A group of approximately 20 diverse older people, including men and women of various ethnicities, are posed in several rows. They are smiling and looking towards the camera. The background is a textured, reddish-brown color. There are teal-colored rectangular blocks in the top right and bottom left corners.

Promoting Well-being: Developing a Preventive Approach with Older People

Helen Lewis, Peter Fletcher, Brian Hardy, Alisoun Milne and Eileen Waddington

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research undertaken by

Nuffield Institute for Health
71-75 Clarendon Road
Leeds
LS2 9PL

Tel: 0113 233 6352

Fax: 0113 233 6348

email: hssccd@leeds.ac.uk

<http://www.leeds.ac.uk/nuffield/ccd/ccdhome.html>

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SUMMARY

This report describes the findings of a research project which explores the ways in which local authorities and health authorities are currently developing preventive strategies and services for older people. It was commissioned by the Joseph Rowntree Foundation and Anchor Trust on behalf of the National Preventative Task Group.

This work adopts a two-fold definition of prevention which incorporates:

- 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 their engagement with the community

The research had three phases:

1. A postal questionnaire to all health authority and local authority chief executives in England
2. A series of telephone interviews with 2 - 3 key staff in local authorities and health authorities in 25 of the areas which responded to the postal questionnaire
3. Two-day field visits by the research team to five areas shown in the first two phases to be undertaking interesting work on developing preventive approaches and services for older people.

This report describes the findings from this research, which took place from the Summer of 1998 until the Spring of 1999. A separate summary of the findings is published by the Joseph Rowntree Foundation in its Findings series.

Chapter 1 of the report sets out the policy context in which authorities are operating, and some of the drivers which are encouraging them to maximise the quality of life and independence of older people.

Chapter 2 describes the first two phases of the research. The first phase involved the categorisation of authorities by the levels of co-ordination involved in their preventive approaches and the number of local services with preventive aims. The second provided more detail on the ways in which authorities were approaching the development of strategies and services. The findings from this phase and the fieldwork are described in the rest of the report.

Chapter 3 explores the reasons why some authorities appear to have progressed further with this agenda than others, and identifies a series of factors which appear to be associated with this kind of progress. These include:

- generation of broad cross agency and cross-sector commitment to goals
- engagement of older people in setting priorities
- strong senior officer/member leadership and ownership
- incorporation of priorities into corporate objectives
- institutionalising commitment in processes and structure
- dedicated budgets and/or dedicated staff

- explicit public objectives
- mechanisms of public accountability to older people
- locally based developments/community development approaches
- and commitment to sustainability.

Chapter 4 describes some of the many ways in which authorities have worked with older people to develop local strategies and services. These include conferences or 'visioning events', supported work with individuals or groups to develop skills, funding and support for organisations to develop their own projects, and frameworks to support older people working as volunteers.

Chapter 5 describes a wide range of services and facilities identified as having a preventive impact in its broadest sense. We have divided them into those which operate inside and outside of people's own homes, and deal separately with those which provide practical/physical support and those which meet personal/social care needs. We also identify the growing resurgence of community development approaches which support and enable older people to develop their own solutions to issues they identify. The importance of good, accessible information, positive attitudes and a culture of respect among staff and organisations are also discussed.

Chapter 6 addresses the issue of resourcing preventive approaches and evaluating their benefits. We found a great reliance on 'soft' and short-term money to stimulate and support many of these projects, but also some incorporation of preventive approaches into mainstream services. We also found a striving to obtain evidence to demonstrate the benefits of preventive working. This is generally expressed - often despairingly - as a wish for quantitative evidence, in terms of particular services resulting in savings elsewhere in the system, especially in mainstream and/or intensive services. This is seen to be what local politicians (and the Department of Health) most want. Some organisations and projects have begun to identify such quantitative data. We also stress the importance of seeking evidence for broader benefits from interventions, and using qualitative evidence from both users and professionals about the benefits. The Best Value agenda is seen as giving authorities the opportunity to explore the value of a range of services in qualitative as well as quantitative terms.

Chapter 7 describes the conclusions from our work. These are:

- it is possible to develop practical and creative preventive strategies and services for older people
- many issues other than health and social care have an important impact on older people's quality of life
- leadership is crucial
- resources need to be in place
- older people are key partners
- local government has an important role in enabling progress
- new ways of working are often the most productive
- dynamic voluntary organisations are a feature of success
- partners may need to reconsider how to assess evidence for investment.

We found that there are some robust examples of local collaborative working, which involve older people as partners, and which are supporting them and their families and friends to identify their own needs and aspirations, and working with them to develop solutions. There are, however, real challenges in terms of tackling some of the prevalent expectations and attitudes towards the abilities and contributions of older people. Unless older people are valued as equal citizens, the current low priority accorded to their needs will remain unchallenged.

Chapter 1

Introduction

BACKGROUND

The increasing life expectancy of older people 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 the provision of long term care. Changes in legislation relating to community care, and the ways in which it is provided and funded have also stimulated debates about entitlement to help. As more people retire early or find themselves without work in late middle age, there are also growing discussions about the ways in which people can realise the full potential of later life. One of the significant implications 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.

Responses to these challenges can be described as 'preventive.' This report describes the findings of a project commissioned by the Joseph Rowntree Foundation and Anchor Trust on behalf of the National Preventative Task Group to help inform the current debate by mapping the extent to which authorities have developed preventive strategies and services for older people. It will be particularly helpful in providing additional information for authorities developing preventive strategies and services in response to the recent guidance on the development of partnership, prevention and carers grants (Department of Health, 1999 and 1999a).

WHAT DO WE MEAN BY PREVENTION?

It is important to be clear what is meant by prevention, if there is to be a common understanding about the purposes and outcomes from approaches labelled as 'preventive.' For the purposes of this research we have used definitions developed in earlier work (Wistow and Lewis, 1997). This defines prevention as having a dual focus:

- services which prevent or delay the need for more costly intensive services
- strategies and approaches which promote the quality of life of older people and engagement with the community

Recent policy initiatives have reinforced the importance of this dual approach. In the following section we further explore this policy context, before moving on to discuss the research project in more detail.

POLICY CONTEXT

1. PREVENTING AND DELAYING DEPENDENCY

There is a growing policy interest in how to make best use of limited health and social care resources, by preventing or delaying ill health, and preventing the need to use the most costly and intensive services. A series of national policy documents refers explicitly to the

need to develop services which help older people maintain or regain as much independence as possible. These policies focus mainly on older elderly people or those who are very frail or disabled, and seek to maximise the quality of life of older people, promote community-based living and limit expenditure on statutory services.

The 1997 Department of Health circular *Better Services for Vulnerable People* emphasises the importance of 'timely recuperation and rehabilitation opportunities.' Two recent Audit Commission reports (*Home Alone - the role of housing in Community Care*, and *The Coming of Age - Improving Care Services for Older People*) both highlight the importance of early intervention. The former emphasises the need for timely adaptations to property, saving the need for additional support and improving the quality of life of the people concerned. *Coming of Age* emphasises the negative impact of a 'vicious circle' which reinforces the need to spend money on hospital and long-term care beds - because of a lack of services in the community to prevent admission to hospital - and a lack of rehabilitation services to help people return home rather than going into long-term residential or nursing care.

The 1998 *National Priorities Guidance for Health and Social Services* includes 'promoting independence' as a joint national priority, and requires authorities to implement jointly agreed plans for improving rehabilitation services. This theme is developed in the 1998 White Paper *Modernising Social Services*. It proposes to extend the direct payments schemes to people over 65, giving people more control over how their care needs are met. It also proposes a 'partnership grant' of nearly £650 million over three years, to foster partnership between health and social services in promoting independence for adults. In addition, there will be a 'prevention grant' of another £100 million over three years to stimulate the development of preventive strategies to target low level support at people most at risk of losing their independence.

2. PROMOTING WELL-BEING

There is also a growing national and local policy emphasis on improving the general health and well-being of populations, rather than focusing solely on the management or cure of ill health. The 1997 Green Paper *Our Healthier Nation* articulates a preventive philosophy, including 'increasing the length of people's lives and the number of years people spend free from illness.' It refers to the creation of 'healthy neighbourhoods' which are particularly geared to improving the living environments of older people. It also refers to 'empowering people and giving them the tools to take greater responsibility for their health' and 'building on existing strengths of the local community.' These themes are further developed in 'Health Action Zone' areas where health and other local agencies are working together in innovative ways to try to tackle health inequalities. A number of these zones have included a focus on older people. Health authorities, in partnership with other agencies, are now required to produce Health Improvement Programmes (HIImPs) which describe how they intend to improve the health of their populations.

In parallel, the White Paper *Modern Local Government: In touch with the People* sets out a proposed new duty on local authorities to 'promote economic, social and environmental well-being' via strengthened partnerships with other public, private and voluntary organisations and also with local people. Such partnership is also to be fostered between central and local government and is expected to characterise working within local authorities themselves. In the broadest sense, local authorities have long been responsible for promoting the health of local communities (and for preventing ill health). Many would argue

that collectively they do more in this respect than health service organisations. However, the current policy message is that this must become much more of a coherent corporate approach: explicitly embracing not just social services, housing and environmental health but also leisure, transport, environmental planning and other related services. Elected members are increasingly expected to provide leadership in promoting the well-being of their local communities, and to do so via 'joined-up thinking' and action not only within local authorities but across the range of public, private and voluntary organisations.

3. OLDER PEOPLE'S EXPECTATIONS AND ASPIRATIONS

The themes of empowerment and community involvement are also key elements of the Cabinet Office Initiative on Better Government for Older People. Twenty-eight local authorities are working to develop 'integrated strategies for an ageing population.' Promotion of a positive old age and prevention strategies are at the heart of this work, with older people involved as key partners in the development and delivery of these projects, which involve a wide range of agencies, departments and organisations. They focus on improving the ways in which older people are able to influence local decision making. They tend to look at the attitudes of society towards older people as they approach pensionable age (over 50) and promote a positive attitude to older people and later life.

The Better Government initiative builds on a growing awareness of the rights of older people to be treated as equal citizens. The expectations and aspirations of current and future older people are also changing. Consumer research is showing that even very frail older people want to retain control over their lives, and they have aspirations about a wide range of quality of life issues, not just those related to health and social care. These include adequate income, suitable housing, home help, good advice and information and transport, as well as personal care. The targeting of community care resources at the most vulnerable at the expense of providing lower intensity services to a wider range of people has greatly constrained some of these choices (see Godfrey, 1999 for a discussion on the targeting of home help services). Recent research found that people identified 'keeping mentally and physically active' as a key aim as they get older (Henwood and Waddington, 1998). Other studies highlight the emphasis people place on the importance of access to leisure and education opportunities. (Details of this research are included in a previous briefing paper prepared by the Nuffield Institute (see Fletcher et al, 1998).) Access to sufficient income plays a key role in the ability to achieve some of these aspirations - where people are 'comfortably off' and able to pay for their own support, run a car or take taxis, they clearly have more control over some aspects of their lives than older people with low incomes.

AIMS AND OBJECTIVES OF THE RESEARCH

This research was commissioned in this context of a rapid growth of interest in the area of preventive and promotional work with and for older people. The Nuffield Institute for Health was asked to assess the current level of activity in this area, and to explore the characteristics associated with success. The study maps current activity across England which relates to the two types of 'preventive' aims described above - prevention of deterioration and promoting quality of life.

The aim of the project was to explore:

- the extent to which local agencies are addressing these issues
- the ways in which they are doing so

- key factors which promote the success of such approaches.

The research also identified examples of innovative practice which could be usefully duplicated elsewhere in the UK. The study did not encompass work with and services for older people with mental health problems, or people with a learning disability. It looks at activity across a wide range of statutory and voluntary agencies and the contributions they make to the quality of older people's lives, rather than focusing solely on the responsibilities and activities of the NHS and Social Services Departments.

The project was commissioned before the publication of the Social Services White Paper which introduced the Partnership and Prevention Grants. However, given the close links between this policy development and the remit of our research, this work has been co-ordinated with the Social Services Inspectorate's work on the development of guidance (Department of Health, 1999a). Two of our field visits were conducted jointly with staff from the Social Services Inspectorate.

OUR APPROACH

The study had three components:

- a questionnaire sent to all health and local authority chief executives in England (Summer 1998)
- telephone interviews with a sub-sample of 25 of those areas (Autumn 1998) « field visits to five areas (Winter 1998/9).

The questionnaire was designed to enable us to obtain a wide spread of responses from across the country to gauge the development and breadth of activity and approaches to preventive strategies and services. We deliberately sought responses from chief executives in recognition of the important influences that a range of local government departments have on the lives of older people. We received responses from 117 local authorities and 23 health authorities.

Authorities were asked about strategies and activities which related to preventive approaches for older people and the involvement of older people in those strategies, using our identified definitions shown above. From the responses to the initial questionnaire, we selected 25 areas for follow-up interviews by telephone. We sought interviews with a cross-section of authorities, some of which appeared to have well-developed strategies and a well-developed range of services, some of which appeared to have one or other of these, and a small number where little development was in evidence in either strategic planning or services.

Finally we approached five areas where there appeared to be significant local commitment towards developing a strategic approach towards improving the quality of life of older people, and a range of interesting local projects which were contributing to that. Members of the research team then spent two days in each of these areas, meeting a wide range of individuals and organisations involved in the development of preventive strategies and services, including older people themselves.

PRESENTATION OF FINDINGS

The report begins by identifying national and local drivers which were seen to have influenced the development of local preventive work. It moves on to describe the

preliminary phases of our research which map current progress on developing services and strategies. In Chapter 3 it explores the range of factors which appear to be present in areas which have been most successful in developing this kind of agenda, and some mechanisms which have been used to develop preventive strategies.

Chapter 4 describes a range of ways in which authorities have involved older people in the identification of priorities and the development of services. Chapter 5 describes the range of preventive services which we found, grouping them into those which are provided inside and outside of people's homes, and those which relate to practical help and those which relate to personal and social needs.

Chapter 6 describes how authorities have gone about identifying resources to fund preventive services, and the ways in which other policy initiatives such as Best Value are stimulating local work. It also explores a range of possible approaches to evaluating the benefits of preventive services. Chapter 7 pulls together the main messages from our research.

