collaborating Centre for Mental Health, 2010). Similarly, despite the consensus best practice guidance on frailty (British Geriatrics Society, 2014; British Geriatrics Society and the Royal College of General Practitioners, 2015), population screening using currently available instruments is not recommended (British Geriatrics Society, 2014; Turner and Clegg, 2014). Nevertheless, older people should be assessed for the presence of frailty "during all encounters with health and social care personnel" (British Geriatrics Society and the Royal College of General Practitioners, 2015: 1).

It may be that preventative health care and early intervention for older people and the 'older old' (those aged 85 and over) will be more accurately focused following the changes in the GP contract (the primary medical contracts, 2014/15) and the recent demand that primary care funding be increased for those aged 75 and over (NHS England, 2014b). Every patient (aged 75 and over) will be provided with a named GP, supported through holistic health checks, provided with a personalised care plan and have ensured follow-up if admitted (or readmitted) to hospital. The recent implementation of these actions mean little evidence is available to either support or understand effectiveness. However, the ongoing pressure on primary care and limited face-to-face GP/patient time will require workplace and skills innovation in any GP surgery, if such holistic care is to be effectively delivered.

6.2 Vaccinations

Two **vaccinations** are particularly relevant to older people – the influenza and pneumococcal vaccines (Oliver *et al*., 2014), owing to the increased risk of morbidity and mortality, e.g. around 90% of all influenza-related deaths are among the over 65s population (Dixon-Woods *et al*., 2004; Prati *et al*., 2012). However, despite such vaccinations being readily available in primary care, the World Health Organization's target of 75% of all older people taking up the influenza vaccine has not yet been achieved in England, reported last year to be at 73.2% (Public Health England, 2014a). Similarly, only three-quarters of those aged 65 and over receive the pneumococcal vaccination (Public Health England, 2014b). Data are available that indicate there is a slightly higher take-up in hospital, residential or nursing care than in the community (Shah *et al*., 2012), with non-adherence linked to four factors: socio-economic status, health beliefs, fear of side-effects and the location of the health promotion message (While *et al*., 2004; Brien *et al*., 2012). A one-off home-administered influenza vaccination programme did not produce any long-term changes in vaccination behaviours (Dixon-Woods *et al*., 2004), although greater successes in increasing take-up have been produced through the combined use of multiple approaches – flyers, collaborative consultations (GP, community nurses or social care professionals), personalised care planning and peer support (Prati *et al*., 2012; Bakhshi and While, 2014).

6.3 Day services or day opportunities

A range of interventions are encompassed through the use of the terms 'day services' or 'day opportunities', e.g. adult day centres, day respite, lunch clubs, social groups for older people with mental health problems and drop-in centres (Age UK, 2011). Different types of services within a group setting support different functions and needs, including social support, specific health needs (e.g. post-stroke support), and nutritional and daily living needs (Manthorpe and

Moriaty, 2013). The continuing implementation of the personalisation agenda (Glendinning *et al*., 2008; Forder *et al*., 2012) has seemingly resulted in day centres for older people becoming "sites of contestation and delegitimization, reviving older concerns about 'warehousing'" and perceived as part of a 'one-size-fits-all' welfarist agenda (Needham, 2013: 91). That is, there is an expectation that faced with 'old-fashioned' statutorily provided day care, often outside or separated from the wider community and with few planned or delivered activities, older people will simply choose to spend their personal budget on different types of provision, e.g. attending cultural activities or purchasing season tickets for sporting events (Glendinning *et al*., 2008). In response, and faced with further cuts in overall budgets, statutory authorities would seem to be closing down day centres, although the actual rate of decline is not known (Beresford *et al*., 2011). Nevertheless, local authority expenditure on day care in England is still substantial: £360 million in 2011 (Manthorpe and Moriaty, 2013: 353). Similarly, between a third and a half of older people indicate that they would prefer to use day centres even if in receipt of a personal budget (Bartlett, 2009).

There is a range of evidence that demonstrates positive outcomes for older people and their carers, although much is small scale and concentrates on specific delivery models (e.g. day respite care or adult day centres). Where available, it would seem that day centres ensure improved social care and quality of life for users and carers; reduce social isolation (Caiels *et al*., 2010); may delay institutionalisation for people with dementia (Age UK, 2011); provide a sense of purpose for individuals (McCormick *et al*., 2009); but are unlikely to reduce health service use (Iecovich and Biderman, 2013). It would also seem that greater benefit is accrued by those older people with higher levels of need and who attend more than three times a week (Caiels *et al*., 2010). However, as with much of the literature around preventative provision, the different structures, processes, staff to user ratio and planned or delivered activities are all likely to affect how far effectiveness can be translated or applied across day care provision (see Section 8 below).

