

Developing a preventive approach with older people

There is a growing interest in the implications of an ageing population, including how older people can be helped to maintain their independence for as long as possible. There are also issues about the balance between 'preventive' services, geared towards promoting independence, and the targeting of resources on people who are already vulnerable. The White Paper *Modernising Social Services* explicitly recognised the importance of 'preventive' approaches, and announced 'prevention grants' to encourage authorities to reinvest in them. This research looked at what authorities in England are already doing in developing preventive strategies. The study found:

- f** Those authorities which did have a strategic approach typically had not developed a free-standing prevention strategy but a range of strategies with prevention as one of their main aims.
- f** The need to tackle 'ageist' attitudes towards people's ability to contribute was widely acknowledged but seldom addressed explicitly.
- f** Older people's involvement varied from limited consultation to substantial involvement in strategy development and service delivery. Where such involvement existed, it was seen to generate commitment and ownership amongst older people and partner agencies.
- f** Authorities have had to be creative in identifying resources for explicitly preventive services for older people.
- f** Areas with a strong local voluntary sector were more likely to have a wide range of preventive services.
- f** Managers often felt under pressure to specify the financial benefits of preventive services. They were concerned that other measures of effectiveness, especially qualitative measures, were under-valued.
- f** Most evaluation work had been done on pilot projects with explicit short-term objectives. Less attention had been given to defining the objectives and outcomes of services which sought to promote quality of life more broadly. This makes it difficult for such services to compete for funding.
- f** The researchers conclude that:
 - The value of investing in prevention needs to be judged not only by quantifiable reductions in expenditure on other services, but also by improvements in quality of life and independent living, as perceived by older people themselves and by service professionals.
 - Preventive approaches need to draw upon a range of organisations, professionals, communities and older people. They should promote quality of life in general, not simply focus on preventing admission to hospitals or institutions.

Introduction

Increasing life expectancy is raising many important policy issues. There has been a growth in public awareness and interest in issues related to ageing - particularly about pensions and long-term care. As more people retire early or find themselves without work in late middle age, there are also growing discussions about how people can realise the full potential of later life. One significant implication of an ageing population is the challenge of promoting independence and preventing or delaying deterioration in the health and quality of life of older citizens.

This study aimed to help inform the current debate by mapping the extent to which authorities in England have begun to develop preventive strategies and services for older people. The study defined 'prevention' as both: services which prevent or delay the need for more costly intensive services; and strategies and approaches which promote the quality of life of older people and engagement with the community.

Policy context

Recent national policy documents have underlined the need to develop services which help older people, especially those who are very frail or disabled, to be as independent as possible. They seek to maximise their quality of life, promote community-based living and limit expenditure on statutory services. Prominent among these documents is the recent Social Services White Paper *Modernising Social Services* (1998) which includes in its proposals:

- the extension of direct payment schemes to people over 65;
- a partnership grant of £650 million (over 3 years) to foster partnership between health and social services to promote independence;
- a prevention grant of £100 million (over 3 years) to develop preventive strategies which provide low-level support to people at risk of losing their independence.

In parallel with the policy interest in preventing and delaying dependency, there has been a corresponding drive towards improving the general health and well-being of the population and promoting social inclusion. Increasing the social inclusion of older people is the key aim of the Better Government for Older People programme.

Approaches to prevention

The research team asked authorities why they were pursuing a preventive approach. Most identified three principal national policy pressures:

- greater understanding of the 'whole system' in health and social care;
- greater emphasis on the importance of social inclusion and active citizenship;

- greater emphasis on the social factors affecting health and well-being.

Interviewees felt there was now encouragement to have a broader agenda for discussion between health and local authorities. Local authority interviewees especially felt that the NHS commissioning strategies had tended in the past to focus on NHS services and particular diseases, while the new commissioning agenda incorporated a broader view of 'health' and the factors which affect it.