Chapter 2

Mapping the National Scene

The research was commissioned to map the extent to which authorities were developing preventive strategies and services. The intention was that this mapping would be at different scales: in the initial phase we undertook a broad national mapping of where, by their own account, health authorities and local authorities were in developing their preventive strategies and services for older people; and, in the last stage, a more detailed study of five localities shown in the prior mapping to be developing interesting preventive strategies and services. In this section, we describe briefly the findings from the two early stages of our research, which give some idea of the level of activity across the country. We then consider in later chapters (in more detail) the messages which can be drawn from those authorities which have been more active in developing preventive strategies and services.

DEVELOPING A NATIONAL MAP

Our questionnaire to all local and health authorities resulted in 140 replies (around a 30% response rate), of which 23 (16%) were from health authorities. Some of the replies from local authorities may have incorporated a response from their local health authority but we were not necessarily able to identify this from the replies.

In using such a large questionnaire survey, the aim was to yield sufficient information to be able to broadly categorise authorities' activities and intentions along two dimensions - first, the scale and scope of their work, and second the extent to which it was multi-agency and cross-sectoral or single agency. In terms of the latter, we also wanted to ascertain whether initiatives were from single departments only, or were corporate, and to what extent they involved older people.

In analysing the questionnaire we used an analytical framework shown below to help us to determine:

- how far authorities had developed a formalised and explicit preventive strategy;
- the extent to which a range of activities and services in the authority are designed to meet preventive objectives;
- the level of activity being undertaken within the area.

In analysing our material we needed to establish criteria for categorising the authorities. These were defined as follows:

Levels of co-ordination

Authorities were categorised as having high levels of co-ordination by:

- having a formal preventive strategy specifically for older people

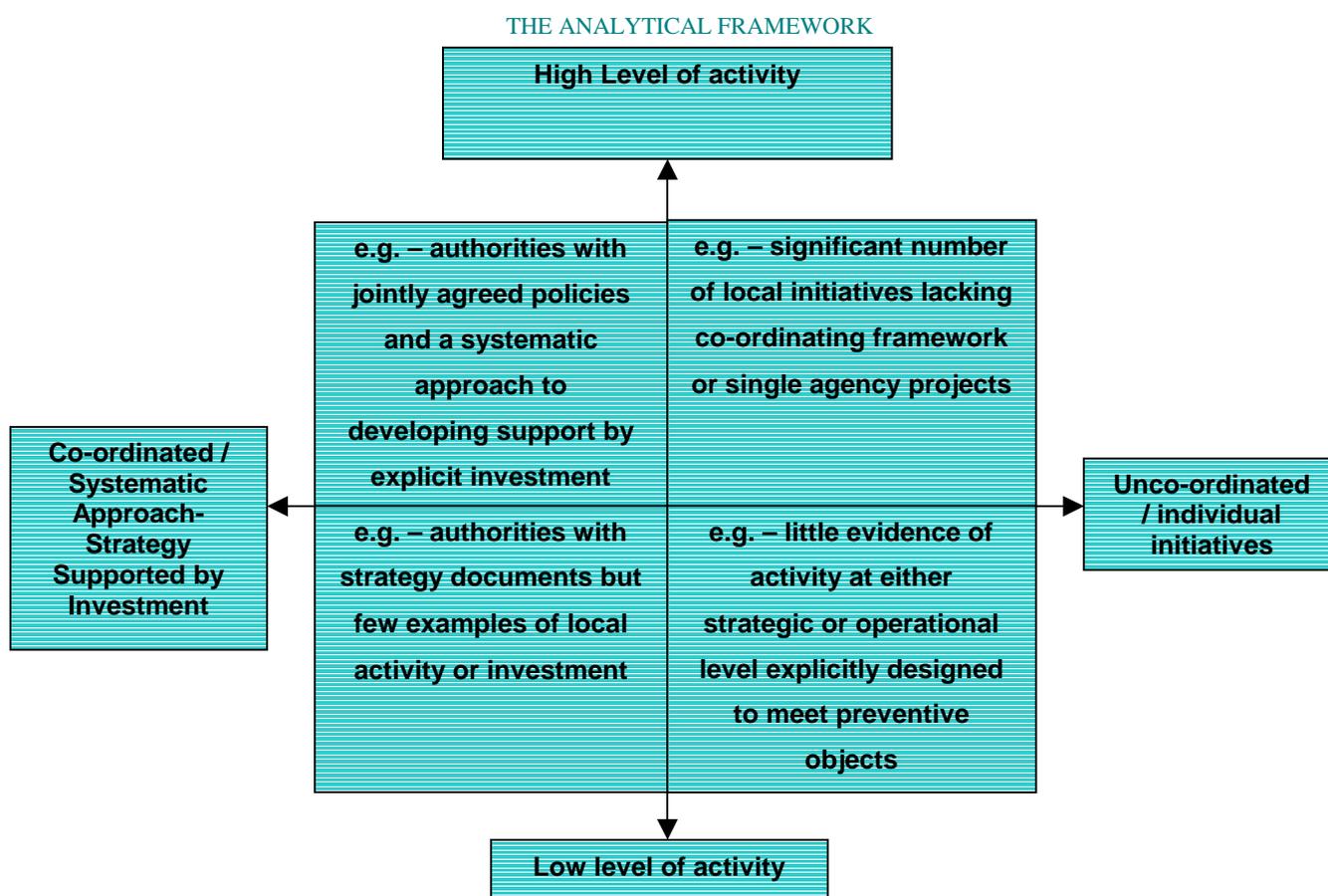
- or developing or intending to develop a preventive strategy
- or having other strategies with prevention as an explicit aim
- and where such strategies were corporate and/or multi-agency.

Other authorities were classified as having low levels of co-ordination.

Levels of preventive services/activities reported by authorities

Authorities were categorised as having high levels of activity if they reported five or more activities. (These figures need to be treated with caution, as authorities may have differed as to whether they reported individual projects such as separate respite care schemes or aggregate responses - 'respite service.')

Other authorities were categorised as having low levels of preventive activity.



Whilst this national survey yielded valuable information concerning the broad state of development of the prevention agenda, it is important to recognise the limitations of the analysis and to view the findings in that context:

- we analysed self-reported data and were unable, within the resources available, to verify the information
- the level of data contained in responses varied and is likely to have been directly affected by both the knowledge and work load of the respondent
- we did not receive replies from some authorities who are known to be active in the field of prevention.

ACTIVITY ACROSS THE COUNTRY

Taking these limitations into account, the initial analysis of the questionnaire showed that:

- 35 responding authorities (25%) could be interpreted as having both a high level of co-ordination in their approach to prevention and a high level of preventive activity;
- 44 authorities (32%) could be interpreted as having low levels of co-ordination but high levels of activity;
- 45 authorities (32%) were categorised as having developed fairly high levels of co-ordination, but as yet still have low levels of activity;
- 16 responding authorities (11%) indicated little or no co-ordination and low levels of activity.

Whereas this may represent a slightly higher proportion of authorities in the first category than might have been envisaged, the distribution of authorities across the remaining cells of the matrix is probably a reasonable representation of the state of development of preventive strategies and services. Many authorities are indicating a wish to move forward in this area, but may appear unsure as to how best to proceed.

TELEPHONE INTERVIEWS

Our telephone interviews with 25 authorities were selected from across the cells of our matrix. However, we weighted the selection towards authorities in the top two cells i.e. those which we had categorised as having an apparently well co-ordinated approach and a higher level of preventive activity. It was felt that this would enable us to begin to develop material to support authorities seeking to become more active in promoting prevention.

The telephone follow-up allowed us to collect more detailed information about the approach being taken by the authority, the partners involved and the preventive developments in the locality. This information has been used to inform the material developed in the following sections of this report. The location of the 25 authorities within our original matrix was reviewed after the telephone interviews. We now found that only a small number of authorities could be categorised as developing a co-ordinated approach to prevention and high levels of activity. A higher proportion of the sub-sample was now more appropriately described either as having developed a high level of prevention activity but with low co-ordination or as having low levels of activity though with higher levels of co-ordination. This is likely to reflect the fact that authorities may have a range of strategies and policies, such as those focusing on promoting community safety or reducing poverty, which can be described as having implicit preventive aims and objectives and indirect preventive impacts. However, such policies were often neither explicitly co-ordinated nor was their impact on older people specifically developed.

SUMMARY

Our national mapping exercise suggests that the development of preventive strategies as opposed to preventive services is patchy. Whilst in the main embryonic and uncoordinated, we found indications that some authorities wish to move forward in this area but are unsure how best to proceed. This wish to move forward is likely to have intensified since our original mapping was carried out, by the growing emphasis on preventive approaches in national policy guidance.

Chapter 3

Developing strategies to improve the lives of older people

In the course of this research we found authorities at different stages of development. We were particularly interested to find out why some authorities had invested time and resources in developing strategies and services and how they had gone about this. In this section we describe the national and local drivers which appear to have triggered and developed preventive approaches. We then go on to explore the processes and structures which had been put into place to develop local strategies for improving the lives of older people.

DRIVERS FOR CHANGE

NATIONAL DRIVERS

Most of the people we heard from during our research were clear that there were a number of national policy pressures which were raising the profile of prevention on their corporate agenda. Most of these have been described in the introductory section to this report. (Our field work was largely completed before the publication of the White Paper *Modernising Social Services* which has raised the profile of prevention still further, particularly within Social Services Departments.) The drivers identified can be categorised as follows:

- greater understanding of the 'whole system' within health and social care
- greater emphasis on the societal factors affecting health and well-being (including the impact of housing, education, transport etc.)
- greater emphasis on the importance of social inclusion and active citizenship.

Greater understanding of the 'whole system' within health and social care

As we have described, a number of recent documents have stressed the need to break the 'vicious circle' of dependency, and to redesign services which help people to maximise their independence. These include the Audit Commission's *Coming of Age*, the guidance contained in *Better Services for Vulnerable People*, and experience with projects funded as part of the Continuing Care Challenge Fund and funding to relieve winter pressures in the NHS. This set of policy initiatives was mentioned by the majority of people surveyed during the research, particularly those working in social services departments or as health authority commissioners.

Greater emphasis on the societal factors affecting health and well-being

People felt that there was an increased national emphasis on the need for multi-agency working and a broader approach to health and health promotion. They mentioned the NHS Green Paper *Our Healthier Nation*, and especially the potential for developing 'healthy

neighbourhoods' and 'healthy living centres.' *The Independent Inquiry into Inequalities on Health* had also reinforced the message that older people have particular health needs. The need to develop Health Improvement Programmes was providing a focus for health and local authorities to work jointly to consider the impact on health of a wider range of factors, and the ways in which these factors could be addressed. Such a joint approach was particularly emphasised by areas where there had been bids to become Health Action Zones.

People we spoke to felt there was now encouragement to have a broader agenda for discussion between health and local authorities and greater permission for the involvement of 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 was very helpful in stressing the importance of the broader context.

Greater emphasis on the importance of social inclusion and active citizenship

The final strand of national policy influence mentioned was the emphasis on considering ways to increase the participation of residents in decision making and society. A number of authorities were linked into the Better Government for Older People programme, and there was growing recognition of the place of older people in the emerging agenda of local democracy.

LOCAL DRIVERS

While these national drivers for change are universal, areas vary in the extent to which they have chosen to respond to them. In some areas the national agenda was seen to have given permission to revisit approaches which agencies felt previous governments had discouraged them from pursuing. Other authorities who had maintained investments in low level support or other 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 who had not really begun to consider the broader issues relating to older people in their areas, but who were clear that the national guidance being issued was stimulating local debates about how to develop this work.

The following sections highlight the local drivers for change identified in our interviews. These include:

- local pressures and incidents
- older people as a growing priority
- strong senior officer/member leadership and ownership
- pre-existing partnerships.

Local pressures and incidents

Local pressures and incidents include financial crises, political will, local lobbying, and the extension of other initiatives to consider the particular needs and rights of local older people. So, for example, a number of authorities said that a very high elderly population or a particular budgetary crisis had stimulated agencies to think more radically about the ways in which services were provided, and to consider investments in prevention. The opportunity to bid for national funding (for example for 'winter pressures' money) was given as an example of a stimulus to thinking about the range of available services.

Another stimulus to activity was an untoward incident - so, for example, the Camden Vulnerable Older People's Project had its roots in a 'lonely death', where an elderly woman had died in her flat and remained undiscovered for some time. The Best Value agenda was also mentioned as a local driver for reconsidering local needs and service responses for older people. In most of the authorities we spoke to, these kinds of responses initially tended to be focusing mainly on health and social care initiatives (sometimes involving housing). However, in some areas such as Manchester, there was a broader emerging agenda considering the impact of services provided by a range of departments.

Older people as a growing priority

In some areas, there had been consideration of the broad range of issues relating to the quality of life of older people. Whilst initial impetus may have come from within the local authority, over time involvement and ownership of the agenda had broadened out to incorporate a wide range of agencies and individuals. This approach was often driven by pressures from elected politicians and/or demand from local communities and voluntary organisations. It reflected a growing awareness of the rights of older people to benefit from public services or related to concerns about the increasing marginalisation of older people, or their migration from particular areas. In some areas work on improving the lives of older people had stemmed from other council-wide work in relation to Agenda 21, or from other initiatives related to community safety or an anti-poverty strategy.

POLICY STATEMENT ON THE OVER – 50S – MANCHESTER CITY COUNCIL

Councillors in Manchester were concerned that the City had a lower than average older Population, due to older people choosing to leave Manchester for other areas and high mortality. They wanted to work to reverse this trend and therefore develop and issue the following policy statement on the over-50s.

"The Council aims to promote opportunities for older people to maximise their potential as active citizens and to encourage them to remain living in the City. It will do this by promoting good practices in the employment of the over-50s, seeking to expand opportunities for leisure, educational and social activities, especially those that promote good health, and by addressing concerns around safety and crime prevention. The Council recognises the valuable contribution that older people make to community life and seeks to involve them fully. Older people come from a variety of cultures and ethnic backgrounds and the Council will endeavour to provide opportunities for all, regardless of race, gender, sexuality, disability or religion."

Strong senior officer/member leadership and ownership

The areas with the most activity aimed at meeting the needs and aspirations of older people tended to have one or more key senior individuals who were driving the agenda. In some areas these were elected members of the local authority, often those serving on social services committees or policy and resources committees who had a particular commitment to the needs of local older residents. In other areas the principal drive was coming from a group of senior officers. Seniority and the ability to influence appeared to be key to success.

