Improving care and saving money

Learning the lessons on prevention and early intervention for older people

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Resource Pack: Making a Strategic Shift to Prevention and early intervention

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Introduction

Prevention and early intervention are at the very heart of our vision for the future of care and support. Promoting the independence of older people through a strategic shift to prevention and early intervention can produce better outcomes and greater efficiency for health and social care systems. Better outcomes for older people also appear to be aligned with approaches which target the right people at the right time and provide personalised responses focused on ‘working with’ the person rather than ‘doing for’ them.

The Partnerships for Older People Projects (POPP) programme was an ambitious initiative designed to increase our learning about how to promote older people’s independence, particularly through joint approaches to reducing reliance on long-term institutional care and acute hospital admissions. The learning from this programme has increased the evidence base about the benefits of prevention, early intervention and the integration of services – all fundamental underpinning principles to the reform of the care and support system and our vision to create a National Care Service.

It is increasingly unsustainable for health and social care systems not to reconfigure the way they work to take on board this learning and good practice. There is a clear need for both health and social care to focus on Quality, Innovation, Productivity and Prevention (QIPP). The experience from POPP will contribute greatly to this QIPP agenda and will help local authorities and primary care trusts (PCTs) to develop better ways of using their resources more effectively and improve quality at the same time.

The national evaluation of the POPP programme paints a very positive picture of the gains that can be achieved, and many of the local evaluations of the 29 pilot sites extend this learning further. This document provides high-level messages about the key learning, which health and social care systems will wish to consider. In doing so it draws together a number of the key policy strands and demonstrates the importance of a preventative approach to most areas of the health and social care agenda.
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The case for change

The medium-term future holds two key challenges:

1. an increase in demand for health and social care associated with an ageing population and changing expectations; and

2. a reduction in the growth of public funding for health and social care.

This need to meet growing demand with diminishing resources will require greater emphasis on innovation and productivity.

Key facts and figures

- We are an ageing society. For the first time ever there are more people over the age 65 than there are under the age of 18.
- There are currently around four people under the age of 65 to every one person above that age. By 2029, this ratio will fall to three to one, and by 2059 it will become two to one.
- Approximately 1.26 million adults receive local authority-funded social care now. Over 1.7 million more adults are expected to need care and support in 20 years’ time.
- In the next 20 years, the number of people over 85 in England will double, and those over 100 will quadruple.
- A fifth of the population of England is over 60, and older people make up the largest single group of patients using the NHS.
- Older people in the UK use three and a half times the amount of hospital care of those aged under 65, and almost two-thirds of general and acute hospital beds are in use by people over 65.
- Older people currently account for nearly 60% of the £16.1 billion gross current social care expenditure by local authorities, and despite a recent downward trend, those aged over 65 still account for approximately 40% of all hospital bed days, with 65% of NHS spend being on those aged over 65.
- Injury due to falls is the leading cause of mortality in older people aged over 75 in the UK.
- There is a huge variation between local authorities in the proportions of their budgets spent on residential care, and similarly in the numbers of older people being admitted to long-term residential care directly from acute hospital beds.
Key messages

1. Doing nothing is not an option.
   Efficiency and prevention are about ensuring that the right person is brought into the right part of the system at the right time. Not only is this the way to deliver greater efficiency and a clearer focus on prevention, it also secures the best outcomes for people.

   *Use of Resources in Adult Social Care, Department of Health, 2009*

2. A strategic shift to prevention has the potential to contribute significantly to this agenda.

   In the past, prevention has been sidelined in times of challenge – we must not allow this to happen again. We must continue to prioritise prevention as the first area to be addressed.

   *The operating framework for the NHS in England 2010/11, Department of Health, 2009*

3. Retrenchment (i.e. raising eligibility thresholds) without transformational change is unlikely to deliver the efficiencies that are required.

   …we conclude that council policy on eligibility has only a very modest effect on expenditure.

   *Audit Commission, 2008*

4. Greater efficiencies are much more likely to be delivered through health and social care pulling together rather than pulling apart.

   …NHS organisations must continue to develop working arrangements with local authorities; partnership is no longer an optional lever – this is absolutely imperative if we are to achieve gains across public services. It is not a time to police boundaries – we need to break them down.