6.4 Case finding, coordination or care management

Case or care management is essential in supporting the user or patient to 'age in place' and remain independent. There is no one single definition that has been applied universally, although it is generally accepted to be "the process of planning, coordinating and reviewing the care of an individual" (Ross *et al*., 2011: 4). The steps in the process include case finding; assessment; care planning; care coordination (e.g. medication management, self-care, advocacy, psycho-social support, monitoring and review); and case closure (Crossland and Dobrzanska, 2007; Gravelle *et al*., 2007; Reilly *et al*., 2010). Care management interventions should reduce unnecessary hospital admissions and improve the care experience and outcomes for users and carers. Much of the care management literature concentrates on concepts, structures and processes (Challis *et al*., 2006; Crossland and Dobrzanska, 2007; Offredy *et al*., 2009), with fewer studies focusing on outcomes. Where available, the evidence base would seem to be mixed with, for example, a systematic review identifying that of the 15 case management interventions included, only eight reported a reduction in hospital admissions, with little evidence of improved care outcomes (Ross *et al*., 2011).

One particular intervention focused on early identification and support of the older person *throughout* their health and social care pathway, found improvement in users' health-related quality of life, reductions in hospital admissions, lengths of stay, and A&E attendances (Mayhew, 2008; Windle *et al*., 2009). The Integrated Care Coordination Service (ICCS) run by the London Borough of Brent involved a multidisciplinary team (secondary and primary care clinicians, social care and third sector staff) and provided case finding, case management and

case coordination. The ICCS focused on identifying older people (aged 65 and over) who were at risk of possible hospital admissions, premature admission to residential care, or causing concern to health, social or third sector professionals. Following a holistic person-centred assessment, a range of interventions were then coordinated, responding to identified needs. Resulting interventions were not solely concentrated in the statutory health and social care environment, but included well-being services, for example 'handyman' and befriending services, information, advice and advocacy. It was found that there were seemingly better outcomes for the younger, rather than the older, age group. For those aged 65–74, their health-related quality of life improved by 151%, while in contrast those aged 75 and over reported a deterioration of 10% (Windle *et al*., 2009). Despite per-person 'savings' of £824 in secondary care, ICCS was not cost-effective; the cost of the intervention outweighing the demonstrated outcomes with poor processes across health and social care limiting the extent to which 'savings' in secondary care could be extracted (Windle, 2012).

6.5 Reablement

The focus of reablement is on restoring a user's independent function, and supporting and empowering individuals to learn or relearn daily living skills that may have been lost through deterioration in health (Social Care Institute for Excellence, 2013). Developed from more traditional 'home care', the intervention is short term, lasting between 6 and 12 weeks, concentrates on activities of daily living and, while adopted across a number of countries, no one effective model or approach has seemingly been identified (Francis *et al*., 2011). While the evidence is also largely silent on the effectiveness of reablement services working alongside those with dementia (Social Care Institute for Excellence, 2013), there is good evidence that such interventions are effective in improving independence, health-related quality of life and reducing social care service use (Glendinning *et al*., 2010). A number of studies highlighted by Francis *et al*. (2011) also found that users of reablement services demonstrated long-term changes to their use of health and social care resources. For example in one study, over three-quarters of users did not require social care services 4 months after receipt of reablement. A further randomised control trial found 86% no longer required services at 12 months and that the reablement group was less likely to use emergency secondary care (McLeod *et al*., 2009; Lewin, 2010 [both cited in Francis *et al*., 2011]). There are also indications that reablement is cost-effective, with one particular study reporting improved outcomes at no further cost (Glendinning *et al*., 2010).

Despite such positive evidence, there are continuing process difficulties in appropriately involving or transferring older people to further service provision. For example, there is some indication that progress made in achieving independence is not maintained following referral to more 'traditional' home care or other statutory and independent services (Care Services Efficiency Delivery, 2009; Francis *et al*., 2011; Social Care Institute for Excellence, 2013). Similarly, if reablement services are to be truly effective, there is a need for a greater understanding of "users' own priorities and concepts of independence" (Wilde and Glendinning, 2012: 583).

7. Tertiary prevention

Services aimed at minimising disability or deterioration from established diseases and targeted toward relatively ill and frail older people are, in the main, managed and delivered through statutory service provision (i.e. health and social care services). The overarching aim of such provision (e.g. RRTs, hospital-at-home, supported home-from-hospital and in-hospital admission avoidance) is to prevent imminent admission to acute health settings. Two particular services are outlined below, one community-based and one operating within the secondary care environment. Again, it is not possible to highlight the evidence base of all tertiary preventative services and others are described elsewhere (see, for example, Windle *et al*., 2009; Allen and Glasby 2010; Oliver *et al*., 2014).