Pre-existing partnerships

Unsurprisingly, we generally found the most activity where there was a history of strong joint working embracing not only statutory agencies, but also key voluntary organisations who were involved as equal partners. These areas often appeared to have a culture that was open to a range of influences, including the views of local older people and their representatives. In some cases, the establishment of a new unitary authority appeared to have provided an impetus to reviewing historical patterns of provision and ways of working, and developing a new vision for the local community.

PROCESSES FOR STRATEGY DEVELOPMENT

The previous sections have described the context in which strategies were developed and the factors which appear to drive the preventive agenda. We also asked people who had been involved in developing strategies and services how they had been developed and pursued. To some extent the processes varied according to whether the main local focus was on 'preventing expenditure' (usually a process driven by the NHS, Social Services and perhaps housing, with some voluntary sector involvement), or whether it was a more wide-ranging corporate initiative. While we did not find examples of broader strategy development where the local health authority appeared to have taken the lead, there are certainly areas such as Sandwell and Portsmouth where they are principal partners and share the same commitment and vision as their local authority partners. (Portsmouth's model for developing its advisory panel is shown opposite). It may be that the development of Health Improvement Programmes where the health authority is the lead agency, will mean that they will increasingly take more of a lead in this kind of work.

We would suggest that as authorities begin to embark on the development of preventive strategies a number of key factors need further consideration. The factors described in the following paragraphs emerged to a greater or lesser extent in each of the authorities we visited. The ways in which they were managed appear to be significant in the facilitation or hindering of progress. These include:

- the involvement of a broad range of local authority departments
- the role of the health service
- the role of front line staff
- engagement of older people in priority setting and monitoring
- locally based developments
- dedicated budgets and/or staff
- methods for incorporating priorities into corporate objectives
- institutionalising commitments into processes and structures.

THE INVOLVEMENT OF LOCAL AUTHORITY DEPARTMENTS OUTSIDE SOCIAL SERVICES

Our study found a mixed picture of the extent to which individual departments appeared to be involved with a broader 'preventive' agenda for older people. In part, this is due to an issue of terminology - many of a local authority's mainstream services will play a significant role in improving or maintaining the quality of life of older people, but this is not considered a key 'outcome' for that department. We found pockets of enthusiasm in a range of departments outside of social services and housing. So, for example, in some areas staff in library services, leisure, education and transport had embraced the challenge of ensuring that older people were able to access their services and saw them as key customers.

PORTSMOUTH'S STRATEGIC ADVISORY PANEL ON OLDER PEOPLE

Portsmouth has established a member-led multi-agency panel to 'advise programme Committees on a co-ordinated approach to the needs of elderly people.' It will work with a range of local organizations, particularly Age Concern, and will focus on working with retired people.

The Advisory Panel will oversee the preparation of a preventative strategy for older people, And will make linkages with other local strategies affecting older people. Its functions are identified as:

- to review the evidence on the key concerns of older people in the city
- to obtain views on these issues from representative groups of older people
- to assess how public, private and voluntary services in the city might meet these challenges
- to promote the inclusion of older people
- to recommend strategic responses to council committees and other organizations.

Strategic advisory panels are a successful model already used in Portsmouth, based on a corporate, consultative approach. Membership includes councillors (the panel is chaired by the Leader of the Council), officers from many of the councils departments and other co-opted members from the statutory and volunteer sector. The panel will build on a shared history of trust and joint working, where older people and voluntary organizations feel valued.

The panel has established four working groups. These will consider: health and social care, lifestyle, the built environment and economic well being. The outputs from the panel will include an action plan and a conference to be held in the autumn. A set of outcome measures are currently being developed which will be used to measure performance against

It may be important to note that some of the enthusiasts for 'joined up' approaches felt the departmentalism of authorities and agencies was a real barrier to creative planning. The development of projects and Best Value approaches which cut across departments and organisations presents a significant managerial challenge, particularly when these require a shift of funding out of one department. In a culture where the power of an individual department is often a reflection of the relative size of the budget it controls, there may be unwillingness both by officers and some councillors to develop approaches which involve a loss of budget or control of a particular service. Within departments, middle and junior managers in particular may have much to lose by the introduction of innovative services, particularly if these involve a strong input from voluntary organisations. In contrast, senior managers are more likely to maintain a role in developing and driving forward changes and may have less to lose.

THE ROLE OF THE HEALTH SERVICE

Our questionnaires, interviews and field visits all included contact with staff in the NHS as well as in local authorities. We found that among those we spoke to, the term 'prevention' was often assumed to relate to a relatively narrow 'preventive' agenda relating to relieving pressures on hospital beds. This focus on tertiary prevention may reflect the strong policy focus on rehabilitation and prevention of admission from recent policy documents, particularly in *Better*

Services for Vulnerable People. We heard very little mention of the role of mainstream primary and community health services in primary prevention, health promotion and screening work, or of treatments with strong preventive impacts such as chiropody services. Clearly there are GPs and primary health care teams who do a lot of preventive work with older people in terms of the early detection and management of disease and disability. However, on the whole primary care teams were felt to have played little part in some of the broader early intervention work, other than in pockets of good practice. A number of respondents felt that there were missed opportunities, for example related to the potential of routine assessments for the over 75s.

The people we spoke to felt that public health departments had often not had a central role, although they had often provided useful information on local morbidity to provide guidance about targeting particular interventions. So, for example, staff in the Portsmouth and South East Hampshire public health department had worked to provide an evidence base for targeting health promotion - for example looking at levels of accidents in nursing homes related to medication, nutritional issues and hypothermia. However, public health departments have often lacked influence within health authorities, and have rarely been a driver for policy changes. The broader based preventive approaches have tended to be thought of as the remit of health promotion departments and often focus on the health and behaviour of children and people in middle age, rather than older people. Such broad based approaches have tended not to feature highly in the commissioning plans of many health authorities except where they relate to specific disease prevention strategies.

We found a real sense in a number of areas that the NHS was now becoming more involved, a change attributed to some of the national drivers described earlier. It was felt more realistic to involve GPs in practical locality based working rather than in broader 'strategic alliance building.' In some areas, a great deal of expectation was being placed on the development of Primary Care Groups (PCGs) to raise the profile of population-based health promotion work. However, others feared that PCGs would simply be a distraction from the progress that had been made. Where there are Health Action Zones in development, these are also seen as a useful focus for inter-agency working, although many of these zones may focus on younger people, particularly to start with, rather than working to improve health across all age groups.

The role of Directors of Public Health was also seen as key to developing evidence based agendas that covered the broad health of populations. The Annual Public Health Report can play an important role in reporting baseline data and monitoring progress. So, for example, the most recent Public Health Report in Camden and Islington Health Authority focused on the health of older people in the area, and is being used to prepare their Health Improvement Programme for Older People.

THE ROLE OF FRONT LINE WORKERS

Most of those we spoke to said that front line workers were too pressed meeting statutory responsibilities (i.e. meeting the needs of those with the most severe and pressing difficulties), to be able to do work with people who were not yet in great need, or to act in a way which simultaneously fosters the development of preventive services. We return to this theme below in chapter 5. However, in some areas (such as Slough), care managers had been included as stakeholders in developing strategy and are encouraged to consider the opportunities for preventive work. Other areas have made imaginative use of front line workers who are already locally based (e.g. using home care workers to carry out accident

prevention audits or deliver invitations for benefits checks, or using local caretakers to provide checks and support for isolated residents).

ENGAGEMENT OF OLDER PEOPLE IN PRIORITY SETTING AND MONITORING

A number of areas have involved older people substantially in establishing local priorities for action, developing action plans, and to some extent in implementing and monitoring those plans. So, for example, conferences have been used to establish a dialogue with older people about their priorities, and to provide a forum for older people and officers from key agencies to discuss the action plans. In some places these gatherings have then become one format for public reporting on progress, an 'accountability' mechanism. We discuss the various mechanisms used to engage older people in such processes in more detail in the next chapter. Where there was a commitment to an ongoing mechanism for the inclusion of older people, there was evidence of additional drive and purposeful investment from older people, who viewed their contribution as genuinely influential and part of a dialogue, rather than as static one-off consultation.

Sandwell's broad-based approach to developing its Agewell strategy involves a strong commitment to the involvement of local older people. This approach is described below in some detail, because of the range of themes it illustrates.

LOCALLY BASED DEVELOPMENTS/COMMUNITY DEVELOPMENT APPROACH

The ability to focus on a particular geographical area (often prompted by special initiatives funding) was mentioned a number of times as an important means of bringing together and securing cohesion among a range of local players. We found that local communities and individuals were more involved where there were active representative groups, such as Age Concern, who worked with older people to facilitate their involvement or to advocate for them. In some areas local authorities or health authorities have established locality fora or one-off community visioning exercises to pull together local views. Active local councillors who take up a campaigning role on behalf of residents also appear to have an impact. In some areas, local churches were important in generating activities. In Sandwell, for example, there is a Sandwell churches link officer (funded from SRB2) which provides a link between churches, the council and voluntary organisations.

As with other planning issues, organisational complexity was critical in facilitating or impeding creativity. So, for example, in one area a local authority was working with seven district councils, two health authorities and numerous parish councils. A locality focus helps to reduce the number of different stakeholders involved in negotiating a local strategy, but creates substantial additional work for the officers in authorities which cover several different localities. While a locality focus was a strong feature of good practice in many areas, such a focus is also acknowledged to raise issues about equity of access to different services, particularly in large and diverse authorities.

THE AGEWELL STRATEGY, SANDWELL

The Agewell Strategy is one of a number of related strategies produced under the umbrella of the joint health authority and borough council Sandwell health partnership; others include a Growwell strategy and a Workwell Strategy. Produced in 1996, the Agewell strategy is described as:

"A vision of short, medium and long-term objectives which aims to increase the expectation of good health and social well being in later life. The strategy will ensure that as people live longer, this added life is of a high quality through appropriate and effective health promotion, disease and accident prevention, care, treatment and rehabilitation".

The strategy "provides a framework for service development and action on an inter-agency basis to minimise ill-health and disability and maximise opportunities for older people to lead healthy and fulfilling lives". (October 1996)

A series of recommendations included:

- promoting positive images and challenging ageism;
- addressing environmental safety issues, particularly falls, safety for pedestrians and road users, and reduction of crime and fear of crime;
- addressing the housing needs of older people; and
- addressing health issues, taking a more proactive role in the creation of health gain opportunities via primary care, health promotion and community development work.

Two of the central elements of Agewell are its multi-agency basis and its commitment not just to listening and responding to older people but involving them in both strategy development and implementation. Thus, following publication of the original document a series of consultation meetings, workshops and conferences with older people and local voluntary organisations culminated in an Agewell Conference 'Breaking the Barriers', in February 1998. Some clear messages from older people about information, attitudes and services emerged from the conference. In response, the Director of Social Services, speaking on behalf of the health partnership, committed the latter to a number of clear action pledges. A follow-up conference - a call to account - took place in March this year to determine how older people themselves thought the partnership had delivered on its prior promises. In addition, the Agewell Older People's Forum expresses the views of older people within the partnership, ensuring that the statutory agencies do not dictate Agewell developments. The Forum maintains pressure on these agencies to listen to older people and to ensure that they are involved whenever key decisions are made.

Although not explicitly a 'prevention strategy' Agewell constitutes one element in - and a clear expression of - a broader approach to prevention within the locality. Other closely related elements will soon be brought together and given even greater coherence under the banner of an inter-agency Vision 2000. Here the preventive links will be clear between not only Agewell, Growwell and Workwell, but also the community safety strategy (devised by the Safer Sandwell Partnership) and the environmental policy produced in 1996. The pervading preventive ethos in Sandwell is shown by the fact that the environmental policy which relates to the built environment and transport, environmental health and safety at work, refers to 'healthy living and working conditions [being] essential to maintaining good health and quality of life.'

DEDICATED BUDGETS AND/OR DEDICATED STAFF

Joint appointments and secondments were both mentioned as effective in developing and progressing a shared agenda. In Camden, an Assistant Director from the Leisure and Community Services Department was given lead responsibility for heading up their Vulnerable Older People's Project: he also works with staff seconded from other departments. In Sandwell, a post in the Voluntary Sector liaison team was funded half by social services and half from regeneration moneys. This post supports the development of voluntary groups, identifies gaps in service provision and helps local communities in developing their own projects and extending informal provision.

Designated funding, (such as winter pressure money, or the Single Regeneration Budget) or the opportunity to bid for such money from external agencies, was also felt to be an important mechanism for engaging key players in promoting preventive approaches. However, where funding is short term, such one-off activities are unlikely to lead to more sustained progress unless they can be incorporated into authorities' mainstream budgets.

INCORPORATING PRIORITIES INTO CORPORATE OBJECTIVES

A number of people we interviewed felt that the mechanisms used to develop Health Improvement Programmes were proving useful in raising older people's issues within senior management teams. However, others were more sceptical. Some people from outside the NHS expressed a feeling that the NHS culture and language was still very far removed from the approaches of local authorities and non-statutory groups. In particular, mention was made of the NHS's lack of experience in broad community consultation and involvement, and its historical focus on health services rather than health gain. It is too early to judge the extent to which Health Improvement Programmes will become genuine vehicles for developing and delivering broad-based strategies for improving the health and well-being of older people.

It is important to note that many areas are not starting from scratch in developing collaborative approaches to preventive approaches. Our research identified a number of examples of fairly long standing joint working between the NHS and other local agencies as part of healthy alliances. These have often focused on accident prevention or other targets previously included in the Health of the Nation, and may prove useful nuclei for broader projects. Again, the issue will be the extent to which these pockets of joint working can be incorporated into a broader mainstream agenda. There is also a question of how far such initiatives have focused on the lives of older people rather than other client groups, such as children and young people. So, for example, while there may be a history of collaborative working, it may not have involved the officers and agencies with a particular interest in older people.

EXAMPLES OF LOCAL ALLIANCES TO DEVELOP SPECIFIC PREVENTIVE PROJECTS

Avonside Accident Prevention Alliance – This alliance involves the health authority, local unitary authorities, police and fire service, NHS Trusts, voluntary organisations (including Help the Aged, Age Concern, Red Cross, Headway, St John Ambulance) and serves as the formal co-ordinating mechanism for the partnership strategy.

Healthy Norfolk 2000 - Health Improvement Alliance (joint funded joint work)
A subgroup manages the project and reviews local opportunities, for example by developing initiatives around lifestyles (food, sexual health, transport, accident reduction).

