

**Devon Prevention Strategy**

**‘Promoting Independence and  
Wellbeing for Adults’**

**2011 - 2013**

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## **Foreword**

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The need to invest in preventive services to delay people's need for social care and health services and to promote the wellbeing of our community is widely recognised. The Devon Prevention Strategy: 'Promoting Independence and Wellbeing' 2011 – 2013 sets out Devon's shared approach across organisations in the public, voluntary and community, and private sector to deliver services to an ageing and often geographically widespread population.

Collaboration across colleagues within Devon County Council, NHS Devon, district councils and the community and voluntary sector has contributed to the design of the strategy and will be central to its delivery for all adults. A major focus within the Devon Prevention Strategy: 'Promoting Independence and Wellbeing' 2011 – 2013 is the need to identify, at the earliest possible stage, the most vulnerable people in our communities who are at risk of poor health, and therefore are likely to require social care as well, to be supported by programmes that promote their capacity to maintain an independent lifestyle.

Across Devon we will face many challenges over the coming years resulting from the projected increase in the number of older people and people with long term health conditions, as well as the increasing pressure on services due to a reduction in funding from central government. Therefore commissioning services that provide 'value for money' and have an 'evidence base' for the improvements in health that can be achieved for local people will be of paramount importance.

It is our belief that implementing this strategy, along with the complementary focus on the engagement and involvement of the community to support the delivery of universal and community wellbeing services, represents a pragmatic and realistic response for the people of Devon to the challenges ahead.

The success of this strategy will depend on the strength of partnership, working across health, social care, housing and other partners, to come together to address the needs and aspirations of people living in Devon to live healthy lives for longer.

We commend it to you and encourage all partners to work with the people of Devon living in their local communities so that they can truly experience activities that bring benefits in terms of people's health and wellbeing.

**Dr Virginia Pearson**  
**Joint Director of Public Health**  
**NHS Devon and**  
**Devon County Council**

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## Executive Summary

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### Background

The strategy reflects the Government's vision for the promotion of health and wellbeing as part of the reforms to the system of social care, as detailed in '**A Vision for Adult Social Care: capable communities and active citizens**' (Department of Health, 2010a). This focuses on the commitments to:

- breakdown the barriers between health and social care funding to incentivise preventive action
- extend the roll-out of personal budgets to give people and their carers more control and purchasing power
- use direct payments to carers and better community-based provision to improve access to respite care

This latest vision reinforces the approach set out in '**Transforming Adult Social Care**' circular (Department of Health, 2009a) to:

*'Create a strategic shift in resources and culture from intervention at the point of crisis towards prevention and early intervention, focusing on promoting independence and improved wellbeing in line with the needs of the local population, reaching out to those at risk of poor outcomes.'*

This strategy also takes account of proposed outcomes framework set out in the document '**Transparency in outcomes: a framework for adult social care, a consultation on proposals**' (Department of Health, 2010c).

It also draws local approaches in relation to the 'Putting People First Programme' and a number of other strategies, for example self care and extra care housing.

### Context

Devon faces a major issue with the increasing percentage of older people within the overall population and the challenge to services that will arise alongside a reduction in the growth of public funding for health and social care.

The population of Devon recorded by the most recent national census in 2001 was 705,880. Of this number, 147,823 (21.0%) were aged 65 or older and 20,953 (3.0%) were aged 85 or older. The population projection for 2031 is 868,606, of which 249,886 (28.9%) will be 65 or older and 45,966 (5.3%) will be 85 or older. When population projections are undertaken then the biggest rises will be seen in the number of 65–85 year olds. The figures suggest that this rise will be by more than 60% by 2031 and the number of people aged 85 and older will be more than double, rising by almost 119%.

Alongside the increase in the older population it is estimated, in 2010, that there are around 14,200 people aged 18 plus living with a learning disability in Devon, of which just over 2,800 have a severe disability. Estimates for people living with a physical disability, aged between 18 to 64, show just over 37,400

living with a moderate physical disability and over 11,500 with a severe physical disability, producing a combined total of over 48,900 people.

Estimates for people aged 18-64 who are predicted to have various mental health conditions living in Devon in 2010 show that over 71,700 people have a common mental disorder, over 2,000 people have a borderline personality disorder, 1,550 people have an antisocial personality disorder and around 1,780 people aged 18-64 have psychotic disorder. It is predicted that these figures will rise by 3% by 2030, with the exception of antisocial personality disorder which is predicted to increase by 5%. It is also predicted that 221 people aged between 30 and 64 in Devon have early onset dementia of which 58% are male. This is predicted to rise by 6% to 235 by 2030. Early onset dementia is most prevalent in the 50-59 age band for both men and women.

The most common mental health problems in older people are depression and dementia. Depression affects proportionately more older people than any other demographic group, because older people face more events and situations that may trigger depression: physical illness, debilitating physical conditions, bereavement, poverty and isolation. Older people with dementia usually continue to live at home with support, but may benefit from specialist accommodation, including extra care housing. There were an estimated 12,561 people suffering from Dementia in Devon in 2010, this is predicted to rise significantly to 23,076 by 2026 (a rise of 84% in 16 years).

### **Aims and objectives**

The aim of the strategy is to ensure that:

- work is focused on helping people to maintain their independence and wellbeing or learn how to be independent when living with a life long disability through working and consulting with them
- through joined up early intervention, more people are helped to avoid a crisis that could lead to unnecessary admission to hospital or longer term care

The objectives for the prevention strategy are based on the seven key principles which reflect the national '**A Vision for Adult Social Care: Capable Communities and Active Citizens**' document and are:

- **prevention** where empowered people and strong communities will work together to maintain independence
- **personalisation** where individuals, not institutions, take control of their care
- **partnership** where care and support is delivered in a partnership between individuals, communities, the voluntary sectors, the NHS and councils – including wider support services, such as housing
- **plurality** where the variety of people's needs is matched by diverse service provision with a broad market of high quality service providers
- **protection** where there are sensible safeguards against the risk of abuse and neglect

- **productivity** where greater local accountability will drive improvements and innovation to deliver higher productivity and high quality care and support services
- **people** where a workforce can provide care and support with skill, compassion and imagination and who are given the freedom and support to do so

### **Evidence base**

The strategy is based on a framework that identifies approaches which aim to reduce vulnerability in the general population, complemented by effective interventions to promote independence and then to reduce high dependency. Within this approach there should be a reduction in the number of people who move through the phases of low to moderate needs, substantial needs and complex needs.

A robust review of international and national evidence underpins the strategy to ensure the recommendations are the most cost-effective and cost-beneficial.

### **Recommendations**

The main recommendations focus on:

- promoting volunteering and community empowerment
- reducing falls and preventing fractures
- promoting assistive technologies
- developing reablement services and enabling approaches
- implementing self care
- delivering intermediate care
- investing in extra-care housing and community housing options

### **Implementation plan**

The implementation plan identifies where work is already underway to produce costed proposals for each of the recommendations and where further work needs to be initiated to inform the prioritisation and allocation of resources to deliver the strategy. This plan will be monitored and updated on a regular basis.