7.1 Rapid response services

Rapid response teams (RRTs) aim to maintain ill people at home who would otherwise need to be admitted to hospital (Young, 2009). Their focus and operation can also be described by applying the definition of intermediate care: a short-term intervention to maintain the independence of people who might otherwise face unnecessarily prolonged hospital stays or inappropriate admission to hospital or residential care. The care provided is person-centred, focused on rehabilitation and delivered by a combination of professional groups (Stevenson and Spencer, 2002). RRTs differ from intermediate care teams in that their care is focused on those individuals at immediate risk of hospital or residential care admission; they do not carry out supported discharge (Martin *et al*., 2004). They operate to avoid admissions, rather than support flow through secondary care provision. Through time-limited comprehensive assessment, immediate treatment and (as necessary) referral onto longer-term provision, RRTs can avoid unnecessary admissions.

No one model would seem to be recommended. Typically, RRTs are multidisciplinary (Griffiths *et al*., 2007), likely to include input from physiotherapy, occupational therapy, therapy assistants (Pearson *et al*., 2013) and generic care support workers (Young, 2009; Windle *et al*., 2014). Variations in team characteristics have been found to be associated with different service and patient outcomes (Smith *et al*., 2013). Increasing the skill mix in the team, by raising the number of different types of staff by one, was associated with a 17% reduction in service costs (Dixon *et al*., 2010). There may also be benefit to the patient's health-related quality of life if a team has a higher ratio of support staff to qualified staff (Dixon *et al*., 2010). Such a finding is likely to be due to the length of time that support workers are able to interact with the patient, delivering any goal-orientated treatment plan. However, as other commentators note, an optimum number of qualified staff would still be necessary to assess patients, set up the treatment plan, train non-qualified staff to deliver these and ensure appropriate onward referral (Smith *et al*., 2013).

There is, as yet, no evidence on whether RRTs are effective in preventing hospital admissions (Purdy, 2010). One review that incorporated 10 trials (1333 patients) found an upward trend in hospital admission during a 3-month follow-up, but this was a non-significant finding and there were no measures included as to whether these admissions were 'inappropriate' or unnecessary (Shepperd *et al*., 2009). The availability of such teams within the health and social care economy does seem to reduce the number of readmissions. One systematic review of nurse-led teams compared with usual care for patients found that readmissions were reduced by around 50% (Griffiths *et al*., 2007). There would also seem to be some tentative evidence that prior contact with staff of an RRT could shorten future bed-day use (Allen and Glasby,

2013). A rapid response service linked with a smart technology programme led to cost savings of £85,837 as a result of reduced bed-days (Bowes and McColgan, 2006).

There is little reporting around the user experience of RRTs; available data drawn from studies of either intermediate care or other types of interprofessional care teams (e.g. geriatric evaluation and management or 'hospital at home' models). In general, it would seem that users report high satisfaction, appreciating that treatment at home was favourable over hospital care (Corwin *et al*., 2004; Leff *et al*., 2006; Regen *et al*., 2008). Users also recognised that the services were able to be more flexible and deliver patient-centred care, supporting their own 'recovery' goals, for example the wish to maintain or increase their level of independence (Jesmin *et al*., 2012). Patients, not surprisingly, reported a poorer experience when services were unable to appropriately collaborate across health, social and third sector care (Wilson *et al*., 2007) or if insufficient capacity led to difficulties in accessing available provision (Michael *et al*., 2005).

7.2 Ambulatory emergency care units

The arguments underpinning the necessity to develop and implement an ambulatory emergency care (AEC) unit response are well understood: "The pressure is on secondary care, it is the point of least resistance and the last man standing" (interview drawn from Windle *et al*., 2014: 33). As discussed, multiple morbidities of long-term conditions are estimated to exceed 20% of the population and multimorbidity is now considered the norm for people over 65 (Smith and O'Dowd, 2007). Many long-term conditions also fall within the definition of ambulatory care sensitive conditions (ACSCs), those conditions for which primary, community or timely acute management should prevent hospital admission (Purdy *et al*., 2009; McCallum *et al*., 2010; Freund *et al*., 2013). ACSCs account for one in six of all emergency admissions in England, cost the NHS £1.42 billion annually (Tian *et al*., 2012) and are projected to rise by 42% over the next 14 years (Dr Foster Intelligence, 2012).

Appropriate management of ACSCs has been highlighted as one of the top ten priorities for commissioners (Imison *et al*., 2011) and one of the clinical commissioning groups' key performance indicators is the measurement of unplanned (emergency) hospital admissions of chronic ACSCs. The AEC centre or unit is also perceived as a central resource within the newly proposed 'Acute Care Hub' (Future Hospital Commission, 2013), this 'hub' integrating a range of resources that will focus on the initial assessment and stabilisation of acutely ill medical patients. In particular, "[C]are will be organised so that ambulatory ('day case') emergency care is the default position for emergency patients, unless their clinical needs require admission" (Future Hospital Commission, 2013: 28).