INSTITUTIONALISING COMMITMENTS IN PROCESSES AND STRUCTURES

The local authority Chief Executive's department or a co-ordinating committee were both seen as very important in developing and maintaining broad corporate commitment. For example, in Manchester the local authority has a Better Government for Older People Working Party (formerly the Older People and Opportunity Working Party) which receives reports from departments on progress made towards improving services for local older people. Some areas were discussing the development of 'scrutiny committees' which focus on reviewing the impact of local authority policies and other developments on the lives of local older people.

The incorporation of work with older people into the corporate objectives of organisations, or the key objectives of an initiative (such as a Health Action Zone or Health Improvement Programme) is seen as critical in obtaining and sustaining action. The greatest progress appears to be made when consideration of the needs of older people and the impact of decisions on their lives is seen as part of the mainstream activity of officers and organisations, and they are required, both regularly and formally, to account for progress made in this area.

Many of the themes identified in our research were also identified by work carried out by the Warwick University Local Authorities Research Consortium (Benington, 1998) on local strategies and initiatives for an ageing population. Their report also contains a series of practical guidelines for action, in order to develop strategies. These include:

- analysis of local socio-demographic data
- mapping of existing policies, practices and services by all local organisations (including those unrelated to formal care)
- identification of areas of duplication, gaps and potential for synergy
- audit of resources
- development of user-driven principles and objectives
- plan the process of change and mobilise support
- establish structures needed to co-ordinate programmes and maintain commitment at both member and officer level
- develop a detailed action plan
- establish continuous monitoring and feedback systems.

SUMMARY

In summary, we found a range of drivers which appear to have contributed to the development of local preventive strategies and services for older people. We also found that the areas which have been most successful in developing strategies and services appear to have put in place many of the building blocks summarised below.

BUILDING BLOCKS FOR DEVELOPING A SUCCESSFUL PREVENTIVE STRATEGY

- 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.

Chapter 4

Involvement of older people in the development and delivery of preventive approaches

As part of our fieldwork we met a range of older people and older people's organisations. We sought to explore the ways in which they had been involved in local work on the preventive agenda. We asked how far they had been involved in determining local agendas for action and shaping the delivery of programmes and projects, and the ways in which they felt the work of local organisations was contributing to their quality of life and that of other local older people.

There are clearly issues about terminology which reflect the broader issue of representativeness. Some older people will be 'service users' in the conventional sense of people receiving or using statutory or voluntary services. Many older people will simply use the range of services and facilities provided for local residents in an area, but may have particular concerns related to their previous experiences, their health, their expectations and so on. Much consultation in relation to community care has focused specifically on the narrower group of people who are in receipt of services or those who care for them. In the areas we visited, there was an attempt, in addition, to involve a far wider group of local people in identifying priorities and implementing action plans. In other words, there was a move towards encouraging 'citizen involvement', not just service user and carer involvement.

INVOLVEMENT OF OLDER PEOPLE IN THE DEVELOPMENT AND DELIVERY OF PREVENTIVE CARE



GENERAL APPROACHES AND MECHANISMS FOR INVOLVING OLDER PEOPLE

CONSULTATION

We found two main approaches to the involvement of older people. The first was a consultation approach, where the local authority or health authority drew up an agenda of priorities and then consulted with forums of older people which were already in existence. Whilst older people in these areas welcomed the opportunity to be consulted, they also felt, in a number of cases, that they were playing no more than a reactive role to someone else's agenda, and did not have the space to determine their own. Consultation fatigue could set in and there was not necessarily a feeling of ownership of either the process or content. This approach reflected a traditional top down approach that has been common in both local government and the NHS in the past.

INVOLVEMENT

The second approach reflected the broader shift currently emerging in local government from government to governance. In these areas older people themselves were facilitated to identify their own agenda and priorities, and the local authority then worked in partnership with those people to move the agenda forward with them. Older people we talked to were quite clear that this second approach constituted genuine involvement, and empowered them to fulfil their potential as active contributing citizens.

Older people were involved in preventive approaches and services at a number of different levels in the areas we visited. These include:

- involvement in developing strategies and setting priorities
- involvement in designing and delivering statutory or voluntary projects and services
- independently running groups or activities.

In some areas older people were involved initially in setting an agenda for action, but not then involved in its implementation. In others, statutory agencies identified priorities and plans, and then consulted local older people on these. Another model involved a 'reporting' mechanism, where officers met a group of older people to report back on the agenda they had agreed. This also gave an opportunity for local people to feed back ongoing concerns to officers about areas they felt had not been tackled satisfactorily, or to raise new areas of concern. A more developed model involved ongoing dialogue with groups of local people both about their concerns and about the ways in which they were able to contribute towards tackling them.

'I personally am very keen to include older people and involve them and I think it is morally wrong to ignore them. We have tried to be clear about what we can and can't do and to deliver on our commitments and promises.' (LA Councillor)

Our research identified a wide range of specific mechanisms used to involve or consult older people. These include:

- conferences

- market research
- use of pre-existing planning groups, such as Joint Care Planning Teams
- links with established older people's groups
- use of dedicated workers to enable older people to participate
- establishing specific groups to progress an agenda.

USING CONFERENCES TO SET AND MONITOR PRIORITIES

A number of areas had set up conferences as a means of engaging older people in setting out their priorities for action. Some were aimed at people who were already involved in local organisations, while others sought to engage a wider audience. In some areas, the conferences were an opportunity for a wide range of stakeholders to meet together to discuss ways to improve the quality of life of older people, while in others the initial conference was solely for older people themselves to develop their 'platform.' These were then followed up by 'mixed events' which included officers from key departments and organisations.

'It's ironic that people are now being asked to speak, after years of being told to keep quiet!'(older campaigner)

This type of event appears to be very successful in stimulating debate and energy, and can lead to the development of a jointly shared vision and set of priorities. However, there are issues about how this momentum is carried forward, and the subsequent roles of older people in monitoring and delivering this progress. Some areas, such as Sandwell, have chosen to use the conference format as an accountability mechanism, so that organisations return at regular intervals to formally account for progress (i.e. to give an account, and to be held to account). Others have used the findings from conferences to inform the development

TALKING ABOUT VULNERABILITY CONFERENCE IN CAMDEN (OCTOBER 1994)

This conference was organised by the Camden Forum of Elderly People, Camden Council, Voluntary Action Camden, Camden Age Concern, MIND in Camden, Camden Healthy Cities, the Community Health Councils, African-Caribbean Older people and the Camden Carers' Forum, following a 'lonely death.' During the conference participants drew up a 'shopping list' for action, sent to the appropriate agencies, who were asked to respond with ideas for action at a follow-up conference. The list included changes to existing services and requests for new services. The event was attended by over 100 older people. Many steps were taken to attract a wide range of participants, and to make the day as accessible as possible, including providing care support and adequate time for lunch, moving around etc.

Application forms were produced in large print, and had a freepost envelope attached. Forms were sent out with meals on wheels, via day centre and community managers, home care managers, and via members of local voluntary groups and tenants' associations. There was also press coverage and posters and leaflets in libraries and churches.

of other work. So, for example, the list generated in the Camden Conference described below was taken forward by the Vulnerable Older People's Project, and the Selston conference formed the starting point for what has now become the Better Government for Older People project.

CELEBRATION OF A GENERATION – SELSTON PARISH, NOTTINGHAMSHIRE (MAY 1997)

This conference focused specifically on the needs and views of older people in the Parish. 80 people attended the conference, and 250 were involved in pre-conference consultation exercises. This conference was one of a programme of Visioning Conferences held around the County, based on 'Future Search', designed to spark enthusiasm from both agencies and individuals, and produce a vision for the future of a specified area, with identified tasks, actions and outcomes for each participant

The themes and projects identified in Selston related to Leisure, Environment, Community Involvement, Transport, Shopping and Community Facilities, Education and Training and Crime and Community Safety.

MARKET RESEARCH

Some areas had used market research techniques to obtain the views of users. These included postal surveys to local residents, surveys distributed by home care or day centre staff, telephone interviews and focus groups. Such processes were helpful in obtaining 'snapshots' of people's views, or in sharing work done by other groups and seeing whether these views were shared by a wider group of older people. As well as their use in identifying priorities, such methods were also often used as part of a quality monitoring approach, with current service users.

USE OF PRE-EXISTING GROUPS, OLDER PEOPLE'S GROUPS AND TENANTS' GROUPS

There are obvious benefits to engaging pre-existing groups of older people and using these mechanisms to seek or share information about strategies and services. Such groups are often small and informal, based around particular estates, villages or social activities, and will not necessarily be known to health or local authorities. They will often play a key role in the social lives of the people who belong to them. The more formal joint planning groups have also been used to develop and deliver strategies, although these will traditionally often have focused mainly on community care issues.

USING PROFESSIONAL STAFF TO ACCESS THE VIEWS OF OLDER PEOPLE AND BUILD CAPACITY

In a number of areas there was recognition that older people needed help and support to develop skills in participating in priority setting and decision making. There were a number of models which used professional staff to work with groups and individual older people to explore their needs and to support them in articulating them to local agencies. In Sandwell, older people were offered training in advocacy, assertion and public speaking, and were helped to organise their own conference as part of the Agewell Strategy. Other examples of supporting older people to articulate their views are shown below.

ENGAGING HOUSEBOUND OLDER PEOPLE – HEALTHLINK, CAMDEN

This project was initially funded through joint finance for 3 years, as part of Camden Healthy Cities. Its objectives are to seek out and establish links with housebound people (concentrating on frail older people), enable these people to have the same access as others to information about and participation in, health and local authority decision-making and to develop relationships with local commissioners and providers. Participation is enabled in three ways

- **Providing Information** ('if you're stuck at home, don't go to places where leaflets are, so you don't find out about things')
- **Having a say** (a questionnaire was used to elicit members' experiences; Quality of Life conference held to identify people's priorities; open meetings to discuss topics with an outside speaker; pilot of telephone conferencing to enable people who cannot get out to talk to one another and to managers)
- **Social Support and activities.**

PARTNERSHIP DEVELOPMENT - NOTTINGHAMSHIRE RED CROSS

This project is funded by Joint Finance and involves a team of two workers with part-time clerical support. The Team helps each of the Joint Commissioning Groups to engage with service users, carers and voluntary organisations. They are assisted by a Reference Group of key umbrella voluntary organisations

ESTABLISHING SPECIFIC GROUPS TO PROGRESS AN AGENDA

Older people sometimes felt that they had been asked to participate in one-off events, and then not encouraged to continue their involvement. One way to encourage continued involvement is by involving older people in steering groups or management groups for particular projects. So, for example, the steering group for the Camden Vulnerable Older People's Project includes a number of local older people from a variety of backgrounds, including those who have been involved in local government and voluntary organisations. This helps to ensure that the project builds on the lessons from other local developments, and maintains an older people's voice in the project. It also means that the people on the group helped to provide publicity about the project to the groups with which they were involved.

INVOLVING OLDER PEOPLE IN GENERAL PRACTICE AND PRIMARY CARE – AGE CONCERN LONDON

Age concern London is carrying out a two-year action research programme to explore ways of involving older people in the work of primary care teams. 6 pilots have been established and a researcher will evaluate the different models of involvement which are developing. The findings from the work will be available in Autumn 1999.

If things fail it's also the responsibility of the residents for not participating and responding. Older people are partners too.' (County Councillor)

INVOLVING OLDER PEOPLE FROM ETHNIC MINORITIES

Ethnic minority older people are a minority within a minority. Because of population patterns, older people represent a smaller proportion for many ethnic minority groupings compared with the white population. So, for example, while over 19% of the white population in the UK is over pensionable age, only 5% of the black and Asian population are pensioners. However, as these communities now age, there is an increasing need for local agencies to consider the very specific needs of older people from minority communities, and often there is a need to develop new services from scratch, because there is no prior history of specialist provision. This provides real opportunities for designing appropriate services alongside users. However, many people in ethnic minority communities have faced life-long disadvantages (including language, poverty and poor housing) which bring very specific additional challenges to maximising their quality of life.

A number of authorities had established consultation groups specifically for ethnic minorities, as part of their community care planning processes (for example, the Manchester Black Community Care Consultative Forum). Where such formal mechanisms already existed, they tended to be the mechanism used by authorities for formal consultation or discussion about broader issues relating to older people. In the Camden example described above, local ethnic minority communities opted to hold separate smaller conferences in their own languages. The findings from these conferences were then fed into the follow-up conference.

A number of difficulties were highlighted during the research, relating to the very diverse ethnic minority communities in some areas and difficulties with language. Some areas had chosen to develop 'linkworker' systems to enable people from ethnic minorities to access mainstream services. Others were seeking to develop parallel services to meet very specific needs identified in particular communities. The Royal Commission on Long Term Care commissioned particular research on the needs of older people from ethnic minorities (Royal Commission on Long Term Care, Research Volume 1). They found that voluntary organisations appeared to have been more successful in 'incorporating a rich cultural component to their services.' Their research showed that 'demand for black and ethnic minorities is not for different or special services but for more responsive and culturally sensitive mainstream services' (paragraph 8.35).

ENHANCING IMAGES OF OLDER PEOPLE AND TACKLING AGEISM

A number of the people the project team spoke to felt that the key to making progress on improving the lives of older people was to tackle ageism. It was considered that ageist attitudes and low expectations among professionals, the general public and older people themselves act as barriers to the development of opportunities and innovative services for elders. In part, this was felt to reflect the dominance of the negative and limiting 'inevitable decline' model of ageing. Additionally, some older people - particularly those who are very elderly or very frail - may have internalised ageist limitations and feel they have little to contribute to society. The aspirations of those 'coming up behind' however, are likely to be higher and may challenge the 'traditional' passive and marginal status of older people.

Many of the projects and approaches described in this report represent an attempt to tackle ageism, although this was rarely an explicit aim. Many authorities regarded the challenge of combating ageism as underpinning the development of strategies for improving services for older people. For example, projects, which support older people in contributing to the

planning and delivery of services, may help to redress the power imbalance between older people and agencies. There is a growing awareness of the importance of challenging ageist attitudes among staff in most service sectors, particularly in terms of the capacities and potential of older people. However, we did not see any specific examples of training in 'tackling ageism.'