### **Implementation and governance arrangements**

The governance of the '**Promoting Independence and Wellbeing Strategy**' will be agreed through the emerging arrangements for the Health & Wellbeing Board for Devon.

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## 1. Background

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### National

- 1.1 The current vision for the promotion of health and wellbeing has been set by the Government through reforms to the system of social care detailed in '**A Vision for Adult Social Care: capable communities and active citizens**' (Department of Health, 2010a). This focuses on the commitments to:
- break down the barriers between health and social care funding to incentivise preventive action
  - extend the roll-out of personal budgets to give people and their carers more control and purchasing power
  - use direct payments to carers and better community-based provision to improve access to respite care
- 1.2 Services will be personalised, more preventive and more focused on delivering the best outcomes. As set out in the sector wide concordat (Social Care Institute for Excellence, 2011) **Think Local, Act Personal**, '*Targeted joint prevention strategies and effective provision of information and advice will be critical to support the changes to service delivery models*'
- 1.3 The priority of this work is highlighted by the Government's commitment to continue to provide additional funding for social care with £2 billion by 2014/15; £1 billion through the NHS and £1 billion in grant funding to local government.
- 1.4 This settlement provides the opportunity for reform and improvement. It will be important to ensure that the services delivered are based on the needs of local people and the evidence of best practice and effectiveness to improve health outcomes.
- 1.5 This latest vision document reinforces the approach set out in '**Transforming Adult Social Care**' circular (Department of Health, 2009a) to: '**Create a strategic shift in resources and culture from intervention at the point of crisis towards prevention and early intervention, focusing on promoting independence and improved wellbeing in line with the needs of the local population, reaching out to those at risk of poor outcomes**'.
- 1.6 The Government has identified the following definition of prevention in a bid to support local authorities and NHS organisations to target their preventive services more effectively (*Making a strategic shift towards prevention and early intervention*, Department of Health, 2008):
- Primary prevention*: provision of universal access to good quality information, supporting safer neighbourhoods, promoting health and active lifestyles etc.
- Secondary prevention*: identification of individuals at risk of specific health conditions or events, such as strokes, falls, those who have existing low level care needs, people who have epilepsy or are at greater risk of health conditions due to complex physical disabilities.

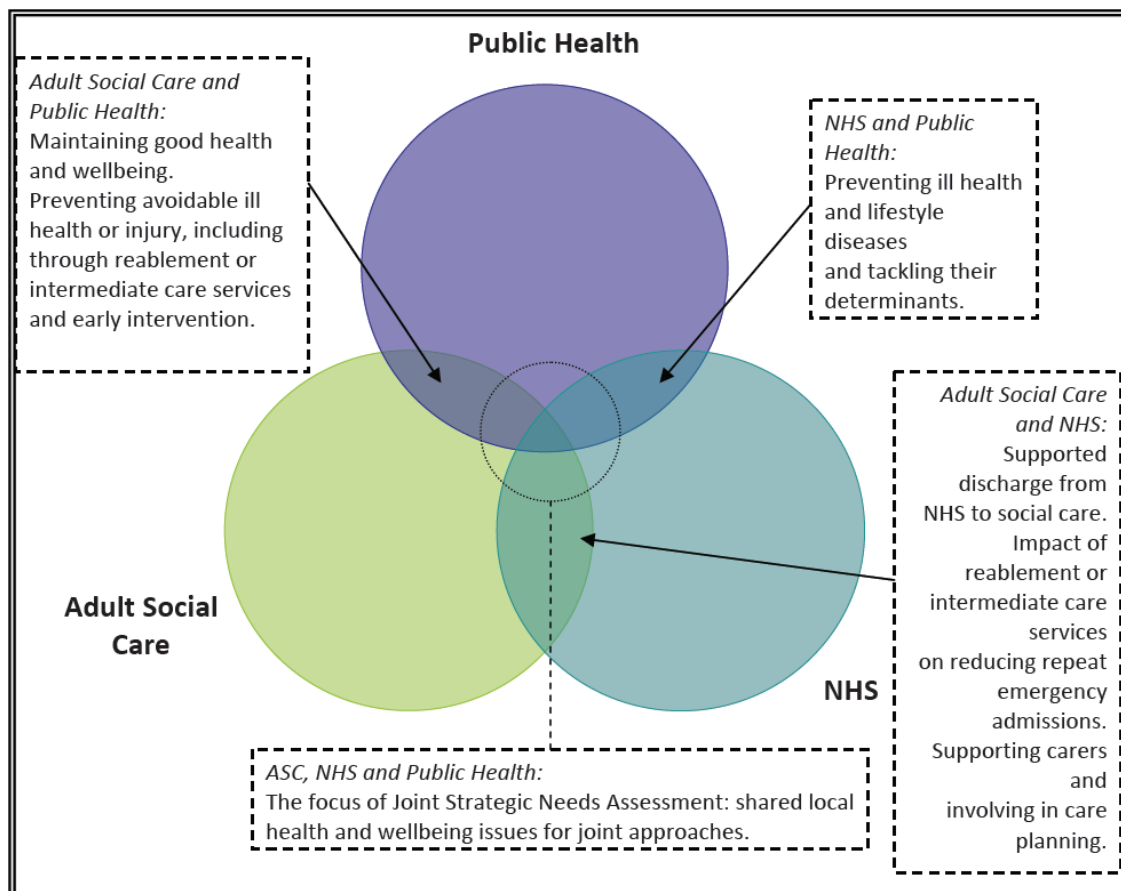
*Tertiary prevention:* maximise people's independence through interventions such as rehabilitation and joint case management of people with complex needs (between health and social care practitioners).

1.7 This strategy will also take account of three independent themes set out in the document **'Transparency in outcomes: a framework for adult social care, a consultation on proposals'** (Department of Health, 2010c):

- outcomes, which services achieve for people, by describing the ends, not quantifying the means, will support the commitment to reduce the burden placed on local services
- quality, which will support more efficient commissioning and provision. (Quality will be demonstrated through Effectiveness, Experience, Safety and Efficiency)
- transparency through the system which will allow for public accountability as the safeguard

1.8 This approach is also reinforced in the recent Public Health Outcomes Framework (Department of Health, 2010c). Essentially, this will be achieved through the alignment of the partner frameworks for the NHS, Adult Social Care and others which will seek to avoid barriers which might act against delivery.