The Royal College of Physicians (RCP) Acute Medicine Task Force defines AEC as high-quality clinical care provided in the interface between community and secondary care, rather than in traditional outpatient or hospital beds. The clinical care delivered may include diagnosis, observation, treatment or rehabilitation and should be available in secondary care as part of an overall flexible emergency response. When placed in acute medicine, "it is care of a condition that is perceived either by the patient or by the referring practitioner as urgent, and that requires prompt clinical assessment, undertaken by a competent clinical decision maker". The healthcare setting may vary, but optimal clinical care will require prompt access to diagnostic support (Royal College of Physicians, 2007: 11).

There is no clarity as to the optimal number and skill set of AEC staff. From a brief exploration across existing grey literature (those reports or data not published in peer-reviewed journals), it

would seem that staffing varies. For example, one AEC unit in South London is managed and run by two Advanced Nurse Practitioners (ANPs), while in contrast, an AEC centre in the north of England is led by a Medical Consultant and staffed by a mixture of ANPs, nurse practitioners and generic healthcare support workers. There is no evidence, as yet, as to whether such different staffing models result in improved system or patient outcomes, e.g. reduction in emergency admissions, readmissions or improvement in health-related quality of life.

A similar lack of evidence exists when the effectiveness of access times is explored. The majority of AEC units are available during standard working hours on weekdays. Where extended or 7-day provision was in place, it was found that a more limited range of services are on offer at the weekend (McCallum *et al*., 2010). Commentators argue that such a structure may result in unnecessary weekend admissions (Ala *et al*., 2012; Duffin, 2013; Freund *et al*., 2013). No evidence is presented or is available that can support or refute this argument.

The core focus of the AEC unit is to assess, diagnose and discharge the patient within the same day. The relatively recent emergence of AEC units as a clinical resource means there is little research that causally associates the presence (or absence) of an AEC unit with an increase in zero bed-days or reduction in length of stay of 1 or 2 days. Much of the literature is either couched in terms of the potential resource impact of ACSCs (Purdy *et al*., 2009) and the likely potential, rather than actual, outcomes (see, for example, Tian *et al*., 2012; Future Hospital Commission, 2013). For example, a publication produced by the NHS Institute for Innovation and Improvement (2007) stated that by reducing the lengths of stay by 1 or 2 bed-nights, savings of at least £683.8 million could be made. There is no discussion as to whether existing AEC units are achieving these savings.

Internal evaluations (reported in the grey literature) have found tentative indications that AEC units are delivering effective outcomes (see, for example, NHS Institute for Improvement and Innovation, 2007; Duffin, 2013). For example, fewer beds have been required to delivery emergency care: “AECs have converted between 20–30 per cent of emergency admissions into same-day events” and patient outcomes have improved (Duffin, 2013: 9). However, these evaluations are of poor quality and validity, using raw rather than standardised or trend data. This lack of findings does not lead to a conclusion that AEC units are ineffective. The evidence is simply not available to provide a transparent link between their high-quality activity and outcomes.

8. ‘Fragmented and underdeveloped’ evidence?

This review (although necessarily limited) has highlighted the wide range of available and effective well-being preventative services that can support older people to live independent and healthy lives. It has demonstrated that the evidence base has developed incrementally over the last decade, beginning to build up an overview as to what works for whom. It could be argued that the evidence in this area is no longer universally “fragmented and underdeveloped” (Allen and Glasby, 2013: 905), evaluations encompassing a range of outcomes and beginning to adopt more rigorous research methods (e.g. quasi-control trials, comparison groups and case control).

However, there are still gaps in the evidence base. Few evaluations were able to explore whether reported changes in quality of life, service use, morbidity or mortality were maintained long term (i.e. 12 months or more), with even fewer reporting cost-effectiveness. There is also little evidence that identifies the types or package of early interventions that should be provided, when these need to be offered to any individual (e.g. at self-referral to clinicians or professionals or at diagnoses of the first long-term condition) and to whom they would make the most difference. For example, while there is early emerging evidence that integrated case coordination would seem to provide a greater benefit to those aged 60–74, mitigating the health and social impact of long-term conditions (Windle *et al*., 2009; Windle, 2012), the wide (and recommended) use of risk stratification tools and the concentration of multidisciplinary teams on the most frail individuals leads to little identification of when and for whom early intervention is likely to be effective.