In some areas people are beginning to develop projects which explicitly address popular images of older people; most of these are aimed at increasing inter-generational

EXAMPLES OF INTERGENERATIONAL PROJECTS

Selston, Nottinghamshire

Older people have been asked to give talks to local schools about the history of the area, and are using local computing facilities at schools and youth clubs. Representatives from the Selston Parish Experience Group (formerly the Older People's Forum) and the Youth Forum meet together at the Local Area Forum. Older people and younger people are currently working together to address issues about the inter-connected needs of older and younger people. For example, there have been positive conversations about the best way to provide a meeting place for younger people, which would reduce the anxiety of older people about young people 'hanging around' and the noise they make.

Camden Education Department

Some young people were working on a variety of projects with older people. These included fund-raising for a local residential home and carrying out interviews with local older people about their own experiences, using a questionnaire developed in conjunction with a panel of older people.

Sandwell

The Housing Department has developed a scheme in conjunction with Age Concern, Sandwell Technical College and South Birmingham College. Using funding from 'Welfare to Work' they are training people to carry out general handyperson support for local older

understanding. Some of the projects involved challenging stereotypes, for example using plays and drama workshops to encourage younger people to consider what it would be like to be old. Others involved inviting older people to participate in school programmes, or encouraging younger people to work with groups of older people. The International Year of the Older Person and the Millennium Debate of the Age are also encouraging agencies to develop projects to promote positive aspects of ageing.

Tackling ageism by example is an important feature of this agenda. Projects such as those described above, which provide opportunities for older people to work as volunteers, highlight the positive contributions that can be made by people with a range of lifelong experiences.

S U M M A R Y

There are, a wide range of mechanisms for involving older people in defining priorities for action and developing solutions. These include:

- conferences
- market research
- use of pre-existing groups, such as Joint Care Planning Teams
- links with established older people's groups
- use of dedicated workers to enable older people to participate
- establishing specific groups to progress an agenda.

We found a range of examples of older people working in partnership with statutory and voluntary agencies to shape services, and many examples of older people themselves working together to meet the gaps they identified. However, skill, time, funding and commitment are needed, if involvement is to be genuine and ongoing, rather than tokenistic and static.

Chapter 5

Putting preventive approaches into practice on the ground

EXAMPLES OF PROJECTS AND SERVICES

The previous chapters have outlined the policy context in which organisations are developing strategies and the ways in which these are being developed, in partnership with older people. As described in the introduction, older people's needs and aspirations will be met in a wide variety of ways, the majority of which may not involve formal 'services' of any kind. Needs for companionship and support, for example, will often be met by friends and family or continuing involvement with local institutions. However, there are some needs which require attention from local agencies, in terms of providing facilities or information, or creating an accessible environment. This section provides some examples of such 'projects' and 'services' which are important in assisting older people to maintain their independence and inclusion in 'mainstream activities.'

One aim of our research was to identify examples of practice which might usefully be shared with other areas. The following section provides a series of examples of services both inside and beyond the home, which relate both to individual's physical and practical needs, and to their personal and social needs. These examples are drawn from our fieldwork and the written material supplied by authorities during the initial stages of the study. The examples are clearly not exhaustive, but are provided as an illustration of the range and scope of the services which may be developed. We are also producing a separate booklet of case studies, which will provide more details about a range of individual projects across England.

There are many different ways to categorise services. We have chosen to divide them broadly into those which deal with practical support and those which deal with people's personal and social needs. We have then divided them further according to whether they are provided in public settings or in people's own homes. This categorisation is simply to provide some structure for the description of a diverse range of services: there will obviously be overlaps between these groupings. A number of types of assistance can be provided in a variety of settings, and a number of types of project may meet both practical and social needs. The following grid provides a list of examples of the types of services which might come into each of these categories. The following sections describe such projects in more detail, and some of the issues which arise in their development.

EXAMPLES OF SERVICES AND FACILITIES WITH A PREVENTIVE AND PROMOTIONAL IMPACT

| | External Environment | Home |
|---------------------------|--|--|
| Physical/Practical | <ul style="list-style-type: none"> • Transport • Personal Safety • Street Lighting • Built Environment (e.g. Pavements, dropped kerbs, disabled access) • Traffic management • Community Centre • Advice centres/one-stop shops • Accessible shops with affordable products | <ul style="list-style-type: none"> • Heating / insulation • Home Safety/Security • Cleaning • Shopping • Gardening • Equipment/adaptations • Community alarms • Use of Technology • Handyperson/repairs • Lifetime housing • Specialist housing • Benefit advice • Equity release |
| Personal / Social | <ul style="list-style-type: none"> • Primary Health Care • Chiropody • Leisure • Life Long Learning • Libraries • Employment • Volunteering • Day care • Luncheon Clubs • Rehabilitation • Step up schemes • Engagement in priority setting • Community Development • Healthy living schemes • Peer support | <ul style="list-style-type: none"> • Befriending • Bathing • Meals services • Carers’ support • Range of personal care including nursing • Intensive home support • Resettlement into sheltered housing • Floating support • Rapid response • Rehabilitation • Advocacy |

PHYSICAL/PRACTICAL SUPPORT OUTSIDE THE HOME

Although not a central or prominent feature of our fieldwork visits, we found strong support for the need to see transport, community safety and the built environment in general as being important elements in any coherent preventive strategies. As the Royal Commission on Long Term Care notes:

‘The environment in which the future older people will be living should in time become more user-friendly. Twenty-five per cent of the population will be over 60 within the next ten years, and with this growth should become accessibility not just in the built environment and access to transport, but to a wider recognition of the determination and right to enjoy arts and leisure activities. Lifetime learning opportunities nurture the spirit, not just the mind. Living in a stress and crime-free environment are other issues

to be addressed to ensure that older people are enabled to live a full and active life. Investment in people will be repaid by an active, wiser and healthier society.'
(paragraph 8.47)

Certainly from the point of view of older people we met in a variety of arenas, transport was seen as the key to many activities. It is vital in a number of related ways. Without transport many older people are simply unable to get access to the full range of community facilities; nor, indeed, can they be properly involved in local planning or decision making. Good transport means transport that is affordable, reliable, flexible, comfortable, properly adapted and properly co-ordinated. Organised outings can have a preventive impact, when arranged for people who are normally housebound or immobile.

Camden provides a good illustration of the development of a co-ordinated approach to specialist transport services. There is a concessionary travel scheme (part of the London Borough's scheme, covering 28,000 pensioners at a cost of £3.5 million), taxicard and the PlusBus interactive scheme run in conjunction with Camden Community Transport. The latter is planned to create a local accessible bus network which uses a range of pre-existing vehicles delivered by a range of different agencies, which can be booked directly by people who are unable to use ordinary transport to access specialist services.

Community safety strategies are now widely developed and increasingly recognise that a crucial aspect of crime prevention is a lessening of the fear of crime (and its associated levels of anxiety and stress). Older people in particular are known to have heightened anxieties about the risk of becoming victims. Crime prevention and community safety comprise not just police force and probation service initiatives but such environmental service initiatives as improved street lighting and the role of the fire service in providing smoke alarms. Seen within a broader context, community safety can encompass attention to prevention of accidents in public places. Risks of falling or other accidents can be reduced by repairing damaged pavements, introducing dropped kerbs, gritting icy roads, looking at the phasing of traffic lights to help road crossing, and other actions which take into account the daily needs of people who have more difficulty in walking, seeing or hearing, or who use wheelchairs.

The most effective preventive strategies will be those making the clearest and most explicit links between service areas: i.e. those which recognise the interrelatedness of transport policies, crime and accident prevention policies, environmental policies and health and social care policies. In Sandwell, for example, there is an initiative by the environmental services department of the local authority to encourage cycling along canal towpaths. This is primarily intended to secure reductions in traffic congestion and air pollution. Both in themselves would lead to some health gain for the general population, but in addition, the more people cycle, the greater will be the direct health promotion benefit in terms of reduced risks of heart disease.

PHYSICAL/PRACTICAL SUPPORT IN THE HOME

Consumer research consistently shows that access to a range of good quality and appropriate housing, together with practical support services into the home, are seen by older people as vital to their well-being. Housing departments and housing associations generally had a good appreciation of the importance of their role in developing a range of housing options and services suitable for the needs of older people. They saw much of their work in a preventive context and recognised that many of the issues required the support of professionals from

other backgrounds in order to make progress. There was also a good understanding that their responsibility goes across tenure, given the particular problems of poor stock condition amongst older home owners, a proportion of whom live in the worst housing in the country.

The Audit Commission's recent study (*Home Alone - the role of housing in community care*) highlighted the shortcomings that still remain in developing integrated strategies on housing for older people with community care needs. Some areas were beginning to pull together issues within a strategic framework, while others had developed some good components of a broader strategy. The initiatives we saw can be categorised as follows:

- making sure the existing home is suitable
- responding to changing circumstances of older people
- role of specialist housing
- new housing
- practical services into the home.

Anchor Trust is also currently developing an innovation and good practice guide, funded by the Housing Corporation, which will provide more information on the role of housing and related preventive services. The guide will describe a range of housing models for older people which provide or support preventive approaches, both in terms of bricks and mortar and in terms of other kinds of support people may need to help them to stay in their current accommodation.

MAKING SURE THAT THE EXISTING HOME IS SUITABLE

Consumer research shows that most older people want to remain in their own homes even if they become frail. The accessibility and suitability of the home is therefore critical if this goal is to be realised, yet many older people live in homes that lack the basic amenities, levels of insulation, or necessary adaptations. A successful preventive strategy needs to address these issues. Examples we found included:

- **Fabric of the dwelling:** initiatives such as Home Improvement Agencies working in partnership with the grants department, lists of reliable building contractors, and the imaginative use of grants such as home repairs grants, were being used to support home owners ensure that their properties were appropriate for their older age. There is an increasing health dimension to this work: for example in the areas of heating and insulation, where a warm home is now recognised as vital to well-being, not just a comfort factor. In Nottingham, the local Age Concern Home Improvement Agency is developing a pilot "housing on prescription" scheme with funding from the Health Action Zone. Working with local practices, the agency evaluates the impact of housing improvements on the health of those referred. Sandwell is also developing "repairs on prescription".
- **Adaptations:** better procedures and joint working to ensure timely and appropriate adaptations were identified by the Audit Commission as a key area requiring improvement. We found a number of areas developing new structures and mechanisms for joint working in order to speed up and improve the co-ordination of adaptations. In some areas that had implemented such changes, for example Portsmouth, significant improvements had been achieved for the benefit of older people.

- **Home safety and security:** a number of areas were building in home safety and security checks as a normal part of the role of workers providing services into the home. Such a role can be carried out by a range of staff from existing agencies at no additional cost, for example, Home Improvement Agency, handyman staff or volunteers from befriending schemes. In Manchester the role is carried out by the Medical Housing team. In Portsmouth it is done by the environmental health department's Homecheck Service and two handyman services based in Age Concern and the local Care and Repair organisation.
- **New technology:** the only examples of new technology we found in this research were call systems. However, the potential of new technology to assist vulnerable people remain in a housing setting is increasingly being explored, particularly for people with dementia. For example, sensors in the home can turn off the cooker or spot potentially worrying changes in normal patterns of activity that might trigger a visit from a support worker. Trials by organisations such as the Edinvar housing association and the Joseph Rowntree Foundation under the heading of Smart Homes are showing promising results.

RESPONDING TO CHANGING CIRCUMSTANCES OF OLDER PEOPLE

Although many changes of home by older people are planned, unexpected changes in circumstance, caused for example by illness, death of a partner, or an issue such as personal safety, can present urgent accommodation crises and risks to continued independence. Some authorities are recognising the preventive potential of playing a more proactive role at this stage in order to help the older person and their family find a solution, that may, or may not, entail a move. Some of the key issues to address include:

- **Lettings policies:** Manchester gives lettings priority to relatives who want to move near to an older family member in order to provide support. Some areas have removed restrictions on older home owners being able to move into rented sheltered housing. Other areas, such as Liverpool, are making easier access routes to housing by developing more co-ordinated systems of letting sheltered housing through a unified waiting list, thereby offering a one-stop shop for older people.
- **Linking health and housing needs:** some areas have developed much more sophisticated models of identifying the housing implications of illness or disability than the "GP letter". The Manchester Medical Housing Team assesses housing needs in relation to health, for people who want to move and people who want to stay at home. Many older people do not know the options available. The team helps older people understand the choices available and then ensures action is taken to turn the choice into reality.
- **Information and advice:** easily accessible information and advice is also being developed on a broader basis than just about local authority and housing association stock. The service needs to cover all tenures, and financial advice on areas such as benefit take-up and equity release also need to be provided.
- **Supporting a housing move:** moving home is increasingly being recognised as a potentially difficult time, and some areas, for example Portsmouth, have resettlement workers to offer support during the move.

ROLE OF SPECIALIST HOUSING

Most authorities recognised that the needs and aspirations of older people as a consumer group are changing significantly, no more so than in relation to their perceptions about sheltered housing. A number of areas, for example Manchester and Portsmouth, are reviewing their sheltered housing, with a view to making the service more responsive to supporting older people in a housing setting if they become frail, rather than them having to move on to institutional care. Some authorities (such as Newark District Council and Nottinghamshire County Council) are specifically working together to develop very sheltered schemes as alternatives to residential care, an approach which has been developed very fully in Wolverhampton.

Sheltered housing was seen to have a strong preventive potential for frailer older people, providing an environment where they can retain control and independence. However, many areas were clear that they still had a long way to go to reshape their sheltered stock and service to meet the changing demographic and consumer needs.

The key issues being considered are:

-
- clarity about the role of sheltered housing, for both older people and staff linking the warden in more closely as part of the assessment and care management
- system and flexible models of delivering personal care and practical support services
- an environment that is enabling not disabling
- an increased community focus so that the scheme supports other older people in the surrounding area.

NEW HOUSING

Most of the current focus on priorities for new social housing relates to younger people and families. The main issue for older people was around the development of accessible or Lifetime Homes standards. Many authorities are incorporating accessible standards into their requirements for new housing, in advance of the forthcoming adoption by the Government of Part M of the Building Regulations, which will enforce the adoption of such standards.

PRACTICAL SERVICES INTO THE HOME

There was an encouraging appreciation of the interconnection and interdependence of action relating to the property with practical services into the home. For example, there is no point adapting a house for someone with a disability if the house cannot be cleaned or the garden maintained, since both of the latter are just as significant factors in determining whether or not a person is able to remain at home.