   *The operating framework for the NHS in England 2010/11, Department of Health, 2009*
Defining ‘prevention’

Definitions of prevention vary enormously, and these differences affect the scale and effectiveness of strategies employed by health and social care systems.

There are four important elements of prevention:

1. **Delay or reverse older people’s deterioration** (or, to put it more positively, promote their independence and wellbeing).

2. **Reduce the risk of crises and the harm arising from them.**

3. **Maximise people’s functioning** (i.e. re-ablement).

4. **Provide ‘care closer to home’** (i.e. arrange for the least institutional or intensive intervention that is able to appropriately meet people’s needs).

Commissioning should address all four aspects of prevention in order to fully optimise the local system. The diagram on page 7 gives an indication of the nature of this spectrum.
Defining ‘prevention’

Population ‘needs’

- General population
- Low to moderate needs
- Substantial needs
- Complex needs

Example interventions

- Citizenship
  - Involvement of older people
  - Tackling ageism – positive images
  - Equal access to mainstream services
  - Making a positive contribution, including volunteering

- Neighbourhood and community
  - Community safety initiatives, including distraction burglary
  - Locality-based community development
  - Intergenerational work

- Information/access
  - ‘No door the wrong door’
  - Single point of access

- Lifestyle
  - Active ageing initiatives
  - Public health measures, including diet and smoking
  - Peer health mentoring

- Practical support
  - Befriending and counselling
  - Shopping, gardening etc.
  - Case finding and case management of those at risk

- Early intervention
  - Intermediate care services
  - Enablement services – developed from home care
  - Self-care programmes

- Enablement
  - Integrated or co-located teams and/or networks
  - Generic workers
  - Case finding and case management of complex cases/long-term conditions

- Community support for long-term conditions
  - End of life care – enabling people to die at home
  - Management of unscheduled care

- Institutional avoidance
  - Hospital in-reach and step-down pathways
  - Post-discharge support, settling in and proactive phone contact

Outcomes: Improved quality of life; increased choice and control; economic wellbeing; improved health and emotional wellbeing; making a positive contribution; freedom from discrimination or harassment; maintaining personal dignity and respect.
A well-optimised social care and health system will:

- have a joint vision and strategy for achieving greater productivity and quality outcomes – with a strong emphasis on prevention, early intervention, and re-ablement;
- be able to demonstrate effective partnership-working between health and social care and other relevant parts of the public and private sectors;
- have governance structures in place which include the involvement of older people (ensuring that they are drawn from different groups and communities that are representative of the local population);
- have a joint understanding of the diverse needs of older people and use this to plan and stratify the necessary interventions accordingly;
- understand the patterns of spend, activity, and outcomes across the whole system;
- be jointly commissioning a range of good-quality and affordable services, explicitly aimed at supporting people in their own homes;
- have in place an agreement on how to share the benefits and risks associated with commissioning decisions, in such a way that encourages joint working;
- pay attention to achieving optimal service effectiveness, with explicit plans for even greater efficiency and productivity over the medium term;
- have benefits realisation processes in place to track productivity and delivery against agreed targets; and
- have a workforce development approach which promotes a culture of, and competencies in, re-ablement, personalisation, and joint working to meet the needs of people with complex needs.
Measuring progress is essential to delivering improvement. Health and social care systems may wish to consider using the following proxy indicators for measuring their progress in making a strategic shift to prevention and early intervention:\(^1\)

Top quartile performance (or a strong reducing trend) on:

- proportion of overall budget spent on institutional care;
- number of long-term placements made straight from hospital;
- emergency admissions per head of population;
- lengths of stay for key pathways (e.g. stroke, chronic obstructive pulmonary disease, dementia);
- delayed transfers of care;
- admissions to long-term care per head of population;
- achieving independence for older people through rehabilitation/intermediate care;
- incidence of fractured neck of femur; and
- number of patients registered with GPs as having dementia, as a percentage of the expected local 65+ population with dementia.