**Figure 1: Supporting better outcomes**



Source: 'Healthy Lives, Healthy People: transparency in outcomes - proposals for a public health outcomes framework' (Department of Health 2010c)



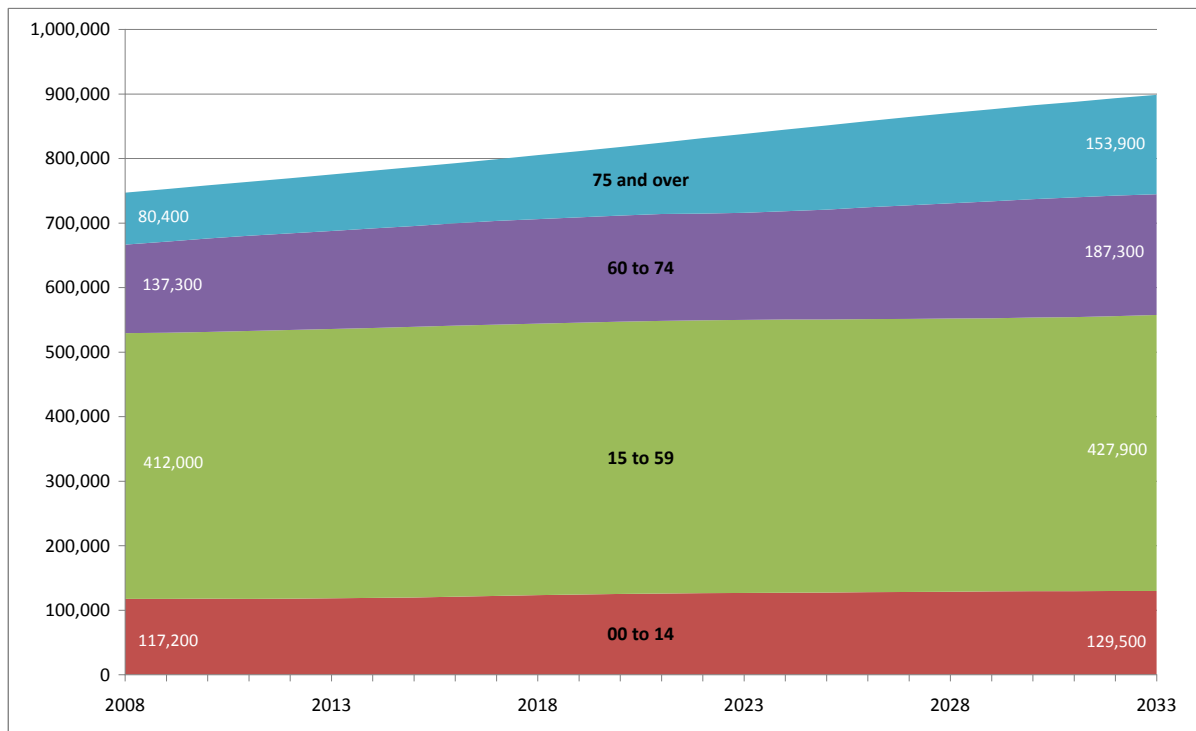
1.9 Figure 1 is taken from ‘**Healthy Lives, Healthy People: transparency in outcomes - proposals for a public health outcomes framework**’ (Department of Health, 2010d) and illustrates how the relationship and overlap between local services which share an interest and where a whole systems approach could support better outcomes.

**Local**

1.10 In line with the overall population of England, the population of Devon is ageing. The population of Devon recorded by the most recent National Census, in 2001, was 705,880. Of this number, 147,823 (21.0%) were aged 65 or older and 20,953 (3.0%) were aged 85 or older. The population projection for 2031 is 868,606, of which 249,886 (28.9%) will be 65 or older and 45,966 (5.3%) will be 85 or older. When population projections are undertaken then the biggest rises will be seen in the number of 65–85 year olds. The figures suggest that this rise will be by more than 60% by 2031 and the number of people aged 85 and older will be more than double, rising by almost 119% (see Figure 2).

Alongside the increase in the older population it is estimated, in 2010, that there are around 14,200 people aged 18 plus living with a learning disability in Devon, of which just over 2,800 have a severe disability. Estimates for people living with a physical disability, aged between 18 to 64, show just over 37,400 living with a moderate physical disability and over 11,500 with a severe physical disability, producing a combined total of over 48,900 people.

**Figure 2: The projected demographic change in the population structure of Devon, by age group, 2008 to 2033**



Source: Sub-national population projections, Office for National Statistics, Crown Copyright, 2010