Furthermore, a number of authorities had managed to maintain or develop a range of such services despite the increasing emphasis of community care in recent years towards targeting of services only to the most dependent. These services very much reflect the areas of need that older people themselves identify as being essential rather than optional in order to maintain their well-being and independence. The main services were:

- handyperson services, often provided by organisations such as Age Concern using volunteers, or as an add-on to a home improvement agency
- Home Improvement Agencies themselves, some run in-house by local authorities, but more often run by housing associations or other voluntary organisations

- gardening services, usually provided by the voluntary sector, with local authority support in some areas, such as Portsmouth
- community alarm schemes, sometimes with mobile wardens
- evidence of new technology being used to report emergency repairs or to monitor carer visits
- befriending schemes, again using mainly volunteers, to provide social support alongside the practical help
- cleaning services into the home
- the provision of aids and equipment, sometimes linked to adaptations.

Many of these services were provided by the voluntary sector, some by volunteers. Their viability often seemed marginal, despite their importance for older people, because of the often temporary or inadequate basis of their funding. There was sometimes the sense of the purchasers trying to get such services on the cheap (the alternative might have been not at all). The prevention funding announced in *Modernising Social Services* may provide the opportunity to put some of these services on a more secure footing.

There were some interesting examples of local authorities funding some of these services through grants rather than contracts, partly to facilitate the flexibility of a volunteer service, and sometimes because the whole aim of the funding was to keep older people out of the care management system. Thus in Portsmouth there were a range of grant aided open access services provided mainly by the voluntary and private sector, specifically to prevent vulnerable older people having to be a part of the care management system.

PERSONAL AND SOCIAL SUPPORT OPPORTUNITIES OUTSIDE THE HOME

The opportunity to continue to engage with the community is an important issue for older people. There is often a danger that as people become more frail and need to use services, these may be delivered in such a way that older people become passive recipients, and cease their active contributions to the communities in which they live. In addition, where services are delivered to people in their own homes, there is an increased risk of social isolation, and people may only have the opportunity to relate to people who are paid to care for them. Others, who do not meet eligibility criteria for statutory services, may not see other people at all, if they are not able to or choose not to pay for private help, and do not have any support from family or friends. For some older people the lack of social and intellectual stimulation can contribute to the onset of depression.

EXAMPLES OF DAY SERVICE PROVISION

As people begin to need to access formal care services, it is important that such services are both flexible and sensitive to the needs of individuals. During the project we saw a rich patchwork of day services, often delivered by the voluntary sector. For some older people a trip to a luncheon club was their only social outlet in an otherwise isolated existence. Many spoke warmly of the dual benefits of a tasty meal and stimulating company. Day centres can also provide an opportunity for people to access information about other schemes and services.

Many of the day services we saw were not necessarily particularly novel. However, they are of particular value in situations where people are in contact with one kind of service and are therefore more likely to come into contact with a worker or a friend who will identify other

needs for support or information, and help them to access this. So, for example, in Portsmouth, where Age Concern is a major provider of lower level day and community services, it is beginning to act as a 'one stop shop' for a range of services including community laundry, day care, bereavement counselling, information services and so on.

REGENT STREET DAY CENTRE, SANDWELL

This centre for black older people attached to a church offers lunch and activities three/four days per week. It is run by the vicar and volunteers provide the meals. It receives a £5,000 grant from the local SSD. The centre is visited by a range of health and welfare professionals who provide advice. Many people who attend have little other contact with people.

As we have discussed above, many authorities are striving to develop ways of delivering ethnically sensitive services. In Manchester we saw a thriving resource centre organised by, and for, Indian older people which is described below. Some authorities, such as Wolverhampton, are building on models from other European countries (i.e. Denmark), where older people play a much more direct role in running their own community centres. Centres cater for a mix of active and less active older people, with support from a minimal number of paid staff.

INDIAN SENIOR CITIZEN'S CENTRE, MANCHESTER

This centre was established by a retired local Indian consultant. It offers a range of activities, some of which are purely social, while others have a more specific health and fitness focus. It receives funding from Manchester Social Services and the local Health Authority funds occupational therapy and physiotherapy sessions. The centre also provides a base from which services are delivered to the local community. These include meals on wheels, befriending and hospital visiting.

SUPPORT FOR SELF-RUN ACTIVITIES AND ACCESS TO MAINSTREAM SERVICES

Many of the older people we spoke to in the course of our fieldwork did not want things to be 'arranged for them' by statutory agencies (although they were often very concerned that such services should be available for others).

'We have had very short shrift when we have asked local people (in a rural area) how they want us to help. Their reply has been to go away and leave us to sort it out, or at least give us the money and leave us to spend it.' (Social Services Manager)

A key theme running through a number of the local projects which we saw was the creation of a climate and environment which enables people to run their own activities and to participate on an equal footing in 'mainstream' activities open to the whole community. Such activity fits well within our broader definition of preventive work. A number of different mechanisms to support such an approach are shown below.

SOME MECHANISMS FOR IMPROVING ACCESS TO LOCAL 'MAINSTREAM' FACILITIES

- enabling groups to have cheap or free access to local authority facilities such as schools or community centres
- provision of subsidised, accessible transport
- provision of mobile facilities such as libraries
- payment of fees or subsidies to attend adult education classes
- encouraging local education providers to run classes locally or in the day time to maximise attendance.

INCREASING ACCESS TO EDUCATIONAL OPPORTUNITIES – MANCHESTER ADULT EDUCATION SERVICE

The Service offers reduced fees or free places for people over 60 to attend classes (as part of the Council's Anti-Poverty strategy). It ensures that courses of interest to older people are offered in a range of locations such as local halls and GP premises, to increase accessibility. It also offers day time classes so that people who are afraid of going out at night can participate.

The aims are to encourage good numbers of older people to participate in educational opportunities and to ensure that the course programme reflects the needs/wishes expressed by local older residents.

A number of the examples we saw focused on leisure or educational opportunities. So, for example, in Manchester, the Leisure Services Department is trying to help marginalised and vulnerable older people access leisure services. Methods for doing this include responding to older people's requests for simple exercise, dance and sport activities held in local centres. Other methods include taking leisure services staff into sheltered housing and other residential units to provide activities there. A particularly exciting venture includes attempting to attract people over 50 to help with the Commonwealth Games in Manchester, in a voluntary or paid capacity.

For many people reaching retirement, the opportunity to use additional time to pursue new interests and hobbies can be a real benefit. The new emphasis on life long learning has, in some places, incorporated the needs of older people. The growth in movements such as the

DEVELOPING EDUCATIONAL OPPORTUNITIES FOR OLDER PEOPLE – SELSTON, NOTTINGHAMSHIRE

As part of its Better Government for Older People Project, a grant has been awarded by the Department for Education and Employment. Staff from West Nottinghamshire College worked with local older people to develop a questionnaire for use in asking older people what kinds of courses were of interest to them. This questionnaire was then used with existing groups of older people (in day centres, sheltered housing schemes, social clubs etc.) to collect responses on their priorities for tailored educational opportunities. This feedback is now helping to develop a series of courses designed to meet these requests. These will include training older people to act as peer educators to enhance communication and IT skills, to work on volunteering in a local community and to enhance knowledge about local services. The funding has also been used to pay for older people to access existing college courses which were previously only available free of charge to people under 50.

University of the Third Age reflects this interest and we saw a number of projects which were attempting to make it easier for older people to access further education and to tailor this education to their needs.

SUPPORTING OPPORTUNITIES FOR VOLUNTEERING

One area for increasing older people's engagement in local communities and to reduce their social isolation is to identify and support opportunities for volunteering, a role in which older people have traditionally been very active. Our research identified a number of projects which were seeking to expand the involvement of older people in this area. Some examples are shown below. Some of these projects use the skills of older people to support peers,

IN TOUCH SCHEME – A PARTNERSHIP BETWEEN CSV – RSVP (Community Service Volunteers, Retired and Senior Volunteer Programme) and Camden Council
A telephone contact scheme is currently being developed in Camden. People who are isolated and usually living alone are asked whether they would like to receive telephone contact once a week from a volunteer. If people do not have a phone, these may be installed free of charge. Many of the volunteers are likely to be housebound older people themselves. Training and support are being provided by a co-ordinator.

AGE CONCERN – TRANSAGE ACTION

This scheme builds on the experience of American schemes to provide 'foster grandparents.' Three pilots are currently underway in the UK (in Camden, Warwickshire and Enfield). In Camden the project is recruiting older people to work with young children in nurseries and other institutional settings, to provide support to young parents.

while others involve contributions to other sections of the community. One example we found in a number of areas involved training older people to run exercise groups at local venues.

PERSONAL AND SOCIAL SUPPORT IN THE HOME

One of the key factors sparking debates about the value of preventive services has been the gradual withdrawal, since 1993, of small packages of home care in most areas. Tighter eligibility criteria have often restricted access to help with housework, for example, to people with higher care needs. Much has been written elsewhere about the value which older people place on help in the home (see Clarke et al (1998) and Godfrey (1999) for examples). The people involved in our research pointed to the preventive benefits of providing one to two hours a week of housework to some groups of older people. So, for example, there are clear physical risks if older people are carrying heavy buckets of coal or firewood from the bottom of their gardens, or if they are used to standing on a chair to change their net curtains regularly. Given what is known about risks of fracturing or breaking bones and the increased risks of entering residential care on discharge from hospital, there are obvious benefits in supporting people to carry out such activities of daily living safely. In addition to physical benefits, there are important issues about morale, status and the maintenance of independence that are described more fully in Heather Clarke's work.

Some authorities have maintained a level of local authority funded home help input, even to those who do not require personal care. Some have contracted with private or voluntary sector organisations to provide housework services. Others have decided not to provide funding for such services, but to provide advice for people who wish to purchase such help privately.

In some areas support has been given to local voluntary groups to set up good neighbour schemes, which may incorporate elements of help provided by a traditional home help service as well as carrying out other functions. So, for example, a good neighbour might offer conversation to a socially isolated person, change a lightbulb, collect a pension, take

VICTORIA VISITING VENTURE - SANDWELL

This limited company with charitable status began through the Caring for People who Live at Home initiative. It offers specialist services to older people from black and ethnic minority backgrounds. It provides a range of services, including personal care, relief for carers, a visiting service, befriending scheme and care for people with dementia. It has set out specifically to recruit carers from a range of ethnic communities. Services are provided both to local authority clients and to private payers

them shopping, or (as in one scheme in Camden) bury a cat! The development of such schemes is dependent on the recruitment of good volunteers (some schemes pay a small stipend), and training and support are both vital.

Social support to people who are housebound may also be offered by visiting wardens or caretakers, or using some kind of telephone checking service. In some areas the community alarm service offers a regular telephone contact, while in others a more extended and personal scheme may be established (for example, the In Touch scheme described earlier in this chapter). Some community alarm schemes (such as the Camden Careline) will send out staff to help if the need arises, rather than simply notifying other agencies. They also offer an emergency stop-gap service, for example if the expected home care worker does not turn up, therefore providing an element of security for clients and their families.

We found a number of bathing schemes, run both by the statutory and voluntary sectors. The ability to have a weekly bath can be described not as a 'health' need or a 'social' need, but as a 'human need.' In one scheme, run by the Red Cross in Newark, clients are given the choice as to whether to have a bath at home, or to come to a centre (based within a residential home). Where people are socially isolated, staff try to encourage them to come out, and the bath therefore provides a stimulus to a small amount of social interaction. The bathing workers also provide housebound people with a link to the outside world, and can give practical advice and support. If one is looking for a 'preventive' effect, some areas include the inability to bathe oneself as one of the criteria for entry into institutional care. If that particular service can be provided (at a cost of about £10 per bath), then it may lessen the need to consider institutional care.

SERVICES GEARED TO PREVENTION OF ADMISSION TO LONG-TERM CARE

We identified a range of services designed to prevent admission to long-term institutional care. Such services had been developed to avoid unnecessary hospital admission, or to help older people regain their skills and independence. Many authorities have accessed money from the Department of Health under the 'winter pressures' initiative to establish schemes. Such schemes include rapid response teams to provide access to health and social care in the home in times of crisis and funding to enable GPs to access short-term care beds in nursing homes. Rehabilitation schemes include 'step down' facilities in homes for the elderly, or using nurse-led wards to enable older people to regain skills and confidence necessary to return home.

The recognition of the valuable role that domiciliary care can play in helping older people regain their skills was evident in a number of projects such as, the Manchester Short Term Assessment and Rehabilitation team, and the Knowle House project in Sandwell. In such schemes home care workers are given additional training and time to enable them to support people in regaining skills, so that the service users can carry out tasks for themselves, rather than having them done for them. Such inputs have proved very successful in reducing the overall levels of domiciliary care input required at the end of the period, and in enabling people to achieve their maximum potential. They also enable people to explore their abilities, and where help will be needed on a long-term basis, staff in these teams can help service users (and their carers, where appropriate) to consider the ways in which they want that help provided.

There is growing evidence of a rapid expansion in the development of community

INTENSIVE HOME SUPPORT SCHEME (PART OF MANSFIELD OLDER PEOPLE'S PROJECT)

This project provides home based care for older people who need acute medical/nursing care.

It includes access to a consultant geriatrician and the diagnostic facilities of the local hospital. Input is provided from a specialist health team (including OT, physiotherapy and pharmacy input as well as nursing and medical staff) and includes dedicated local SSD staff who provide a fast track assessment and care management service to people on the scheme, including access to benefits checks and home care staff.

The Mansfield Older People's Project group has also co-ordinated the development of a range of other local projects to address the needs of older people, including the nursing homes outreach project (described in chapter 6), transitional beds scheme, a development package on GP care of older people in nursing homes and an information system. A scheme to allow GPs to email SSD referral forms is also being developed.

rehabilitation schemes of all kinds. However, many of these schemes have developed as small scale pilots, with short-term funding, and have sometimes been developed by either a health authority or social services department in isolation. There are real difficulties in integrating such schemes with mainstream services, and perhaps even more of a challenge in developing a rehabilitative approach within mainstream services.

A number of people we spoke to in our research talked about the importance of training for front-line staff from all sectors, to encourage them to consider the potential of their clients, and to support them in doing things for themselves as far as possible. There are also issues about sufficient time being made available to staff to work in such a way - 'doing for' and 'doing to' are both usually much quicker than 'doing with', despite the potential long-term benefits of the latter approach, both in terms of self esteem, and potentially in increased self-care.