\(^1\) Department of Health (2009) *Use of Resources in Adult Social Care*. 
Key messages from the national evaluation of the POPP programme

Meeting people's needs with a preventative approach can create efficiencies

- Interventions across the POPP programme have produced an average of around £1.20 saving in emergency bed days for every extra £1 spent on prevention (the range is between £0.80 and £1.60).

- These efficiency gains are on top of the £1 of additional service benefit from addressing older people's presenting needs.

- Higher efficiency gains are immediately available from more intensive, targeted interventions, which involve very close joint working between health and social care. (For example, proactive case co-ordination services, which actively seek out people who may be at risk of deterioration, assess their needs and co-ordinate access.)

Efficiencies are available across the health and social care system

- As well as reductions in emergency bed days, productivity gains in other areas of health service activity were also indicated. Compared with the use of services before the POPP intervention:
  - hospital overnight stays reduced by 47%;
  - accident and emergency attendances reduced by 29%;
  - clinic or outpatient appointments reduced by 11%; and
  - physiotherapy/occupational therapy appointments reduced by 8%.

- The estimated efficiency gains in the health service appear to have been made without any adverse impact on the use of social care resources.

- There is some evidence that improved outcomes for older people are achieved through integrated co-located health and social care teams.

Quality of life can be improved through preventative approaches

- Users who received interventions delivered through the POPP programme demonstrated a greater improvement in health-related quality of life (HRQoL) when compared with those having no POPP intervention.²

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² HRQoL assessed using EQ-5D with the following domains:
- mobility;
- self-care;
- usual activities;
- pain/discomfort; and
- anxiety/depression.
• Projects providing services to individuals with complex needs were particularly successful in improving quality of life, although low-level preventative projects also had a demonstrable impact on quality of life.

• Generally, POPP projects were seen by staff to have offered a greater range of services and improved awareness of, and access to, these services on the part of participants.

Involving older people is important
• There was strong involvement of older people in the POPP projects. The great majority (93%) of sites involved older people in governance arrangements and over three-quarters (77%) involved older people in evaluation.

• With regard to involvement in governance, for many sites the ‘older people’ were largely drawn from voluntary organisations, such as Age Concern. Most of the POPP sites, however, reported a commitment to building upon the engagement of older people developed within their POPP projects, including ensuring involvement beyond those people who are frequently involved.

Preventative services can be sustained
• The overwhelming majority of the POPP projects have been sustained, with only 3% (n = 5) being closed – either because they did not deliver the intended outcomes or because local strategic priorities had changed.

Health commissioners have made a significant contribution to the sustainability of POPP projects
• Primary care trusts (PCTs) are contributing to the sustainability of POPP projects within all pilot sites. Moreover, within almost half of pilot sites one or more projects are being entirely sustained through PCT funding. Altogether, 20% (n = 29) of all POPP projects have been entirely sustained through PCT funding. There is also a further 14% (n = 22) of projects for which PCTs are providing at least half of the necessary ongoing funding.

Effective interventions
• The national evaluation has undertaken some comparisons between broad categories of projects, differentiated in terms of orientation (‘hospital facing’ or ‘community facing’); the focus on level of need (‘primary prevention, secondary prevention’, etc.); and the type of service (e.g. ‘wellbeing’, ‘information’ and ‘advocacy’). Findings from this high-level comparative analysis suggest that:
  – projects providing services to individuals with complex needs were particularly successful in improving quality of life, but low-level preventative projects also had an impact;
  – improved outcomes for older people appear to be achieved through integrated, co-located health and social care teams;
  – intervening early through proactive case co-ordination appears to be effective; and
  – small services providing practical help and emotional support can significantly affect the health and wellbeing of older people, alongside more sizeable services designed to avoid the need for hospital admission.
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Developing a rounded picture

The evidence from the POPP programme needs to be set alongside a wider and growing body of evidence, which includes information on the effectiveness of:

- re-ablement and focused intermediate care;
- early diagnosis of and intervention for people with dementia;
- telecare and telehealth;
- extra-care housing and other supported housing models;
- crisis response services;
- support for carers;
- self-care and peer support; and
- case finding using predictive risk or screening tools (e.g. Patients At Risk of Re-hospitalisation (PARR) and the Emergency Admission Risk Likelihood Index).
The learning and evidence from the POPP programme is relevant and helpful for delivering the current policy agenda facing health and social care, in particular:

- Transforming Community Services;
- joint working in relation to long-term conditions/complex needs;
- re-ablement and intermediate care;
- end of life care;
- carers;
- dementia; and

Putting People First and social care transformation.