1.11 Estimates for people predicted to have various mental health conditions living in Devon in 2010 predicted that:

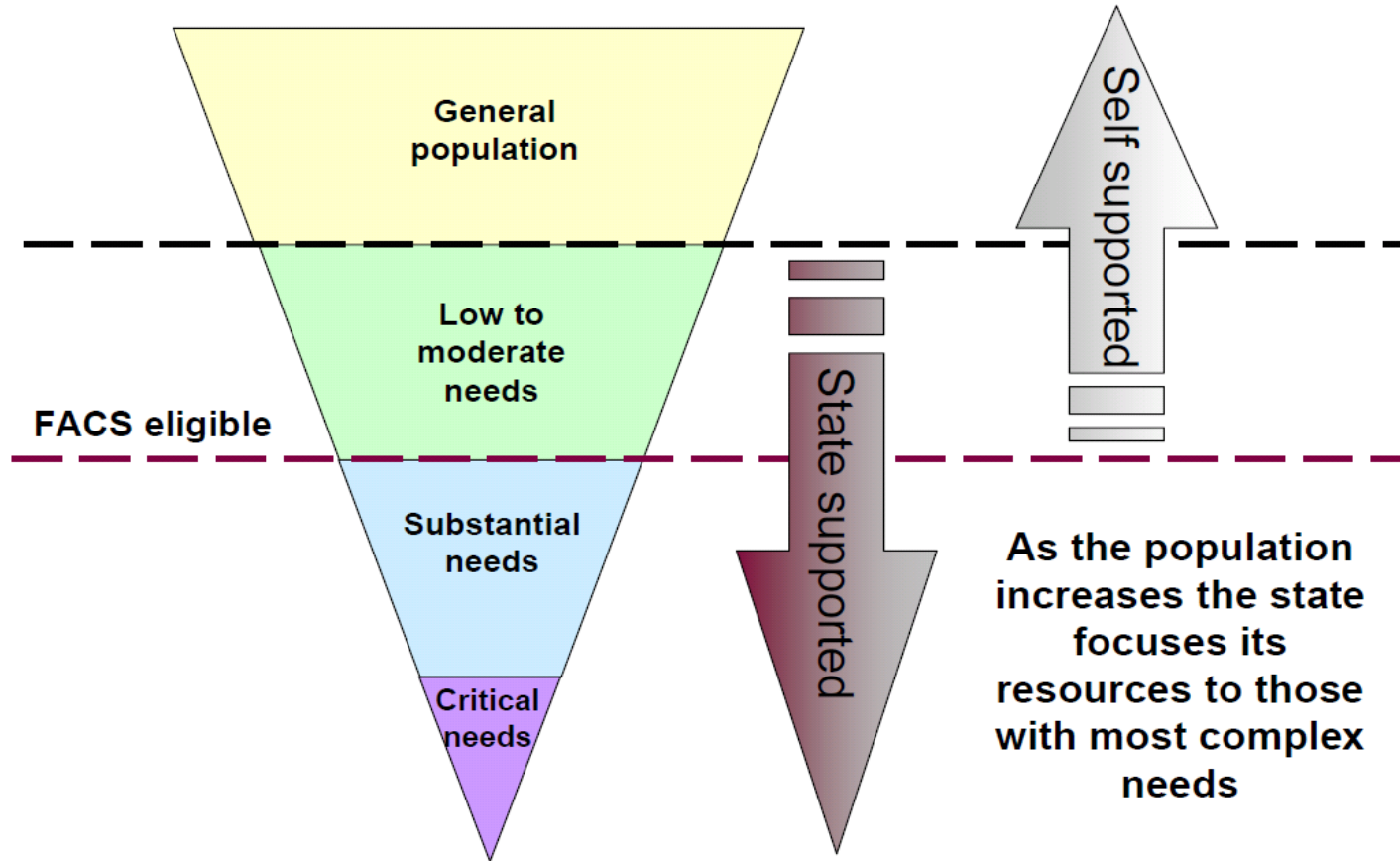
- 71,733 people aged 18-64 have a common mental disorder
  - 2,006 people aged 18-64 have a borderline personality disorder
  - 1,550 people aged 18-64 have an antisocial personality disorder
  - 1,783 people aged 18-64 have psychotic disorder
- 1.12 It is predicted that these figures will rise by 3% by 2030, with the exception of antisocial personality disorder which is predicted to increase by 5%. It is also predicted that 221 people aged between 30 and 64 in Devon have early onset dementia of which 58% are male. This is predicted to rise by 6% to 235 by 2030. Early onset dementia is most prevalent in the 50-59 age band for both men and women.
- 1.13 The most common mental health problems in older people are depression and dementia. Depression affects proportionately more older people than any other demographic group, because older people face more events and situations that may trigger depression: physical illness, debilitating physical conditions, bereavement, poverty and isolation. The majority of people who have depression make a full recovery after appropriate treatment, and older people are just as responsive to treatment as younger people. Communities and support services can help older people address some of the causes of depression such as social isolation, financial problems, or difficulties with their accommodation.
- Older people with dementia usually continue to live at home with support, but may benefit from specialist accommodation, including extra care housing. There were an estimated 12,561 people suffering from Dementia in Devon in 2010, this is predicted to rise significantly to 23,076 by 2026 (a rise of 84% in 16 years).
- 1.14 1 in 10 people in the population are providing unpaid support to family or friends due to age, physical or mental illness or addiction. This means that more than 72,400 people (of all ages) in Devon are carers (Census 2001 figures), which will rise proportionately with the population. 12% of carers were aged 65 years and over, with 6,300 or 9% aged 75 years of age or over. 14,400 (20%) provide more than 50 hours of care and support per week. Carers of people with life long disabilities experience a life time of caring. From the Census 2001 figures it would indicate that in Devon there are just over 2,000 young carers (less than 3% of carers of all ages), although it is believed that there are significantly more. Roughly half of the young carers (1,084) are aged below 16 years of age.
- 1.15 The Devon Joint Strategic Needs Assessment analyses the impact of these demographic pressures in localities and towns in Devon. *The Way Ahead* 2008-13 outlined our joint health and social care commissioning and delivery priorities for 2008-13 and committed us to making the shift from a health and social care system that uses most of its time and money dealing with acute and episodic illness to one that actively promotes prevention. This joint strategy falls within that framework and proposes joint investments in preventative services for which there is a valid evidence basis.
- 1.16 It must also be remembered that over 50% of the people living in Devon live in rural areas. Access and social isolation, especially among an ageing population, are major factors for maintaining health and wellbeing as identified in the recent '**Devon Rural Health & Wellbeing Strategy**' (NHS Devon, 2010).

- 1.17 The anticipated shift in the age-structure of Devon's population in the next few years will have an effect on Devon's care burden markedly higher than that which would be associated with a simple rise in population. The numbers of people with limiting long-term conditions and with dementia are predicted to grow rapidly and imply marked rises in the level of dependency within the population.
- 1.18 Devon's commitment to enabling Carers to be supported to maintain their caring role and have a life outside of their caring responsibilities is outlined in **'Carers at the heart of 21<sup>st</sup>-century families and communities in Devon'**. This commissioning strategy supports the four priorities identified by the Department of Health to:
- Identify carers earlier
  - Support carers to achieve their full education and employment potential
  - Provide personalised support for carers so that they can live a full life
  - Support carers to remain mentally and physically well
- 1.19 In Devon, we spend an unusually high proportion of our adult social care budget on residential care for older people but not for people with other disabilities, whilst our spend per head on services that support people to live in their own home remains relatively low, although Devon is leading the region in giving people choice and control via a personal budget. Part of the motivation for the development of a prevention and wellbeing strategy has been the recognition that current spending within the Devon Health Economy is directed more towards institutionalised care, and thus less towards care in the home, than has been achieved elsewhere in the country (Lang, 2010a). Residential care is often a more expensive way of providing services that can often be provided at lower cost in other settings or that could have been obviated in the first place by the implementation of upstream interventions (Lang, 2010a). This is not necessarily the case for people with learning disabilities where residential care can often be cheaper than other community options.
- 1.20 The **'Putting People First programme'** (Department of Health, 2008) identified a number of factors that influence residential care spend:
- high costs for a small number of people
  - large numbers admitted
  - the eligibility criteria used
  - the need to make use of an existing supply of places, and
  - self-funders who subsequently become the responsibility of the local authority
- 1.21 The overall objective is not to focus on addressing the residential-care system directly for example by altering eligibility criteria, but by shifting the distribution of need in the population downwards, leading to lower numbers admitted and fewer individuals with very high levels of need (see Figure 3).

A similar refocusing of investment into community-based services in the health sector has the potential to reduce demand for acute services via elective and non-elective admissions.