'The intermediate home care team enables people to become independent again. One old lady had had a heart attack. They have been walking her to the shops, which if we'd put her in traditional home care she would probably have received it long term with people doing all sorts of things for her. But they had helped her to become independent again.' (Member of joint agency rehabilitation team)

THE ROLE OF COMMUNITY DEVELOPMENT

The role of individuals who work closely with local communities appears to be critical in

HARTLEPOOL LOCAL SERVICE NETWORK

The Local Service Network Pilot (funded by Anchor Trust and the Department of Health Community Care Development Programme) resulted in the evolution of the Hartlepool Retired Resource Network. Older People are now working on a range of their own issues, including information and transport. These issues stemmed from an audit designed to identify their priorities, which was facilitated by the community development worker.

helping to generate action and involvement. In some areas these individuals were community development workers (sometimes from the social services department, but in other cases from leisure or community services departments, NHS health promotion departments or employed by voluntary agencies). In other areas these were members of the local community themselves, who set up local services in their community centre, or created informal networks of support.

In areas such as Hartlepool a community development approach has been a vital catalyst for enabling self-help groups of older people to evolve at a community level.

ENABLING STAFF TO WORK PREVENTIVELY

The ability to work preventively - to link people together in creative ways to improve their quality of life and those of people around them - appeared to be enhanced in areas where

A MODEL OF CARE MANAGEMENT – PORTSMOUTH CITY COUNCIL

In Portsmouth there is a strong view that the best care management model is one of least intervention and maximum empowerment. The Social Services Department has invested in specialist duty co-ordinators who try, where possible, to refer people with lower level needs to appropriate open access services rather than drawing them into the formal care management system. The open access services available include:

- Shopping and cleaning (Age Concern contract for up to 2 hours per person per week)
- Citizens Advice Bureau Welfare Rights Advice
- Gardening Service
- Bathing Service
- Weekend day care
- Care and Repair
- Luncheon clubs
- Drop-in Centres
- Community Laundry
- Advocacy

In addition, there is a strong emphasis on actively reviewing the care packages provided to people who are being care managed, and the provision of appropriate short-term interventions is also encouraged.

the organisations gave staff permission to act flexibly, responsively and relatively independently. In Camden, Age Concern provides a social welfare team (funded by Social Services) who are able to do casework to solve a variety of problems, as well as acting as

statutory care managers in some circumstances. The existence of a core of pre-existing services or organisations is also influential. These might be statutory organisations or services, local groups, or voluntary sector organisations. As we have discussed in relation to 'anti-ageist practice' one of the training and managerial challenges is in shifting from a paternalistic 'doing to' culture to one where there is more of an emphasis on 'working with' people and their families and friends to identify their needs and provide information.

INFORMATION

Finally, there is little point in developing a range of services, if older people, their families and friends, and professionals with whom they are in contact, are unaware of them. Many people we spoke to stressed the importance of allowing front-line staff some permission to work flexibly, and the critical need for information and training to be regularly available. In particular, the need for cross-department and inter-agency training, and access to up-to-date resource directories was vital.

For example, according to the manager of one Home Improvement Agency:

'Health and social workers don't know about home improvement agencies - they think they're only something for housing departments to deal with. But owner-occupiers and private tenants don't go to local authority housing departments, so they don't see the information.'

Other people felt that the role of providing information and ideas for activities and support to older people and their families was not solely one for statutory or voluntary agencies. Ideas for disseminating information included the use of local papers and local radio, post office, church or other community notice-boards, pension books, local employers and schools.

ADVICE AND INFORMATION SERVICE – AGE CONCERN BLACKPOOL

Blackpool Social Services Department funds its local Age Concern to provide an information and advice service to older people. The service is provided on an open access basis, with written information available from a range of outlets. Age Concern employs a benefits officer who, together with volunteers, provides advice sessions in their local office and to older people in their own homes. The service deals with 5-6,000 enquiries a year and has a 96% success rate in helping individuals secure Attendance Allowance.

Networks of friends and neighbours were seen as important ways to access information, particularly when they can be given additional skills. So, for example, the Benefits Agency in Nottinghamshire is establishing a programme to train older people to share information with peers about the kinds of benefits to which they may be entitled and to support them through the application process. In Sandwell there were discussions about web sites holding information on a wide range of resources and benefits, and the Older People's Forum was working on a resource directory for older citizens. In Camden, Age Concern were developing a database on opportunities for volunteering suitable for older people.

SUMMARY

Putting 'prevention into practice' has been interpreted variously across the authorities taking part in the project and a number of examples of good practice have been identified. Our report has not sought to describe the support and benefit that many people receive from their families and friends, but has focused more on services and inputs from external organisations. Field level services tend to be offered to prevent difficulties arising and to promote personal and social well-being or to provide support with physical or practical tasks. They may be provided in people's own homes or outside them. Promotional aims include the maintenance, or re-learning, of self care skills to ensure independence. Voluntary agencies, who often have a tradition of offering user orientated care, as well as social services home care, are routinely involved in supporting older people with activities of daily living. Preventive aims include the prevention of admission to hospital or to long-term care.

A particular challenge is posed by trying to help frail older people engage with the community and help tackle social isolation. The project identified a range of mechanisms for improving access to leisure, community and educational facilities, as well as ensuring that marginalised older people are offered social support. One way to encourage involvement is to develop opportunities for volunteering.

The expanding role of housing as a provider of both accommodation and care is widely in evidence, and specific investments in housing as a key catalyst for extending community based living and enhancing independence amongst older people have been identified. Additionally, practical services into the home provide evidence that authorities are recognising the link between the welfare of the individual and their personal 'built environment.' The role of 'key facilitators' working closely with communities appears to be critical in facilitating involvement from older citizens, and the development of a preventive culture depends, in part, on how prepared care agencies are to encourage flexible responses from their staff and to invest in low level, accessible services. The role of information was also highlighted as key in enabling older people to make choices and access services.

Chapter 6

Resources

A consistent theme running through many of our interviews was a concern about the affordability of preventive approaches. Social Services Departments in particular stressed that they were required to meet the needs of the most needy people and this demand consumed the majority of their current resources. While there was an understanding of the value of preventive or early intervention work, it was felt that this had to be a lower priority than responding to immediate pressures. Similarly, health authorities often focused mainly on preventing or reducing pressures on hospital beds, rather than on a broader preventive and promotional agenda. Performance indicators, waiting list targets and winter pressures have worked together to reinforce this kind of priority setting.

Notwithstanding the importance of such resource constraints, we did find evidence from our fieldwork that some areas are maintaining and developing preventive services for older people. This chapter looks at the ways in which funding is being made available, and the kinds of arguments and evidence which are used to support this expenditure.

THE IMPORTANCE OF ALTERNATIVE RESOURCES

One common theme was the importance of 'soft money' in stimulating, and, in some cases, maintaining lower intensity services. Alternative funding sources included access to money from central government (winter pressures money, challenge fund money, money from the Single Regeneration Budget and its predecessors), lottery funding, money from the European Union or Rural Development Commission, and charitable funding (such as the Church Urban Fund). Access to commercial sponsorship has also been helpful in developing some small-scale projects and some private sector funding has also been obtained by local authorities as part of planning agreements.

CONTRIBUTING TO ACCESSIBLE TRANSPORT – CAMDEN COUNCIL

In Camden, funding towards accessible buses was obtained from local supermarkets and developers as part of negotiations about planning permission. These buses are now being used as part of a wider network of accessible transport across the borough to enable people with disabilities to access mainstream facilities.

Despite the acknowledgement of the value of such resources in keeping low intensity and creative services alive, there was widespread dissatisfaction about the time and energy required to bid for such funding. Short-term funding discourages long-term planning, and the need to constantly seek more funding distracts staff from their core roles in delivering or developing services. These drawbacks of fixed short-term grants are as true for one-year contracts from local statutory funders as they are for external bids.

CONSIDERATION OF BEST VALUE

Some projects have developed out of joint working and joint planning, and a recognition that integrating and redesigning existing services may create a more effective use of existing resources. During our research we repeatedly encountered discussions of Best Value. This approach is encouraging consideration of the range of services provided to a client group, including the ways in which assessments are carried out. In a number of authorities there were strong feelings that it was common sense that earlier interventions represented 'better value' than crisis interventions. In part those feelings have been reinforced by emerging findings from some local pilot schemes funded by winter pressures money, where practitioners are working simultaneously with people receiving early intervention or more intensive support, while others receive the traditional response.

BEST VALUE AND THE USE OF THE VOLUNTARY SECTOR

Where strong voluntary sector organisations exist, with traditions of delivering a variety of 'lower level' schemes, it is more likely that they are asked to continue or to provide more. The voluntary organisations themselves are likely to continue to raise the issues of access, evidence unmet need and rising demand, and keep these issues on the agenda. We also found a strong view from elected members in some areas of the value of preventive work. A number of people we met talked both of the cost advantages of using the voluntary sector to provide a range of services, but also of the ways in which such organisations tend to be more flexible and responsive to the needs of local people, and their services more acceptable to a wider range of people than those provided by 'the Council.' Additionally, working in a creative way with local communities can create 'added value', by encouraging local people to contribute their energy and commitment to run their own activities or address issues for themselves.

'There is a very active voluntary sector and a very engaged community. This is very important in low level services that keep people going. It is largely funded through the council and health authority through grant aid and the imaginative use of regeneration moneys: it is about empowering communities to deliver their own services.'

(Health Partnership Manager)

DEFINING OBJECTIVES AND USING EVIDENCE

In the course of our research we asked people whether they had done any evaluations of the projects they described. We found a thirst for quantitative evidence (usually in terms of saving money, or reducing demand for another service). There are clearly difficulties in carrying out formal evaluations and particularly in identifying the extent to which particular benefits can be attributed to particular interventions (see Milne et al, 1999). Existing research evidence about the impact of a range of 'preventive services' is described in a companion volume to this research (Godfrey, 1999). As that review shows, while there is a need for more research into this area, there are real difficulties in carrying out such research. As the Royal Commission on Long Term Care notes: 'There is clearly a need for more longitudinal research to track the processes and outcomes of preventive interventions and to assess their impact both on quality of life and long-term costs' (Recommendation 8.3). The evaluation of the Better Government for Older People programme being co-ordinated by the University of Warwick will help to provide further evidence about the effectiveness of different approaches to developing and implementing strategies. The work currently being carried out by the Audit Commission will also help authorities develop frameworks within which to evaluate

their current provision of rehabilitative services and begin to assess their effectiveness.

QUALITATIVE APPROACHES

Many managers and service providers (as well as older people themselves) spoke strongly of the great benefits of 'preventive' services in improving the quality of life of older people, and of the rights that people had to access services and facilities that younger or fitter people may take for granted. However, we found a general sense that qualitative work was somehow perceived as less valuable than quantitative data which could 'prove' savings or shifts in resource use.

'I think we have shied away from putting in some seemingly anecdotal evidence. I believe there is evidence there and we ought to find it.' (Social Services Manager)

'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.' (Planning and Development Manager, SSD - rural area)

Some providers challenged this mindset:

'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!' (Bathing Scheme Manager)

In an echo of the 'ordinary life' discussions around services for people with a learning difficulty, many people spoke powerfully of the goal of social inclusion as a legitimate aim for much of the activity we have classified under the broad umbrella of 'prevention.'

Where objectives are broader than preventing expenditure, broader measures of success are needed. So, for example, increased take-up of benefit entitlements, increased enrolment of older people in leisure or educational activities, decreased fear of crime (as evidenced in opinion polls) were all cited as objectives for particular strategies and intervention. Portsmouth Council is currently identifying a range of such performance indicators as part of its approach to improving the quality of life of older people. A scheme intended to identify people at risk of social isolation and help them to extend their networks could rightly be judged both by the numbers of interactions the people involved had at a certain point after the original intervention, and by the clients' perceptions of whether they felt less isolated. To the extent that such schemes may reduce the risks of depression, and that depression is associated with admissions to residential or nursing home care, such schemes may also have impacts on expenditure or service use, but these will be much more difficult to measure and to identify as resulting from those interventions.

"The underlying philosophy of the Department is to promote independence. In order to evaluate expenditure, we should assess to what extent our services do promote independence.' (Chair, Social Services Committee)

Perhaps inevitably, our research found that most attention had been focused on evaluation of specific pilot projects where there were more explicit short-term objectives. Most commonly these were framed in terms of successful diversions from hospital, reduced admissions to institutional care, or reduced long-term usage of other statutory services by providing intensive rehabilitation input. As has been described elsewhere (Kings Fund and Audit Commission, 1998) a number of evaluations have found that a range of rehabilitation or

prevention of admission projects have some impact on service use at least in the short term, and can be regarded as having successfully 'prevented' the use of more costly services. However, such pilot schemes often created unease, particularly in terms of equity both within

SOME EXAMPLES OF EVALUATIONS AND OUTCOME MEASURES

RESIDENTS OF CONCERN – CAMDEN COUNCIL

The Residents of Concern project identified 278 people, of whom 65% were assessed to be vulnerable or socially isolated. 20% of these were not known to any support network (either informal or statutory). 84 people were referred to a wide range of services including statutory services, community alarms, welfare rights, mobile libraries and utilities. The programme had benefits to the target group of vulnerable people (by helping to connect them to supportive social networks), the wider community (by reducing social exclusion and its costs), local agencies (by informing the development of services) and local politicians.

EQUIPMENT FOR INDEPENDENCE – NOTTINGHAMSHIRE RED CROSS

SSD funded scheme employing three drivers and an equipment cleaner. Drivers have been trained by OTs to fit aids. The team delivers, fits and collects all local OT equipment in Greater Nottingham. It now takes less than a week between assessment and equipment being issued. The team, incidentally, has also been successful in recovering large amounts of equipment worth substantially more than the cost of the team (6,000 items in 1998).

NURSING HOME OUTREACH TEAM – KING'S MILL CENTRE FOR HEALTH, ASHFIELD, MANSFIELD AND SHERWOOD

Pilot project using 3 sessions of a consultant in healthcare of the elderly, and 5 specialist nursing sessions, to serve 8 local nursing homes who were high referrers to hospital. Local analysis found that around 5 per cent of acute medical admissions over a 12 month period are from residential and nursing homes. The pilot aimed to explore whether alternative care could be provided successfully in nursing homes, preventing the need for admission, and to build supportive relationships with nursing homes, including identifying and meeting training needs. The team arranged appropriate medication (with follow-up prescribing from the GP), diagnostic investigations, and enabled homes to carry out treatments such as intramuscular antibiotics, IV diuretics, subcutaneous fluids and nebulised bronchodilators, which would otherwise have required hospital admission. The project evaluation suggested that the Nursing Home Outreach Team could have prevented up to 62% of hospital

and between areas. Care managers spoke of the knowledge that some people were getting the optimal service, while at the same time others were still waiting for the minimal mainstream input.