While a number of studies were successful in including ‘seldom heard’ or excluded groups, there was little data around effective targeted services (see, for example, Bauld *et al*., 2005), the majority of interventions involving the white, female population. The increase in ethnic diversity in England and Wales, with 14% of the population identifying as part of an ethnic minority group (Office for National Statistics, 2012), a figure likely to increase to 20% by 2051 (Sunak and Rajeswaran, 2014), demands a focus and inclusion of the views and needs of minority ethnic groups. Similarly, with few exceptions, we know little about what works for older people in long-term care facilities, notably those who are frail or over 85.

In the short term, there is a multitude of evaluative or research activity that needs to be undertaken if we are to improve the evidence base around prevention and early intervention. Perhaps the most important is to identify the particular ‘life’ or ‘diagnosis’ point when individuals should be supported to use well-being or early intervention services. It could be argued that there is a relatively transparent pathway for single health diagnoses. For example, regular testing of sugar levels alongside appropriate patient engagement and empowerment (see, for example, Coulter *et al*., 2013) would support the identification and adherence to lifestyle changes and use of relevant support services to prevent type II diabetes. The question becomes more complicated when exploring socio-economic health and lifestyle impacts, e.g. social isolation or loneliness and multimorbidity. At what point and to which activities should the individual be signposted? How can we identify those at risk of social isolation or loneliness before they become socially excluded? Similarly, should social isolation be mitigated by community development, provision of individual support or a combination of both? Further research needs to be undertaken to begin to identify and map effective preventative pathways.

If the impacts of differential preventative pathways are to be understood, there needs to be some limited coherence of provision. While evaluations of national preventative strategies and services provided findings of effectiveness and cost-effectiveness, each was hampered by the existing model of prevention encouraged by central and local government. That is, while allowing a locally prescribed (grass roots) development of preventative services was seemingly positive, the extent and range of services developed led to little clarity around effectiveness, structure or process.

To address this gap, central and local government must first be clear as to the purpose of piloting or implementing any preventative interventions. Ettelt *et al*. (2015: 329) highlight four typologies of pilot projects: piloting for experimentation ('policy trial/experiment'); piloting for early implementation ('pioneer'); piloting for demonstration ('demonstrator', 'beacon'); and piloting for learning ('trailblazer'). As the authors argue, the focus of the pilot will dictate the selection of those evaluative or research methods suitable to determine effectiveness or cost-effectiveness. For example, the latter typology, piloting for learning, demands a concentration on a formative or realist evaluation if wider lessons are to be effectively diffused across the health and social care environment (Pawson and Tilley, 1997; Rycroft-Malone *et al*., 2010; Ettelt *et al*., 2015).

Any pilot must also ensure a stratified concentration on well-being services and different populations, in particular those 'seldom heard' groups. While any research should include a comparison or control group (preferably with the 'gold standard' of randomisation), it is recognised that 'matched' or 'cohort' samples may necessarily be selected. Central and local government may perceive the expense of such 'gold standard' research as irrelevant, given that any decision to 'roll out' interventions is often reliant on political values (or ideology), rather than demonstrable effectiveness (Rutter, 2012; Ettelt *et al*., 2015). Similarly, in a financially constrained health and social care environment, national and local commissioners may view as unethical the exclusion (even for a short time) of individuals from innovative projects. Nevertheless, such barriers will need to be negotiated if clear recommendations are to be provided.

9. Discussion – the future role of services to 2030

The nation has long been exhorted to get serious about prevention – to finally enact and implement the range of strategic, policy and programme interventions that will ensure healthy and independent ageing (e.g. Wanless, 2002, 2004). To achieve such outcomes by 2030 will require a revolutionary change in the way services are funded, which organisations, individuals or communities are trusted to deliver prevention and early intervention, and how such services are implemented.

9.1 Revolutionary change in service funding and commissioning

There would seem to be a dissonance between the policy enacted and the monies available to health, social and third sector care in order to deliver prevention and early intervention. The recent enactment of the Care Act 2014 identifies well-being and prevention as a guiding focus of care: **'the well-being principle'**, applicable in any and all care and support functions (Department of Health, 2014a: 1). The overarching health strategy (NHS England, 2014a) stated that there must be "a radical upgrade in prevention and public health" (p. 3). However, as other commentators have detailed, "the budget for preventative healthcare and other measures to promote better health is a tiny fraction of the budget for 'downstream' services to treat illness" and is also under threat; seemingly diverted to other services to negate the worst impacts of the recent cuts in funding (New Economics Foundation, 2014: 40). Any remaining monies is likely to be further reduced following the announcement by the Chancellor of the Exchequer (June 2015) that there is to be a £200 million cut in funding to public health budgets (Toynbee 2015; Williams, 2015). Such paucity and tenuous nature of monies to support prevention and early intervention is further challenged by the difficulty of moving monies around the existing health and social care system (Ham *et al*., 2012). A range of preventative services have demonstrably reduced unscheduled hospital admissions and lengths of stay (Henderson *et al*., 2010; Sheaff *et al*., 2014; Windle *et al*., 2009, 2014). However, there has been no mechanism that can enable the subsequent transfer of funds from secondary to community care, to support further preventative programmes (Windle *et al*., 2009).