**Transforming Community Services**

The Transforming Community Services programme identifies a number of ‘high impact changes’ which are thought to have the greatest potential to improve care and achieve the highest quality services. These can be summarised as follows:

- Use a proven tool like the combined predictive model (PARR+) to risk assess your local population.
- Support and enable people to take appropriate and effective self-directed care and greater responsibility for managing their own health.
- Use case managers as key workers to work proactively with very high-intensity users and those with complex care needs. Develop shared care plans with realistic goal setting.
- Invest in telehealth and telecare to empower people to take control of their needs, under the guidance and support of the case manager.
- Develop personalised care plans using joint care planning/integrated assessment, and join up multidisciplinary working along the care pathway.
- Engage service users and carers as a means of offering choice and personalisation. This will include encouragement to participate in expert patient programmes with personalised budgets. This should also include participation on stakeholder forums and working groups.³

Poole: integrating care services
The three-mile radius that makes up Poole Unitary Authority holds hidden pockets of deprivation that are among the worst 10% in the country. This deprivation and the poor identification of older people’s social and health needs was an issue that had largely been created by the lack of integration between the services. The result was that potentially avoidable admissions to hospital were occurring, putting an unnecessary strain on the health system and reducing the quality of life for older people in Poole.

The solution, which was enabled by the POPP pilot scheme, was to create a unified way of working and eradicate the cultural silos that existed within health and social care. An integrated staff team working on a locality basis was developed, which included a locality co-ordinator (with a background in social care), a Community Matron and Intermediate Care Assistants (providing both health and social care support). In addition, new joint ways of working included:

- The adoption of a case finding model with Poole Hospital NHS Foundation Trust utilising information used by ward staff but previously not accessed by social care professionals. Thus rather than maintaining the historic referral and allocation model which led to extended lengths of stay, older people admitted to Poole Hospital are reviewed by a member of a locality team within 24 hours.

- General practitioners supporting proactive whiteboard systems established within the surgeries, whereby primary care staff identify people known to be at risk to the locality team in advance of a crisis occurring.

- Paramedics having direct access to team leaders in order to avert admissions to hospital.

- The creation of a new form of worker, the Intermediate Care Assistant, which has overcome the traditional boundaries between Home Care Assistants employed by local authorities and Nursing Auxiliaries employed by PCTs.

The agreed approach to changing the way in which social services and the health authority were working included a number of steps. Initially, available data was used to define structures and agree the areas that needed to be addressed. Integrated teams were established and a team leader was appointed and given the authority to make decisions that involved both health and social care. These newly integrated job roles worked closely with GPs and older people themselves to ensure that needs were being met at a grass-roots level. The merging of professional boundaries was a significant cultural shift in the way in which Poole had previously been operating in its care of older people.

Joint working in relation to long-term conditions/complex needs
People with long-term conditions or complex needs are intensive users of health and social care services. Numbers are predicted to increase due to factors such as an ageing population and certain lifestyle trends. Evidence from a variety of sources suggests that there are significant benefits for older people, as well as efficiency gains to be made, if health and social care communities develop effective working arrangements.4

4 Department of Health (2008) Raising the Profile of Long Term Conditions Care: A Compendium of Information.
Devon: Complex Care Teams

Devon’s Complex Care Teams consist of District Nurses; Community Matrons; therapists; social workers; community care workers; Domiciliary Pharmacists (in some areas); Community Psychiatric Nurses and Approved Social Workers; and each team also includes an active and paid voluntary sector representative. They work alongside GP practices, undertaking case management and associated treatment and rehabilitation interventions for individuals who may have a combination of complex single or multiple conditions and intensive needs, and whose care requires co-ordination. They are also proactive in case finding and intervening early through the use of predictive risk tools.