- 1.22 The second aim for the work has been to identify what provides the most effective early intervention and prevention to redirect the flow of current spending and halt, or at least slow, the potential growth in future spending that will otherwise accompany the demographic shift.
- 1.23 There is a range of preventive work being undertaken across public, private and third sector organisations in Devon which, as individual services, are having a real impact on people's ability to remain living independently and maintaining their quality of life.
- 1.24 Locally, third sector organisations have a long and successful record in service user involvement in the design of services - the process now being called 'co-production'. Greater local voluntary sector engagement and participation in strategy development will help achieve a more holistic approach to the commissioning of services, together with helping to improve the understanding of how to improve the planning, design and delivery of local services.
- 1.25 The development of these preventive services will need to be of a scale and scope that addresses the increase in demand whilst taking account of the reductions in public funding for Devon.
- 1.26 From the social care perspective, the approach to prevention needs to focus on evidence-based interventions that produce outcomes which promote independence and recovery, particularly in older people.
- 1.27 In summary, the future holds two challenges for organisations working within or on behalf of local health, social care and housing organisations:
  - an increase in demand for health and social care associated with an ageing population and changing expectations and
  - a likely reduction in real terms of public funding for both health and social care

Figure 3: Transforming the Care System



(FACS - indicates Fair Access to Care Services)

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## 2. Aims and objectives

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- 2.1 The aim of the Devon Prevention Strategy is to ensure that:
- work is focused on helping people to maintain their independence and wellbeing or learn how to be independent when living with a life long disability through working and consulting with them
  - through joined up early intervention, more people are helped to avoid a crisis that could lead to unnecessary admission to hospital or longer term care
- 2.2 The objectives for the Prevention Strategy are based on the seven key principles which reflect the national **'A Vision for Adult Social Care: Capable Communities and Active Citizens'** document.
- **prevention** where empowered people and strong communities will work together to maintain independence
  - **personalisation** where individuals not institutions take control of their care
  - **partnership** where care and support is delivered in a partnership between individuals, communities, the voluntary sectors, the NHS and councils – including wider support services, such as housing
  - **plurality** where the variety of people's needs is matched by diverse service provision with a broad market of high quality service providers
  - **protection** where there are sensible safeguards against the risk of abuse and neglect
  - **productivity** where greater local accountability will drive improvements and innovation to deliver higher productivity and high quality care and support services
  - **people** where a workforce can provide care and support with skill, compassion and imagination and who are given the freedom and support to do so
- 2.3 These principles are also in line with the emerging research and best practice as identified in the **'Principles of Effective Preventive Services - A toolkit to support the commissioning of targeted Preventive Services'**, produced by South West Joint Improvement Partnership in July 2010 (see Appendix 1).
- 2.4 Through working to deliver improved outcomes by aligning preventive services to this strategy, we will be able to:
- demonstrate the success of investment in prevention to inform ongoing financial planning decisions
  - ensure effective joint working across the whole system and to make the most efficient use of investments in preventive services by maximising their impact

- 2.5 A number of national and local strategies are complementary to the aims and objectives of the Devon Prevention Strategy. The main ones are outlined in Appendix 2.

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### **3. The conceptual framework**

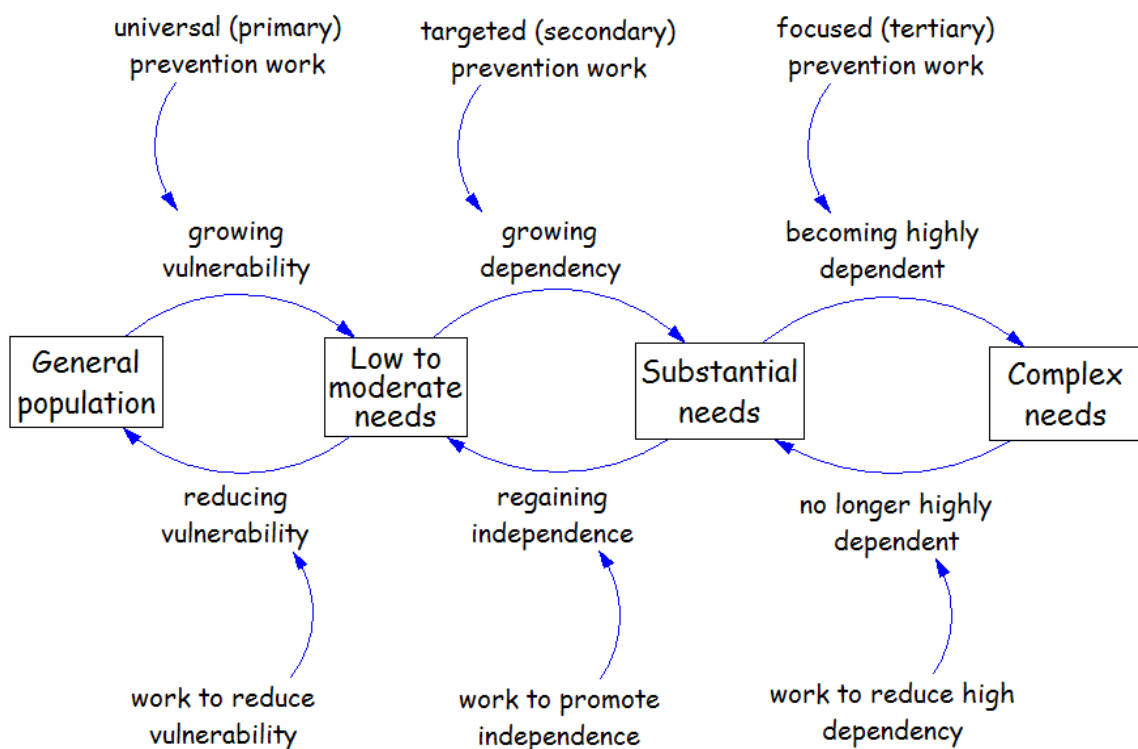
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- 3.1 When making the case for prevention Government propose that: **A whole system approach is crucial to prevention. Many social care interventions produce reductions in the usage of health services; many health interventions can have an impact on reducing the use of social care services. Jointly planning and explicitly sharing the risks and benefits have the potential to produce the greatest improvement for all.** (Department of Health, 2009b)
- 3.2 Locally, Devon County Council and NHS Devon's initial work undertaken to address the issues of prevention and wellbeing defines:
- *prevention* as services or programmes that prevent or delay people needing health or social care support (recognising that for people with life long disabilities this will start at early years and the school stage)
  - *wellbeing* is defined as services or programmes that improve the overall health and wellbeing of the individual or family and thus prevent or delay people needing health or social care support
- 3.3 There are six stages at which intervention could be focused to prevent people from developing health and wellbeing problems and to reduce the levels of need of those with existing problems. These are:
- universal (primary) prevention, for example smoking cessation or information and advice on lifestyle choices
  - targeted (secondary) prevention, for example self care
  - focused (tertiary) prevention, for example falls prevention
  - work to reduce vulnerability, for example volunteering and empowerment programmes
  - work to promote independence, for example reablement
  - work to reduce high dependency, for example intermediate care
- 3.4 The course of someone's journey through prevention services is not necessarily a straight line with a person moving through the levels of preventative services in a successive way. For example, a person may still benefit from good quality information (primary prevention) whilst they are in or being discharged from Intermediate Care (tertiary prevention).
- 3.5 Although broader in scope, the interventions identified in this strategy are in line with the approach underlying the recent King's Fund review of what works in avoiding hospital admissions: to bring together different parts of the health and social-care system, to do things we know are effective, to stop

doing things we know are not effective, and to evaluate the outcomes of things we do not know about (Purdy 2010).