USING STAFF RESOURCES

The report has already identified the importance of challenging ageist attitudes as a key component in raising the status of older people, and supporting investment in services which encourage the involvement of older people and promote preventive aims. The adoption of a preventive stance in work with older users has the capacity to facilitate anti-ageist practice, recognising the contribution of older people to society and in promoting user involvement and partnership principles.

'At the heart of this work is good quality assessment. That requires that some of the ageism which is inherent in departments as well as elsewhere has to be tackled.' (Social Services Manager)

Whilst recognising the pressure upon many agencies to primarily respond to those users 'in greatest need', there does appear to be significant potential for developing preventive approaches amongst front line staff, particularly care managers. Examples of 'preventive approaches' include home care workers being trained to help older people recently discharged from hospital perform activities for daily living for themselves, rather than the home carer doing them.

The empowerment of care managers to offer genuinely creative and flexible care packages was identified as another way to prevent limited and constrained responses to older people and to promote independence. Partnerships between field staff in health and social care were evidenced as offering broader opportunities to develop preventive alternatives to admission to a care home or hospital.

Whilst adopting a preventive approach to work with older people may be more time consuming in the short term, there is evidence of longer-term pay offs, both in terms of user and staff morale and in relieving more intensive service usage. There are both time and training implications of developing preventive work, particularly for care managers. Although financial constraints may appear to be a barrier to preventive practice, evidence suggests that this is a much more fruitful and useful investment of human resources, and benefits older users to a significantly greater extent than current practices, which are dominated by an 'inevitable decline' model of ageing and limiting perceptions about the potential of older people.

POLITICAL WILL - REVISION OF CORPORATE PRIORITIES

The enthusiasts we spoke to felt that if older people were considered to be a local political priority, then their needs were treated more seriously when budgets were set. As we have discussed in terms of the importance of incorporating older people's priorities into corporate objectives, where such needs are considered to be critical to the well-being of the population, funding is more likely to be forthcoming. So, as described earlier, Manchester City Council adopted a policy statement on the over-50s. Departments such as Leisure Services then translated this policy statement into action, by reshaping services and budgets to increase opportunities for this age-group.

Where preventive services are being introduced for the first time, they seem to face higher hurdles and requirements in terms of evidence for cost-effectiveness. This appears to be particularly true when the services are introduced within social services departments, where the funding is diverted from other services. However, there are other services in other local authority departments (such as subsidised bus passes, for example), which do not appear to be subject to the same levels of debate about costs and benefits, but are considered to be an important amenity to local people.

Political will and issues of citizenship are critical in this debate. Where there are powerful players committed to improving the lives of older people, their particular needs are more likely to be reflected in corporate priorities and budget setting. As projects develop which help older people to have their voices heard, and as they become an increasingly important proportion of the voting population, their views are likely to gain greater impact.

SUMMARY

Our 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. We have identified a number of avenues which authorities have used in an attempt to balance these tensions. These include:

- maximising resources coming into the authority and area
- application of the Best Value agenda
- developing effective partnerships with the voluntary sector
- developing an evidence base
- making most effective use of the skills of existing staff
- harnessing political will.

There remains a mismatch between attempts to assess the impact of preventive approaches focused on improving the quality of life of older people and evaluative approaches which are overly reliant on quantitative measures. There are also issues around assessing the impact of strategies and services where returns may only be visible in the long term, but the collection of evidence focuses on short term measures. It may be that the real challenge is to develop user driven qualitative measures which are capable of quantitative evaluation, to try to redress the current imbalance in evaluative approaches. Authorities will need to address these issues in the evaluations they put in place.

Chapter 7

Summary and Conclusions

The purpose of this study has been to establish a broad map of the activities of authorities in developing strategies and services which seek to promote the independence and quality of life of older people and prevent or delay deterioration in health and well-being. An important starting point has been to ascertain the extent to which such an agenda is being addressed at all. It is encouraging to be able to highlight that our research has found examples of authorities who are actively pursuing a preventive approach in their work with older people, and we know there are other authorities we did not visit who are similarly pursuing this agenda. On the basis of the experience of the areas we have had contact with, we have begun to identify similarities in approach and the outcomes they have sought to achieve. We have used this material to describe:

- the building blocks for developing a preventive strategy
- approaches to involving older people as partners in this process
- a framework for developing a range of preventive services on the ground
- the resource and investment decisions which need to be addressed.

In this final section we summarise the overall findings from the research and suggest ways in which this material could be used to promote the independence and quality of life of older people. Authorities will need to consider these findings in the light of current policy developments, particularly those outlined in *Modernising Social Services* and the recently issued supporting guidance (Department of Health, 1999 and 1999a).

Our key messages are as follows:

- It is possible to develop practical and creative preventive strategies and services for older people
- Many issues other than health and social care have an important impact on older people's quality of life
- Leadership is crucial
- Resources need to be in place
- Older people are key partners
- Local government has an important role in enabling progress
- New ways of working are often the most productive
- Dynamic voluntary organisations are a feature of success
- Partners may need to reconsider how to assess evidence for investment.

DEVELOPING A PREVENTIVE AGENDA FOR OLDER PEOPLE IS POSSIBLE

Our research found clear evidence of a range of activities and approaches which were improving the quality of life of older people and enabling them to act more independently. This was the widely held view, not just of service providers, (both staff and elected members

or management committees) but also of people who lived in those areas and used those services. In some areas there was a broad strategic framework for such activity, jointly owned by a wide range of local organisations and local older people. In others, there was no such explicit strategic framework, but nevertheless there were excellent examples of a wide range of resources, services and opportunities.

IT'S NOT JUST ABOUT HEALTH AND SOCIAL CARE

The evidence from our research shows the key role of a wide range of local authority departments - in addition to social services - in promoting the quality of life of older people, and in meeting the aspirations that older people locally were outlining. It shows too that not only a corporate, but a multi-agency approach is essential to making progress on the broader agenda. Within local authorities tangible and consistent commitment from the Leader of the Council and Chief Executive are critical to ensuring that individual departments take the agenda seriously. In some authorities this has taken the form of a policy statement or corporate objective about 'improving health and well-being', or 'encouraging active citizenship.' However, broad policy statements alone are insufficient to create change. They must be backed up by the setting, formulation and monitoring of achievable policies and plans which contribute to the realisation of such aspirations.

Our research found a belief in a number of areas that Health Improvement Programmes and Primary Care Groups would both provide significant opportunities to make progress in improving the lives of older people through the development of clear, coherent preventive approaches. Where Health Action Zones are being developed and older people are included in their action plans, they may provide a focus for a broad based agenda for improving health and quality of life. It is important that health and local authorities work together on this agenda, and the mechanism of the Health Improvement Programme may be one way to do this. However, there are substantial contributions to be made by a wide range of other agencies, organisations - in the statutory, voluntary and private sectors - and by individuals. Many of these will not see themselves as natural partners in an NHS-led process, and in many areas there is no tradition of the NHS working closely with them or of involving and building on the strengths of local communities.

Our findings suggest that engagement of a broad range of players may be more realistic in relation to smaller geographical areas than across a whole authority, and it may be that Primary Care Groups will assist in providing a framework for such activities. However, their agenda will be huge, and it seems likely that initial attention will be focused on the commissioning and delivery of traditional statutory services. It will require leadership and drive to encourage the development of creative models of services and broad based approaches to improving the quality of life of older people.

LEADERSHIP IS CRUCIAL

There is clearly no substitute for strong leadership if the lives of older people are to be placed high up the huge list of tasks facing health and local authorities. Without the explicit commitment of elected members, non-executive directors and senior managers, it is unlikely that there will be sufficient drive to develop this agenda in other than a piecemeal way. We would argue that there is a need for a 'product champion' or a team of such champions, particularly within health and local authorities. Such champions may also come from the

voluntary sector, or be strong local older people, who put pressure on the relevant statutory organisations to sustain and to account for progress.

RESOURCES

As we have described in previous work (Wistow and Lewis, 1997), there are tensions in the current system which work against the development and sustainability of creative and non-traditional approaches to preventive working. Current financial limitations in both health and local authorities create further pressures on existing services, and make it more difficult to break out of traditional cycles of provision. While small grants from central government are important in raising the profile of a preventive approach, there was clear recognition from all the people we spoke to that pilot projects and short-term funding make it very difficult to develop services that are sustainable and affect the nature of mainstream provision. Access to non-traditional funding sources, particularly by voluntary sector groups, has undoubtedly helped to develop some lower intensity services, but again these are often only short-term and fragile sources of income.

As described in the introductory chapter, there is a very real shift in national policy, towards a recognition of the value of early intervention in a range of services, and a change of focus which recognises the contributions of older people to a vibrant society. While the Partnership and Prevention Grants highlighted in *Modernising Social Services* are small amounts in relation to the whole expenditure of health and local authorities, they do represent explicit designation of mainstream funding into beginning to shift the balance of expenditure back towards early intervention, away from a targeting of services on people who are already most in need. The emphasis on the health of the population, and the statutory responsibilities of both health and local authorities in this area, will also require concerted reshaping of services towards maintaining and promoting health and quality of life.

INVOLVING OLDER PEOPLE AS PARTNERS

We found a very wide range of approaches to involving older people as partners. These included consulting them on priorities, involving them in monitoring progress, involvement in designing and delivering services, and supporting them to act independently. What is required, however, is a two-fold recognition: that consultation is, in itself, only a weak form of involvement; and that the development of preventive services and strategies requires active involvement by older people as citizens, not just current older service users and their carers.

GOVERNANCE NOT GOVERNMENT - A BROADER ROLE FOR LOCAL GOVERNMENT

There is an increasing recognition of the shift in the role of local government (and to some extent, of health authorities) to that of enabling and facilitating service developments across the whole range of agencies operating in the area. While this broader role does not prevent authorities from providing services directly, it reflects an awareness of the value of engaging and seeking to provide a co-ordinating framework for a wide range of partners in improving the well-being of local people.

NEW WAYS OF WORKING

A broad and innovative approach to improving the lives of older people appears to flourish in an environment where there are a variety of features of less traditional and hierarchical ways of working. In addition to elements of involvement and partnership, we found that organisations which gave permission to staff at all levels to be creative appeared to be more successful in generating responsive and successful schemes. This 'can do' culture, allowed experimentation and risk taking, both in relation to individuals and services, and often involved seeking out and grasping opportunities for seed money or short-term funding to test out ideas. Such opportunities often included a community development approach, by funding workers to support communities to identify their own priorities and develop their own solutions.

DYNAMIC VOLUNTARY SECTOR

Our research found that a dynamic voluntary sector contributed greatly to the development and delivery of services which enhanced the lives of older people. Some of the organisations we came across were very small, and locally based (tenants' associations, small befriending schemes, schemes for individual ethnic minority communities). Other larger organisations such as Age Concern delivered a range of direct services, provided advice and information, and harnessed the skills of fitter older people to provide advocacy and befriending to others. Such organisations can provide an important reference point for local older people and their relatives and friends, as well as to statutory workers who may find it difficult to keep track of the range of resources and benefits available.

Local authorities and health authorities differ greatly in the ways they fund such organisations. In some areas they are funded only by social services departments and/or joint finance to deliver services to people meeting community care eligibility criteria. However, in others, they are funded on a block grant basis (for example through community services departments) to provide an open access community resource. Concerns about fixed-term funding, and the time consumed by having to constantly re-apply for funding were raised repeatedly during our visits.

APPROACHES TO EVIDENCE

As part of our research we asked organisations whether they had evaluated the projects we discussed. We found a common view - and a fairly general frustration - that the only evaluations that seemed to carry weight were those which yielded quantitative evidence. Where information had been collected it usually related solely to the processes (how many people had received services) rather than the outcome.

We would suggest that although it is extremely important to define the objectives of particular services, strategies and activities, such definitions may be defined in qualitative terms; for example those relating to the World Health Organisation definitions of health as complete physical, mental and social well-being or enabling people to have more control over their lives or more choices. Increasingly there is a realisation that some of the strategies or inputs are geared to enabling people to be treated as equal citizens, and to have equal access to facilities which are taken for granted by others.

Where those are the objectives, the evaluation will need to look more broadly for outcomes than monitoring figures such as the number of admissions to residential or nursing home

care. Evaluations should include the perceptions of both older people and staff about the benefits of particular projects as well as data about take-up of particular services, feedback from surveys or opinion polls, or assessments of relative costs.

CONCLUSION

This study has provided valuable information about the range and extent of preventive approaches across England. It has found a range of approaches which are seen to be successful and identified some of the difficulties that may have to be overcome. It contains practical suggestions for those authorities and their partners who are currently seeking to develop existing initiatives, and also provides pointers for those who are beginning to embark on the prevention agenda.

Our discussions suggest that the term 'preventive' may be interpreted as referring solely to services targeted at people who are perceived to be vulnerable. Such services are clearly an important component of local provision. However, we would suggest that it is also important to work with local older people to develop an overall vision for the lives of older citizens, which encompasses their whole range of needs and aspirations, and to seek to shape a culture which is sensitive to these. These need to be taken into account in all areas of work - from planning roads to siting libraries; from providing accessible information to developing support for people with specific disabilities. We also need to recognise that older people often have the resources and will to shape solutions to their own problems, if provided with appropriate support and opportunity.

We are grateful to all those who contributed to this work, and particularly those older people and their carers who shared with us their own experiences, hopes and aspirations for the future.

Chapter 8

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Promoting Well-being: Developing a Preventive Approach with Older People

**Helen Lewis, Peter Fletcher, Brian Hardy,
Alisoun Milne, Eileen Waddington**

One of the significant implications 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 report explores the ways in which local authorities and health authorities, in conjunction with the voluntary sector, are currently developing preventive strategies and services with older people. It also looks at the reasons why some authorities appear to have progressed further with this agenda, and identifies a series of factors associated with this progress.

This research draws on postal questionnaires sent to all health and local authority chief executives in England, 25 follow-up telephone interviews and field visits to five authorities. It provides the first indepth study of developing preventive approaches and services for older people.

Promoting Well-being: Developing a Preventive Approach with Older People will be especially helpful in providing additional information to authorities developing prevention strategies and services in response to recent Government guidance on partnership, prevention and carers' grants.

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