If early intervention and preventative care are to be appropriately managed and implemented, there is now an urgent need to recognise the continuing demands by a range of commentators (including the Baker Commission) that a single health and social care budget be applied (Ham *et al*., 2012; King's Fund, 2014). However, any such change needs to incorporate further budgets, in particular housing and transport. Similarly, it can be argued that there can no longer be a range of commissioning points. There have been a number of well-documented difficulties around clinical care commissioning groups (Clough, 2015) and concerns of capacity and capability (Ashman and Willcocks, 2014). If overarching targeted commissioning is to be delivered, there is a need to move commissioning to a single point, either through joint commissioners based in local authorities or strengthening the structures and processes of existing health and well-being boards (Humphries and Galea, 2013; King's Fund, 2014).

9.2 Individual responsibility, organisational support and placement

Many states in the USA administering the Medicaid system (health insurance for those with low incomes) have instituted a personal health responsibility clause that results in higher or lower

coverage dependent on the individual's behaviour and activity in managing their health (Leichter, 2003; Horton *et al*., 2014). Similarly, in Germany, individuals may no longer claim free treatment for any complications that have arisen from particular choices around 'lifestyle' (e.g. continued alcohol consumption), while those with long-term conditions or multimorbidity are required to adhere to recommended treatment or pay more towards their healthcare costs (Schmidt, 2007). Such enacted demand for individual responsibility (and adherence) is controversial; not least as such policies rarely take account of existing health and social care inequalities (Marmot, 2010).

It is recognised that a balance is needed between personal responsibility and statutory or voluntary provision or support. However, it could be argued that there are a number of multifactorial existing (and near unsurmountable) barriers to "privatizing responsibility" (Ilcan, 2009). Information and advice is central to supporting independent and healthy living. However, research has not (as yet) been able to detail whether access to timely and appropriate information and advice maintains independence, or improves quality of life (Godfrey and Johnson, 2009). Access and, more importantly, adherence to correct and up-to-date advice is dependent on socio-economic status (SES) or social capital. Those individuals with lower SES are less likely to discuss health problems with their peers or have access to support groups or wider information sources, for example the internet (Bell, 2014). The proliferation of information technology to deliver health or social care information further disadvantages older people; almost three-quarters of those aged 75 and over (71%) reporting never having used the internet (Age UK, 2013).

A second functional barrier to taking on individual responsibility for health is confusion around which service to access for specific needs (Manthorpe *et al*., 2009). Recent demands for the NHS to make cumulative savings (Department of Health, 2010b), the continued fragmentation of health and social care (New Economics Foundation, 2014) and the rise of specialism and niche practice (Detsky *et al*., 2012) have all combined to often leave the older person unable to access timely, appropriate and holistic care. Locating the right services at the right time is seen as a difficult task, owing to the absence of a "system-level navigation tool" (Bhandari and Snowdon, 2012). Navigating the care system has been described by patients as complex and frustrating. They report having to tell the same story to numerous professionals and to go through the same assessments (Ravenscroft, 2010). When navigation is difficult, overuse, underuse or inappropriate use of services has been reported (Ferrante *et al*., 2010; Jackson *et al*., 2012). Patients often delay care or fail to get care, instead seeking support in inappropriate but more accessible settings, e.g. A&E departments (Albert, 2012).

Perhaps the final barrier to rebalancing the responsibility for health and well-being is the extent of undiagnosed depression and anxiety in older people (Collerton *et al*., 2009; Bosanquet *et al*., 2015). Along with contributing to higher mortality and morbidity (Rodda *et al*., 2011), if an individual is to understand and apply healthy living lessons, there is a simple need to be able to access such health messages – physically, intellectually or emotionally. Undiagnosed and untreated mental health problems limit the extent to which an individual is able to self-manage their health (Entwistle and Cribb, 2013).