- 3.6 Figure 4 depicts a system-level overview of transitions between stages of dependence. These stages (general population, low to moderate needs, substantial needs, complex needs) are depicted in boxes, with the flows into and out of them depicted as the arrows joining them. The factors potentially affecting these flows are located at the top part of the diagram (for factors potentially preventing flow towards reduced independence) and the bottom part of the diagram (for factors potentially promoting regaining of independence).

**Figure 4: System-level overview of flows between different stages of dependency**



Source: Lang 2010a

## 4. Evidence of effectiveness

- 4.1 Following a review of the evidence to support the Prevention and Wellbeing work stream of the Devon Health Economy Transformation Programme (Lang 2010a see Appendix 3) recommendations have been made to support the joint strategic commissioning of services. The focus of the recommendations is on those identified as being most cost-effective and cost-beneficial in relation to prevention and wellbeing in Devon for adults, but with a particular focus on Older People (Lang, 2010b).
- 4.2 As emphasised earlier the key to increasing prevention activities across health and social care will be to work in a 'whole system' way. This will include 'joining up' work which should bring positive benefits to the long term health of the individual. A good example of this are the opportunities the

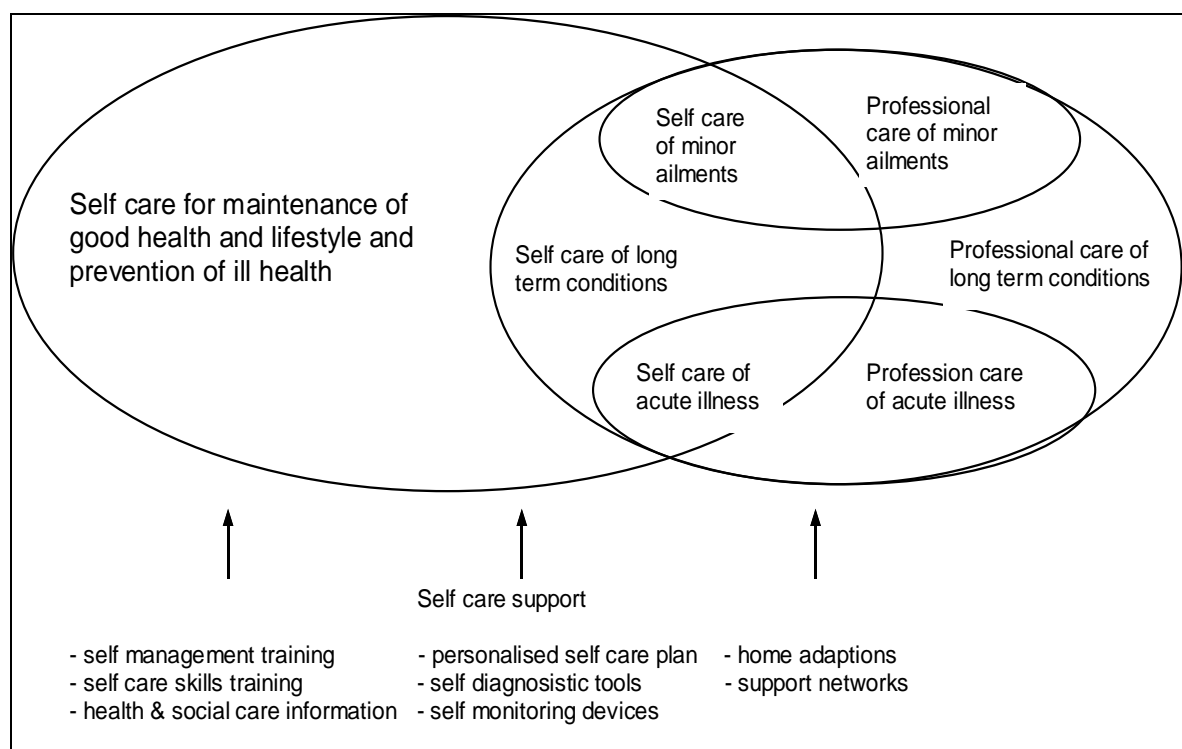


recent ‘**Supporting self care and self management joint commissioning strategy and guidance**’ (Devon County Council, 2010) identifies, as outlined in Figure 5.

4.3 A number of existing county strategies have been considered as part of the review. The set of strategies for “Intelligent progress towards prevention” (Tolley, 2009) within the Devon Health Economy has been put forward based on existing evidence of effectiveness. Each strategy is based on three elements:

- effective commissioning
- anticipation of changes in demand
- prevention

**Figure 5: Improving the health of people with long term conditions**



Source: Improving the health of people with long term conditions (Department of Health 2010e)

4.4 The emphasis of the work undertaken was to establish where there was good evidence on effectiveness and cost effectiveness, with a particular emphasis on identifying areas with potential for good return on investment. The universal primary prevention interventions will be covered within the forthcoming Public Health Joint Health and Wellbeing Strategy.

4.5 The focus of this strategy is on ways of promoting independence to develop and maintain life skills or regain them when they have been lost. This involves two strands, each described briefly below: maintaining independence and helping people regain independence when they have faced a crisis or challenge, such as a fall or being admitted to hospital. Ways in which independent people are helped to maintain their independence and which are available across Devon include:

- 4.6 Ways in which independent people are helped to maintain their independence, and which are available across Devon, include:

#### **Self care**

- 4.7 Self care involves people who are at a higher risk of ill health in learning how to cope with their symptoms (for example by servicing information and advice on lifestyle choices) and therefore reducing the risk of needing healthcare and treatment. Support for self care needs to be built into care systems so that people – staff as well as service users – can receive appropriate education and training.
- 4.8 It is recognised that where an individual has a carer, the carer may play a significant role in supporting self-care; without this the individual may seek support from health and social care at an earlier or more frequent point in their journey.

#### **Falls prevention**

- 4.9 Falls prevention involves interventions or packages of interventions intended to reduce falls and fall-related harm. The prevention may be primary (intended to prevent falls and fall-related harm in those who have never fallen) or secondary (intended to prevent further falls and related harm in those who have previously fallen).

#### **Volunteering**

- 4.10 Volunteering involves working without payment, typically towards some social, political, or cultural cause, as well as enhancing social capital within the community. Local volunteering also has the potential to make the life of the volunteer more meaningful and connected.