North Yorkshire: specially trained Generic Workers

Prior to the implementation of the POPP pilot programme, adult and community services in North Yorkshire were suffering from an overlap of responsibilities between health and social care, with the consequence that the same tasks were being performed by the different teams. The effect of this overload was two-fold: a costly waste of resources and an exhausting experience for those people in receipt of the services. The opportunity presented by the POPP programme to make strategic changes to this system and put in place a network of ‘Generic Workers’ was welcomed, and the outcome has been impressive.

The first stage of the North Yorkshire POPP programme was a training package for Generic Workers to develop in them the necessary skills required across health, social and community mental health care. This process involved Generic Workers being trained alongside healthcare assistants and receiving day-to-day supervision from other qualified professionals. Using multidisciplinary meetings to discuss the needs of each case, referrals were made to the generic teams and the entire needs of the person were then met.

For older people themselves, receiving care from a designated Generic Worker means that they are able to build a relationship with one person and be confident that the multitude of needs that they may have are being met.

The cross-agency approach that North Yorkshire Adult and Community Service implemented as a result of POPP has generated benefits across the system. The local evaluation reports that net savings have been made from the reduction in the number of hospital admissions, residential admissions, and use of district nursing and ambulance/accident and emergency services. There appeared to be no significant increase in the demand for social care, and in terms of the benefits to older people themselves the service is more streamlined and as a result is better set up to meet their health and social needs.
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**Re-ablement and intermediate care**

Interventions which help support people to maximise their function and recover faster from illness are essential in any system. They can be a key part of strategies to prevent unnecessary acute hospital admission or premature admission to long-term residential care, as well as supporting timely discharge from hospital.

As the latest guidance on intermediate care indicates, it is helpful to think of this tier of intervention as a function rather than a discrete service. It can incorporate a wide range of different services, depending on the local context of needs and other facilities available. It is part of a continuum spanning acute and long-term care, linking with social care re-ablement.

As noted in the guidance, it is important that intermediate care is inclusive of older people with mental health problems if there is a goal that could be addressed within a limited period of weeks.

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Leeds: Rapid Response Intermediate Care Team

In 2004 it was recognised that the issues that faced Leeds were complex and required a system-wide review to challenge and ultimately change the service model being used to address the mental health needs of older people. Becoming one of 29 pilots for the POPP programmes enabled Leeds to implement a number of these changes and reap the rewards, including a significant reduction in the number of hospital admissions of older people with dementia.

The main issue that faced Leeds was the large number of older people with mental health needs being unnecessarily admitted to hospital, and their length of stay being increased due to an ineffective discharge process. The POPP programme, which included the setting up of a Rapid Response Intermediate Care Team, is locally estimated to have contributed to a significant reduction in the numbers of admissions for primary diagnosis of dementia to Leeds Teaching Hospitals NHS Trust. A correspondingly high number of mental health needs were consequently being met, within the home environment. The community-focused care has also meant that older people and their carers are more engaged with the services being offered, which is having a positive impact all round.

Prior to POPP, Leeds’ provision of acute healthcare and specialist tertiary services were overshadowing the preventative and proactive management of mental health. Recognising this, Leeds set about large organisational development of its workforce planning, including the NHS, social services and voluntary organisations such as Age Concern (to be known as Age UK from spring 2010) and the Alzheimer Society. Now, mental health intermediate care is delivered by the rapid response team, provided by Leeds Partnerships NHS Foundation Trust, supported by the Adult Social Care Mental Health Community Enablement Team to provide a service seven days a week. There is also the provision of hospital aftercare teams to help with the re-adjustment to home life on discharge from hospital.

The large reduction in admissions has meant that Leeds Partnerships NHS Foundation Trust has been able to reduce the number of acute care wards for mental health patients and has plans for further reductions. People who had previously been treated in hospital are now being treated at home, with their needs being better met by a range of therapeutic and rehabilitation services offered by a more cohesive team of health and social care professionals. This new workforce plan is something that Leeds intends to build on, and to continue to deliver a higher standard of services and care for older people with mental health needs.
End of life care

Good end of life care is a fundamental issue of dignity, choice and control. There is, however, a mismatch at present between people’s preferences for where they want to die and their actual place of death.6

- Most people want to die at home, but only around 18% do so, with a further 17% in care homes.
- Acute hospitals account for 58% of all deaths.
- Some 4% of people die in hospices.