There are a number of techniques that can appropriately support older people to self-manage, ensuring continued independence. One that is being further adopted across health care (see, for example, www.england.nhs.uk/house-of-care) is that of the "The House of Care" (Coulter *et al*., 2013). This model emerged from the Diabetes Year of Care (Diabetes UK, 2011) and places the patient at the heart of the delivery system. It ensures shared decision-making, co-production of health and well-being and most importantly the emergence of the goals, wishes and wants of

the patient. If patients are engaged and 'activated' to self-manage (Hibbard *et al*., 2005, 2009), there is growing evidence that health and well-being outcomes can be improved by managing and mitigating disease pathways (Greene and Hibbard, 2012; Hibbard and Greene, 2013; Turner *et al*., 2015). Using this model and integrating this further alongside personalised care planning in the social care system, self-directed support and individual personal budgets (Glendinning *et al*., 2008; Forder *et al*., 2012), barriers and facilitators to user or patient self-management could be identified, discussed and removed.

Nevertheless, those principles underpinning user self-management and patient activation – individual choice, empowerment, equality, timeliness and control over the wider environment (e.g. diet, exercise) – demand time, continuity of care, knowledge of the health and social care system, a willingness on the part of the older person to discuss their needs, and ongoing review and discussion; requirements that are often inconsistent with existing statutory health and social care provision and practice. If appropriate care is to be delivered to support independence, strengthening individual responsibility for their own health, there is a need to ensure urgent cultural changes in existing health and social care provision, service integration, or placement of health promotion and early intervention in the voluntary sector.

9.3 Implementing preventative services

If appropriate management of future pressures on the health and social care environment is to be delivered, the system needs to be rebalanced toward well-being interventions, primary, secondary and tertiary prevention (Allen and Glasby, 2013; King's Fund, 2014; NHS England, 2014a; Health Foundation and The King's Fund, 2015). While there is emerging evidence that particular innovation is effective (e.g. befriending, care navigation, reablement, social prescribing), research and evaluative outputs either concentrate on one specific intervention (e.g. physical exercise and its role in preventing a range of health problems), or provide listings of those services that are perceived necessary in any preventative strategy. The result is often a 'smorgasbord' or 'pick and mix' approach by commissioners, putting in place one or two interventions (e.g. reablement and falls prevention) while ignoring the necessary well-being provision (Allen and Glasby, 2010; Allen and Miller, 2012; Buckinghamshire County Council, 2012). The limited evidence base that can support identification of those services essential for an effective and cost-effective preventative pathway (see Section 8 above), is further compounded by a lack of practical guidance as to the structures, processes and actions necessary to implement and embed preventative provision. Drawing on the findings from existing national evaluations (e.g. Glendinning *et al*., 2008; Windle *et al*., 2009), there are a number of factors that need to be considered when planning and implementing preventative initiatives; some specific to preventative projects, while others perhaps align with more general lessons around implementation.

Perhaps the main challenge of reorientating provision toward preventative care is that there first needs to be an accepted clarity from all partners in the health and social care environment as to *what* is being prevented. Commissioners and providers need to decide whether the focus of any strategy is the prevention of unnecessary hospital admissions and readmissions (tertiary prevention) or general ill health (physical, mental or emotional). If the former, then a range of community-based, 24 hour, 7 day a week services (intermediate care, hospital-at-home, supported home-from-hospital, RRTs, AEC) need to be in place. If the latter, identifying and implementing necessary provision is perhaps more of a challenge given the limited evidence base, although the well-being services highlighted here (i.e. befriending, social activities, information and advice, volunteer schemes, exercise groups, assistive living technology and CNs) will need to be universally available. However, whether the focus is solely on tertiary

prevention or on the longer-term support of independence and healthy living (well-being services, primary and secondary provision), effective implementation demands a number of actions.

In setting up well-being and preventative services, it is essential that these are inclusive as to age. Psycho-social determinants (e.g. income, health-related behaviours, social exclusion and poverty) will affect need and consequent service use (Marmot and Wilkinson, 1999; Marmot, 2010). The national preventative programmes (see Section 3 above) all ensured that of the full age range of individuals that could benefit, those aged 45 and over were involved in the planning, delivery and receipt of any intervention or innovation. For example, there were indications in the POPP programme that those individuals from the most deprived areas in receipt of secondary or tertiary preventative services were 18 years younger than their counterparts in the most 'affluent' areas (Windle *et al*., 2009: 116).

Implementing well-being, primary, secondary and tertiary preventative services will demand "double-running costs" (Health Foundation and The King's Fund, 2015: 6). All new models of preventative services, necessarily developed, scoped and structured through wider community and older people consultation, take at least 12 months to demonstrate sufficient capacity and consequent activity (Glendinning *et al*., 2008; Windle *et al*., 2009; Forder *et al*., 2012; Hendy *et al*., 2012). Commissioners and providers will then need further additional time to identify the impact of the service on the older person's care pathway, assess whether savings are being demonstrated and understand where there may be opportunities for innovation or decommissioning (Windle *et al*., 2009). For example, while some findings around group interventions to mitigate loneliness or social isolation have emphasised reductions in primary care appointments (Cohen *et al*., 2006; Pitkala *et al*., 2009), it is highly unlikely that funding will be withdrawn from general practice provision. Rather, such findings may support the development of different models of care, e.g. a re-emphasis on patient self-management, greater use of social prescribing or increased nurse-led provision. Without 'double-running costs' implementation of preventative services will be difficult, if not impossible (Windle *et al*., 2009).