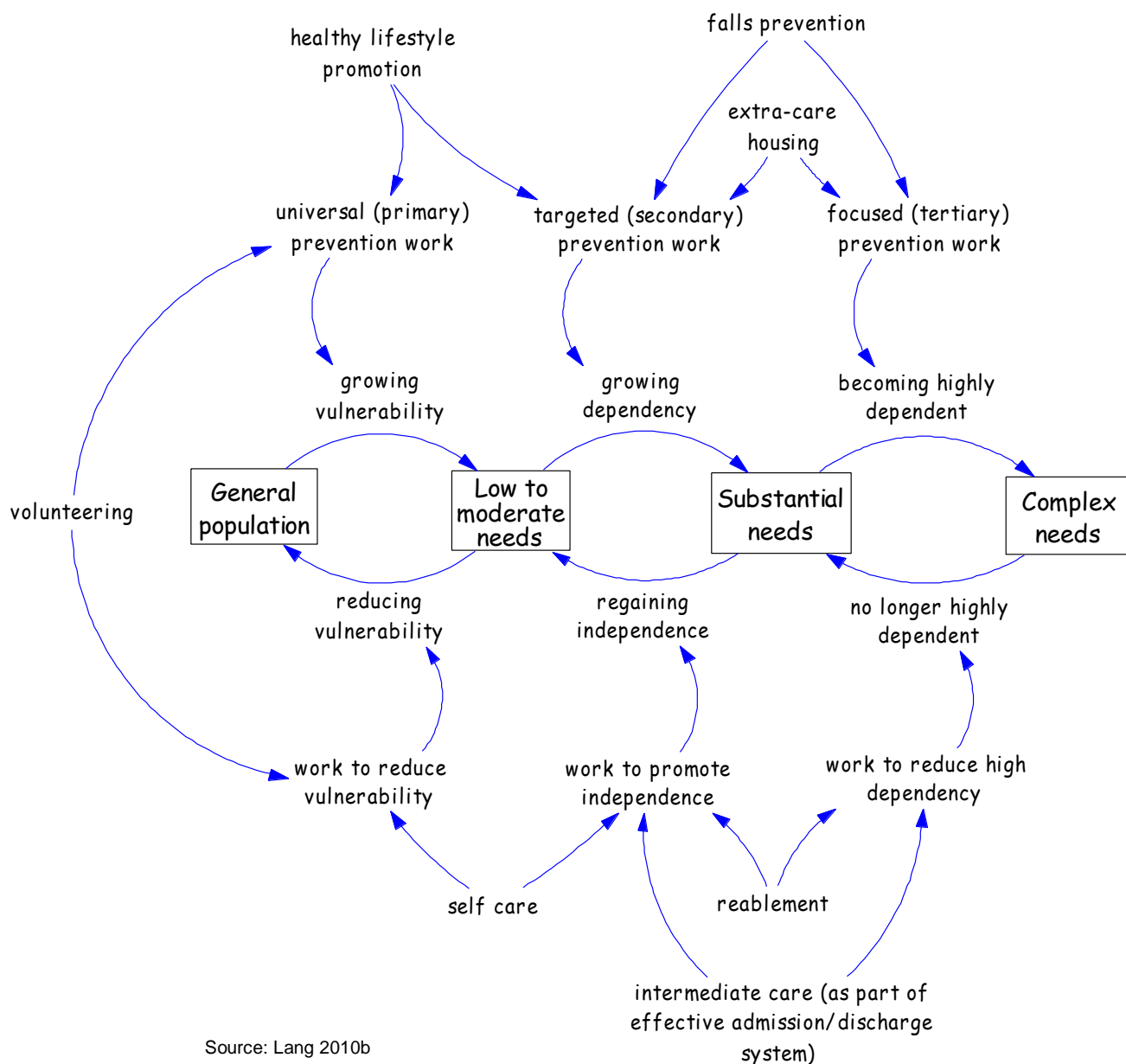
#### **Extra care housing**

- 4.11 Extra-care housing is an extension of sheltered housing that aims to meet the housing, care and support needs of older people, while helping them to maintain their independence in their own private accommodation. The qualifying age for entry may be below 65 years but most entrants are older than this. Extra-care housing offers support and care to residents for 24 hours a day, and has been viewed as a possible alternative to moving into a care home. (Department of Health, 2004)
- 4.12 Ways in which people are helped to regain independence after a crisis include:

#### **Social care reablement**

- 4.13 Reablement involves services for people with poor physical or mental health that help them accommodate their illness by learning or relearning the skills necessary for daily living (Allen and Glasby, 2010). It is different from but complimentary to rehabilitation, which involves services for people with poor physical or mental health to help them get better and similarly focussed on recovery.

**Figure 6: System-level overview of flows between stages of dependence showing the potential contribution of different interventions**



Source: Lang 2010b

### Intermediate care

4.14 Intermediate care is provided to individuals who would otherwise face long hospital stays or be referred to in-patient care inappropriately. It involves individualised care intended to maximise independence and enable individuals to live in their own homes. Intermediate care involves a single comprehensive assessment framework and cross-professional working and information sharing. It should be provided for six weeks at most (Department of Health, 2001).

### Self care

4.15 In a similar way to supporting people at a high risk of ill health, self care involves patients and their carers in learning how their condition affects them and reaching a better understanding of how to cope with their symptoms. It is

of greatest use to people with long-term conditions, such as asthma, who often report that they feel more in control and more able to enjoy life as a result (Corben and Rosen, 2005). This approach also requires support for self care needs to be built into care systems so that people – staff as well as service users and their carers – can receive appropriate education and training.

- 4.16 Figure 6 shows the potential contribution of different interventions to the stages of dependency.

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## **5. Recommendations for action**

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- 5.1 The aim of this strategy is to help people maintain independence and wellbeing through early intervention to avoid hospitalisation or longer term care which includes, where appropriate, enabling mainstream universal services to support people who have less of a need for specialist services for example people with physical or learning disabilities or mental health needs. This will be by:

### **Promoting volunteering and community empowerment**

- increasing the percentage of people in Devon who volunteer
- maximising opportunities to increase social capital
- narrowing the gap in social involvement across Devon
- prioritising inter-generational volunteering
- increase the number of 'social capital' programmes supporting local communities

### **Reducing falls and preventing fractures**

- decreasing the rate of falls and fractured neck of femurs
- developing fracture liaison clinics in community and acute settings that respond to the first fracture to prevent the second
- delivering a range of evidence based primary prevention activities in collaboration with local councils and voluntary sector providers that prevent frailty, promote bone health and reduce accidents – through encouraging physical activity, healthy lifestyles and reducing environmental hazards
- reviewing therapy resource levels across inpatient and community for rehabilitation
- implementing the falls and fracture risk assessment tool Devon wide
- maintaining a register of high risk fallers who are prioritised for support

### **Promoting assistive technologies**

- increasing the number of people in Devon receiving targeted support through assistive technologies

### **Developing reablement services and enabling approaches**

- increasing the number of people receiving reablement including hospital discharge
- extending the offer to include community equipment prescriptions and telecare solutions
- exploring integrated solutions with NHS rehabilitation, primary care and complex care teams and Devon Partnership Trust to deliver reablement to individuals with more complex needs
- extending the offer to non FAC's eligible individuals

### **Implementing self care**

- implementing the Devon self care and self management strategy
- increasing the range of conditions for which appropriate advice and information is available in accessible formats (for example through libraries and health hubs)
- increasing the number of people with long term conditions being supported through self care approaches
- increasing the number of staff receiving education and training for self care

### **Delivering intermediate care**

- undertaking a review and options appraisal for the reconfiguration of Intermediate Care Pathways, with an emphasis on delivering and linking quality individual patient rehabilitation and reablement needs in a domestic or community setting.
- developing an intermediate care strategy for Devon
- increasing the number of people receiving intermediate care in the most appropriate setting
- increasing the amount of integrated service delivery in intermediate care services across health and social care.