Current end of life care appears to make significant inappropriate and unwanted use of acute hospital care.

Good end of life care is care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.7

Leicestershire: Decisions at End of Life pathway

In a concerted effort to improve its services to older people, Leicestershire County and Rutland developed its Decisions at End of Life (DALE) pathway. Older people’s choice to remain at home to die is being better met as a result of the DALE project. This was demonstrated by a reduction in hospital admissions and positive qualitative evidence provided by relatives who were interviewed during and after their experience of end of life care. From April 2007 to March 2009, DALE enabled 791 older people in Leicestershire to die in their own homes.

Prior to POPP, Leicestershire was experiencing a number of issues regarding its management of end of life care. First and foremost, case management was cluttered and quite often involved a number of third sector agencies working with the same aim but without clearly defined roles. Another issue that needed to be addressed was the inaccessibility of equipment required by community nurses in order to respond to a patient’s end of life needs. Their difficulty in obtaining this equipment was delaying discharge from hospital and putting patients at risk of being admitted to hospital unnecessarily. There was also evidence to suggest that ‘out of hours’ doctors were more likely to admit patients to hospital for symptom control and that care home residents were much more likely to be admitted to hospital at the end of life.

DALE created more clearly defined roles for community nurses and third sector carers in providing an intensive care and support service for the last seven days of a patient’s life. The project funded a range of improvements to the overall home care package for end of life care, which included a community staff nurse to be attached to each community team, 22 full-time Marie Curie healthcare assistants, a rapid response equipment service and a handy-person service.

Community nurses now have the authority to act as care co-ordinators for a patient’s end of life care. Community nurses have reported that GPs are now far more willing to prescribe pre-emptive drugs and reduce the need for ‘out of hours’ support from GPs who may not be familiar with the patient and their needs. Training and support has also been delivered to care home staff to increase their skills and confidence in managing end of life care, and therefore reducing their tendency to admit the patient to hospital.

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7 The National Council for Palliative Care, 2006.
The DALE pathway is now an established model of care within Leicestershire, and has given older people the confidence that their choice to die at home will be supported and will come with an appropriate care package.

Falls

“Falling is a serious and frequent occurrence in people aged 65 and over. Each year, 35% of over 65s experience one or more falls. About 45% of people aged over 80 who live in the community fall each year. Between 10 and 25% of such fallers will sustain a serious injury.”

Recent national guidance sets out developments, which commissioners should prioritise:

1. Improve patient outcomes and improve efficiency of care after hip fractures, through compliance with core standards.
2. Respond to the first fracture; prevent the second.
3. Early intervention to restore independence through falls care pathways, linking acute and urgent care services to secondary prevention.
4. Prevent frailty, promote bone health and reduce accidents through encouraging physical activity and healthy lifestyles, and reducing unnecessary environmental hazards.

West Norfolk Falls Service. This service follows up older people who have fallen and presented to accident and emergency, in order to prevent a further fall. Advice and support is also offered to older people who have fallen or who are at risk of falling. Other work includes the training of professionals and raising awareness among older people, including in care homes, where there has been a high rate of hospital admissions due to falls.

Carers

Supporting carers is vital to promoting the independence of older people. The vision in the Carers Strategy is that by 2018:

- carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role;
- carers will be able to have a life of their own alongside their caring role;
- carers will be supported so that they are not forced into financial hardship by their caring role; and
- carers will be supported to stay mentally and physically well and treated with dignity.

A range of interventions will be required to support this.

Calderdale’s Carer Support Project had several elements, with the aim of reducing the number of situations where care breaks down by supporting carers to self-care and manage their situation more effectively, increasing the economic wellbeing of carers and meeting carers’ needs in a more effective way. The key element of the project was an expert carers programme providing ‘Looking After Me’ courses. These are led by trained volunteer tutors, who themselves have experience of caring for a relative. The courses run over six weekly half-day sessions and help carers to:

- learn new skills to manage their caring situation more effectively;
- develop the confidence to take more control of their life;
- develop more effective relationships with health and care professionals;
- use their skills and knowledge to lead a fuller life; and
- meet with others who share similar experiences.