While these national pressures are universal, areas vary in the extent to which they have chosen to respond to them. In some, the national agenda was seen to have given *permission* to revisit approaches which agencies felt previous governments had discouraged. Other authorities which had maintained investments in preventive approaches, often by giving grants to local voluntary organisations, felt that the perceived sea-change in national policy was providing *legitimacy* to their approach. Finally, there were authorities which had yet to consider the broader issues relating to older people, but were clear that the national guidance was stimulating local debates. In addition to these national policy pressures some important local pressures were identified, which typically included: local incidents and media attention; growing recognition of the place of older people as citizens; strong senior officer/member leadership; and pre-existing partnerships.

The study looked at whether authorities had developed, or were developing, formal preventive strategies for older people; and, if so, whether these were devised corporately or by local agencies in partnership. Those authorities which did have a strategic approach typically had not developed a free-standing prevention strategy but a range of strategies which have prevention as one of their main aims. Common examples were the growing number of community safety, anti-poverty and urban regeneration strategies which have clear preventive impacts.

The areas which have been most successful in developing a broad preventive approach appear to have put in place many of the following building blocks:

- generation of broad cross-agency and cross-sector commitment to preventive goals;
- engagement of older people in setting priorities;
- explicit public objectives;
- mechanism of public accountability to older people;
- locally based developments/community development approaches;
- strong senior officer/member leadership and ownership;
- dedicated budgets and/or dedicated staff;
- incorporation of priorities into corporate objectives;

- institutionalising commitment in processes and structure;
- a commitment to sustainability.

There were two notable examples - Portsmouth and Sandwell - of localities having developed a preventive approach involving a range of local authority departments and a range of other stakeholders as active partners, including older people. In Portsmouth, for example, a member-led multi-agency panel has been established to oversee the preparation of a preventive strategy for older people. The panel is employing a broad definition of prevention focusing on health, social care, lifestyle, the built environment and economic well-being. It is identifying the key concerns of older people and then assessing how public, private and voluntary services in the city can respond. A set of outcome measures is being developed to measure performance against objectives.

Involving older people

A key aim of the study was to identify how far older people had been involved in developing and delivering preventive approaches. The study found that their involvement varies from limited consultation to substantial involvement in strategy development and service delivery. Where such involvement existed it was widely seen to generate commitment and ownership, not just among older people themselves, but also amongst local partner agencies. One of the best examples is the Agewell Strategy in Sandwell. In a succession of conferences and workshops older people identified a clear set of needs. The Health Partnership publicly pledged itself to meeting a number of objectives; the Agewell forum of older people will 'hold these agencies to account'.

One of the things which was widely acknowledged but seldom explicitly addressed was the need to tackle 'ageist' attitudes, which assume limited ability and willingness of older people to contribute as equals. In the best authorities, care was taken to identify how older people can contribute to service planning and delivery as equal partners. There was a general recognition too that there were particular challenges in engaging older people from ethnic minorities or those with sensory disabilities. Genuine and long-lasting involvement of older people, rather than tokenistic and intermittent consultation, needed significant investment of time, skill, commitment and (not least) funding.

Putting 'prevention into practice'

The absence of a formal preventive strategy or other strategies in which prevention is an explicit aim does not mean that authorities will not have successfully developed a range of services with a preventive aim or impact.

Some services address needs for physical and psychological/social support, while others are geared to providing practical help. Some are provided in

people's own homes, while others are provided in community settings. There are also facilities which are not provided with prevention as their specific aim, which are of great benefit to older people in maintaining their quality of life. Some examples of the range of services included:

- **Improving the local environment**

Older people constantly stress the importance of good transport and a safe environment in enabling them to continue to live independent lives. Preventive approaches included addressing the provision of affordable, accessible transport, low level kerbs, user-friendly road crossings, good street lighting, and support to help older people overcome their fears of becoming victims of crime.

- **Helping older people to remain socially active**

There is evidence that social isolation increases the risk of depression. A range of approaches had been developed to help older people take part in community activities. These include tailoring education and leisure opportunities to meet the needs of older people (in terms of location, timing and content of programmes), and support to establish their own projects. There was also a range of projects which benefit from and develop older people's skills by providing opportunities for them to volunteer to help others.