Any well-being or preventative service must be designed to ensure sustainability, not just of the project itself, but of the model adopted. A recent evaluation identified that a RRT supported older people at home at a per-patient cost of £264; far lower than the £954 average cost reported by other RRTs (see, for example, Curtis, 2013). Non-cashable savings in secondary care of almost £1 million per annum (£940,212) were also found. The RRT consisted of two advanced nurse practitioners, two emergency care practitioners, two nurses, two mental health nurses and six healthcare support workers. Funded through non-recurring 'marginal resource tariff' monies, the capacity and structure of the RRT radically changed following removal of this funding stream. No longer having access to healthcare support workers or mental health nurses owing to reduced funding, the remaining members of the RRT were told by their operational managers to simply "admit patients to hospital", negating their function, increasing per-patient costs and reducing the user's and carer's quality of life (Windle *et al*., 2014). It is essential to recognise that effective models of care are reliant on all members of any multidisciplinary team and that effectiveness of any project development must include a range of realistic funding options to ensure sustainability; 'boutique pilot projects' cannot support lasting change (Barab and Luehmann, 1987).

Finally, in designing and implementing preventative services, placement or location needs to be carefully considered. Many well-being services are more appropriately contracted through and delivered by voluntary organisations (e.g. befriending, social prescribing and care navigation). If

such provision is commissioned by health or social care (or indeed jointly), it is not enough to manage these at ‘arm’s length’, itemising delivery through a simple service level agreement. If a preventative strategy is to be put in place, there is a need for contracted provision to be fully integrated in primary, secondary or tertiary prevention. Those projects in POPP, run by the third sector but fully integrated in any multidisciplinary teams, were found to outperform ‘arm’s length’ services (Windle *et al*., 2009). Ongoing contact with the integrated team enabled sharing of information around the user and their family as well as building an accurate understanding of available provision. Those with concerns around the health of particular individuals were also able to quickly and appropriately refer them into the multidisciplinary team who could then take further action. Stand-alone services, while perhaps reducing the governance and delivery workload of statutory provision, may not deliver optimal outcomes.

10. Conclusion: Supporting independence and healthy living

There is a range of services that can support older people's independence and healthy living. Well-being services contribute to continued independence, early identification and resolution of developing support needs, while primary, secondary and tertiary services can ensure appropriate management and mitigation of likely long-term conditions (Windle *et al*., 2009, 2010). If prevention and early intervention are to be effectively delivered, they need to be implemented as a coordinated whole. A RRT may ensure immediate and appropriate home treatment, negating the need for an unscheduled hospital admission. However, if users or patients and their families do not also have access to universal well-being services (e.g. befriending, shopping, aids and adaptions), there will be an increase in service demand and a reduction in the user's quality of life.

While the policy drive for integrated services would seem to be resulting in some positive impact on the quality of patient care (Nolte and Pitchforth, 2014), operational integration does not always demonstrate improved outcomes for older people (Beech *et al*., 2013; Sheaff *et al*., 2014). A further mechanism will be necessary to support older people to achieve continued independence. It is recommended that a care or CN model is universally adopted as a central intervention in ensuring the development of a 'seamless' pathway. CNs, often employed by the voluntary sector, but with a core role in multidisciplinary teams, identify available services, signpost and support access (Windle *et al*., 2009, 2010a) and facilitate appropriate service integration through their role as 'link worker' (Anderson and Larke, 2009). While the CN role has been implemented in many different ways (Cameron *et al*., 2009; Egan *et al*., 2010; Pedersen and Hack, 2010), the identified core tasks consist of assessment of need, education, collaboration, communication, support, coordination and follow-up of care across the relevant pathway (Lemak *et al*., 2004; Ferrante *et al*., 2010; Griswold *et al*., 2010). Outcomes from previous (albeit limited) evaluations have demonstrated reduced use of out of hours GP services and A&E; fewer repeat attendances at GP surgeries by patients for non-clinical matters; improved take-up of outpatient clinics; and improved health-related quality of life (Ferrante *et al*., 2010; Bhandari and Snowden, 2012; Manderson *et al*., 2012; Windle, 2012).

Finally, we need to begin to embed the rhetoric of prevention into service delivery and support for older people. To do that, there is an urgent need to refocus care delivery, increasing available monies to support the promotion of health and well-being rather than the management of disease.

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