Dementia

The National Dementia Strategy has set a clear direction for the development of health and care services to support people with dementia and their carers. A number of the major planks of this strategy are focused on delivering a preventative approach, including:

- improving public and professional awareness and understanding of dementia;
- good-quality early diagnosis and intervention for all;
- good-quality information for those with diagnosed dementia and their carers;
- enabling easy access to care, support and advice following diagnosis;
- development of structured peer support and learning networks;
- improved community personal support services;
- implementing the Carers’ Strategy;
- improved quality of care for people with dementia in general hospitals;
- improved intermediate care for people with dementia;
- considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers;
- living well with dementia in care homes;
- improved end of life care for people with dementia;
- an informed and effective workforce for people with dementia; and
- a joint commissioning strategy for dementia.

Bradford Intensive Support Teams

Prior to embarking on the POPP project, Bradford was experiencing a number of issues in the management and delivery of its services for older people with mental health problems. The opportunity to be one of the 29 regional POPP pilots was welcomed, and, four years on, the project has been deemed a huge success by those involved. By creating a clearer vision and allocating funds to meeting the needs of people with dementia and functional mental health problems, Bradford has become less reliant on hospital beds. A large proportion of those people who received intervention via POPP and who previously may have ended up in hospital or in long-term care are now able to live comfortably and safely at home. The Bradford POPP pilot is a clear example of where early intervention in the care of older people can prevent costly hospital admissions and, most importantly, increase quality of life for the person being cared for.

The approach adopted aimed at providing community-based support to older people with mental health problems at risk of institutional care. This was achieved through flexible, instrumental and psychosocial support delivered to older people over a 6 to 12-week period. Service users were those considered to be at risk of admission to hospital or long-term care, or those requiring support to facilitate earlier discharge from hospital.
Putting People First – access to information and services

Improving access to information and support services is an increasingly high priority and there is an increasing recognition that this is relevant to all older people regardless of whether they meet eligibility criteria for social care funding or not. *Putting People First* states that a personalised system will include: “A universal information, advice and advocacy service for people needing services and their carers irrespective of their eligibility for public funding.”

The guidance accompanying the Transforming Adult Social Care grant explains that: “For those funding their own support and care it will mean that there are clear information points and support and brokerage services that enable them or their supporters to navigate the system, access qualified and appropriate advice and purchase quality services of support which meets their needs.”

Various models were developed within the POPP and LinkAge Plus programmes. It is best to see these interventions as being located along a spectrum graded on intensity of contact. The following diagram illustrates this.

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First Contact Checklist

The Nottinghamshire First Contact Checklist (developed within the LinkAge Plus programme) provides a way for front-line practitioners from a range of statutory and voluntary sector organisations to undertake opportunistic ‘case finding’. A simple checklist of questions is completed by the first organisation to make contact with the older person and a ‘back office’ facility such as the council customer contact centre ensures that referrals are automatically recorded and distributed to the appropriate organisation for action.

Brent Integrated Care Co-ordination Service

At the more intensive end of the spectrum, proactive care co-ordination is the term used to describe an approach to working with people that comprises an holistic assessment of their needs and makes arrangements for them to access the support they require. In the majority of cases this does not result in the setting up of ongoing care managed services (though in some variants there can be significant cross-referrals both to and from mainstream social care). A set amount of time is allocated to each case.

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Summary and conclusion

The POPP programme has significantly increased the evidence base about the effectiveness of preventative approaches, particularly where these are undertaken as part of joint working between health and social care. There can, however, be some misalignment between which part of the system makes the investment and which part reaps the benefits. Given the significant improvements in outcomes for older people, as well as the financial imperative to achieve even greater efficiencies in public spending, it is incumbent on local health and social care systems to resolve the misalignment of investment and benefits through joint commissioning and/or risk-sharing agreements. ‘Opting out’ from joint work on prevention is not an option. The agenda is also wider than health and social care; there are performance and outcome drivers that are relevant to wider local government functions and other partner agencies.