- **Improving the quality of people's homes**

Appropriate housing is vital in maintaining the quality of life and health of older people. Housing services have a critical role to play in delivering a preventive approach. Important examples included: help with maintenance, heating and insulation; rapid, good quality alterations to make homes safer and more accessible; availability of a range of housing, including intensive sheltered housing, as alternatives to residential care; and access to support, for example through wardens, caretakers and alarm systems.

- **Supporting people in their own homes**

Projects to help people in their own homes ranged from those providing practical support or befriending, to those meeting needs for personal care, including support for bathing. There was a growing range of rehabilitation services to help older people improve and maintain their levels of functioning and schemes to avoid unnecessary admission to hospital.

In addition, for older people to make the best use of available services and facilities, they and their families needed access to good quality information. This seemed best provided where the workers with whom they come into contact were well-informed about local facilities and free to be creative in meeting older people's needs.

Many services will have an additional impact on the quality of life of older people, beyond the immediate effect. So, for example, a bathing service

will have an immediate effect on physical health and hygiene and a benefit from reducing social isolation. It may also have a potential medium-term benefit of reducing the likelihood of entering institutional care, as well as the less tangible, but no less important, improvements to morale, self-esteem and human dignity.

Resources

Authorities have had to be creative in identifying resources for explicitly preventive services for older people. Alternative funding sources included not only central government money - Winter Pressures, Single Regeneration Budget - but also lottery funding, money from the European Union or charitable funding such as the Church Urban Fund. Commercial sponsorship has also been helpful in developing some small-scale projects and some private sector funding has been obtained by local authorities as part of planning agreements. Such funding, however, is often short term and requires considerable time and energy to obtain.

The localities with a wide range of preventive services typically benefited from a strong voluntary sector which cultivated the strengths of local communities. Voluntary sector organisations had often provided 'low level' services with non-statutory funding, even when statutory agencies had withdrawn provision. They also drew on volunteers to increase the resources available. If preventive strategies are to be widely developed, however, it is important for authorities to develop preventive approaches within their mainstream services, with volunteers supplementing not substituting for mainstream services.

In order to obtain mainstream funding for 'low level' services, managers often found that they were under pressure to demonstrate effectiveness and financial benefit, 'When you're battling for resources it doesn't matter how much you might believe in prevention if you can't really prove the value of the outcome'. There was a general view that qualitative measures were seen as less valid than quantitative 'proof' of savings. One manager, keen to challenge this attitude, said pointedly: 'Why are you asking about the benefits of having a bath? No one asks you what the benefit is when you choose to have one!'

Perhaps inevitably most evaluation had been done on pilot projects with explicit short-term objectives. Less attention had been given to defining the objectives and outcomes of services which sought to promote quality of life more broadly. This makes it difficult for such services to compete for funding.

Conclusion

The research found evidence that a number of authorities were beginning to promote a preventive agenda. However, there are real tensions between the wish to promote the quality of life and general well-being of older people and the service needs of individuals. The study identified a number of avenues which authorities have used in an attempt to balance these tensions. The researchers conclude that issues of political will and citizenship are critical in this debate. Where there are powerful local players committed to improving the lives of older people, their needs and wishes are more likely to be reflected in corporate priorities and budgets.

About the study

The study was conducted by staff at the Nuffield Institute for Health (Helen Lewis, Brian Hardy and Eileen Waddington) and two of its Visiting Fellows (Peter Fletcher and Alisoun Milne). Questionnaires were sent to all the chief executives of health authorities and local authorities in England to ask about their preventive strategies and services for older people. Telephone interviews were held with staff in 25 areas, and field visits then took place in five areas where preventive working appeared to be well-developed. The research was commissioned by the JRF and Anchor Trust on behalf of the National Preventative Task Group.

How to get further information

For further information about the research, contact Eileen Waddington, Community Care Division, Nuffield Institute for Health, 71-75 Clarendon Road, Leeds LS2 9PL (hssew@leeds.ac.uk), Tel: 0113 233 6352, Fax: 0113 233 6348. Full copies of the report, **Promoting well-being: developing a preventive approach with older people**, can be obtained from the Anchor Trust, Fountain Court, Oxford Spire Business Park, Kidlington, Oxon OX5 1NZ (01865 854093); price £15 (inc p&p), ISBN 0 906178 48 7.