### **Investing in extra-care housing and community housing options**

- increasing the volume and geographical availability of extra-care housing to promote independent living
- implement the recommendations of the Devon extra-care housing strategy

## 6. Implementation plan

6.1 The following implementation plan identifies where work is already underway to produce costed proposals for each of the recommendations and where further work needs to be initiated to inform the prioritisation and allocation of resources to deliver the strategy. This plan will be monitored and updated on a regular basis.

Issue	Recommendation	Lead Officer	Devon Strategy produced?	Implementation Plan developed?	Status of Plan R A G	Current Funding	Gap Analysis
1.	<p><b>Promoting Volunteering and Community Empowerment</b>            Volunteering involves working without payment, typically towards some social, political, or cultural cause. Community empowerment includes the development of resilience and capacity which may involve 'meaningful employment'.</p>	Roger Grainger  Paul Collinge	Volunteering Policy  Community Mentoring	Implemented  Service currently being re specified	G  A	Within DCC service budgets  2010-11 £500k 2011-12 £280k	Focus on DCC as an employer rather than promoting volunteering in wider community  Funding to be identified.
2.	<p><b>Reducing Falls and Preventing Fractures</b>            Falls prevention involves interventions or packages of interventions intended to reduce falls and fall-related harm. The prevention may be primary (intended to prevent falls and fall-related harm in those who have never fallen) or secondary (intended to prevent further falls and related harm in those who have previously fallen).</p>	Paul Collinge	Devon Falls Strategy 2008  South West Falls, Bone Health and Fractures Review 2010 DoH/NHS South West	To be developed	R		Actions are either outstanding or incomplete in parts of Devon  Funding to be identified for purposes relating to primary prevention

3.	<p><b>Promoting Assistive Technologies (including telecare)</b></p> <p>Assistive Technology (AT) can be defined as 'any item, piece of equipment, product or system that is used to increase, maintain or improve the functional capabilities and independence of people with cognitive, physical or communication difficulties'.</p>	Alison Golby	Assistive Technology Strategy	Yes. A project plan is in place to develop an integrated commissioning and contracting framework	A	TBC	Six workstreams are set up to review existing services and propose new specifications for: <ul style="list-style-type: none"> <li>- REMAS</li> <li>- Minor adaptations</li> <li>- Home Improvement Agency</li> <li>- Independent Living Centre</li> <li>- CADLS</li> <li>- Telecare</li> </ul>
4.	<p><b>Developing Reablement and Enabling Approaches</b></p> <p>Reablement involves services for people with poor physical or mental health that help them accommodate their illness by learning or relearning the skills necessary for daily living. It is different from rehabilitation, which involves services for people with poor physical or mental health to help them get better.</p>	Paul Collinge	Social Care Reablement Strategy Business case and specification of service  Linked to Intermediate care strategy	Yes (Phase 1)  Phase 2 implementation plan in development (extending scope of service)	A	TBC	Funding for phase 2 to be identified.  Responsibilities for commissioning reablement services for 30 days post-discharge being transferred to acute trusts.
5.	<p><b>Implementing Self-Care</b></p> <p>Self-care involves people who are at a higher risk of ill health in learning how to cope with their symptoms and therefore reducing the risk of needing healthcare and treatment by being empowered to learn how they can take care of</p>	Jayne Carroll	Self-care Strategy in draft form	Implementation plan to be developed.	A	None	Governance arrangements to be agreed.  Implementation plan to be costed or funded.

	their own health for example in improving healthy eating or increasing mobility						
6.	<p><b>Delivering Intermediate Care</b></p> <p>Intermediate care is provided to individuals who would otherwise face long hospital stays or be referred to in-patient care inappropriately. It involves individualised care intended to maximise independence and enable individuals to live in their own homes.</p>	Paul Collinge	No overarching strategy	Under development	A	TBC	<p>Overarching strategy not developed.</p> <p>A range of services are available but not under the umbrella of a single strategy.</p> <p>Joint funding agreements not reached</p> <p>Inconsistencies in services available in localities.</p> <p>Funding to be identified.</p>
7.	<p><b>Investing in Extra-care Housing and Community Housing options</b></p> <p>Extra-care housing is an extension of sheltered housing that aims to meet the housing, care and support needs of older people, while helping them to maintain their independence in their own private accommodation. The qualifying age for entry may be below 65 years but most entrants are older than this. Extra-care housing offers support and care to residents for 24 hours a day, offering an alternative to moving into a care home.</p>	Alison Golby	Commissioning Strategy for Extra Care Housing	<p>Yes</p> <p>10 year strategy for investment in extra care housing projects according to projections of locality based need</p>	A	<p>£2.5mn/yr capital investment</p> <p>(2011-12 investment deferred)</p>	<p>Take-up in new Okehampton scheme lower than projected.</p> <p>Health and social care services in the community will need to be co-ordinated into schemes.</p> <p>Funding to be identified.</p>



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## **7. Implementation and governance arrangements**

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- 7.1 The governance of the '**Promoting Independence and Wellbeing Strategy**' will be agreed through the emerging arrangements for the Health & Wellbeing Board for Devon and through the Joint Commissioning Group as an interim arrangement.
- 7.2 The lead agency for the development of this strategy will be required to complete an Equalities Impact and Needs Assessment (EINA). The first draft of the EINA should be available with the publication of the strategy and form part of any consultation. Governance for the EINA is via the NHS Devon and Devon County Council Joint Engagement Board.
- 7.3 Copies of the Strategy and EINA will be made available for the agreed period of consultation on the 'Have Your Say' section of the Devon County Council website and copies made available for circulation via membership of the Joint Engagement Board.
- 7.4 Where, as a result of the implementation of the strategy any service changes impact on disadvantaged groups, a service level EINA (if not already in place) should be developed.
- 7.5 Risk management procedures will support performance monitoring of the actions set out in the implementation plan and ensure issues relating to demographic delivery of actions or financial pressures will be identified at an early stage and remedial action put in place.

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## **8. Summary**

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- 8.1 The Strategy is aligned to the national vision for Adult Social Care and the principles underpinning the 'Think Local, Act Personal' approach. It has a robust evidence-base informing the recommendations.
- 8.2 Seven areas of work are recommended for implementation of which five have detailed work programmes in place to produce costed commissioning plans whilst falls and preventing fractures and self care are two areas where work is being initiated to identify joint commissioning approaches.

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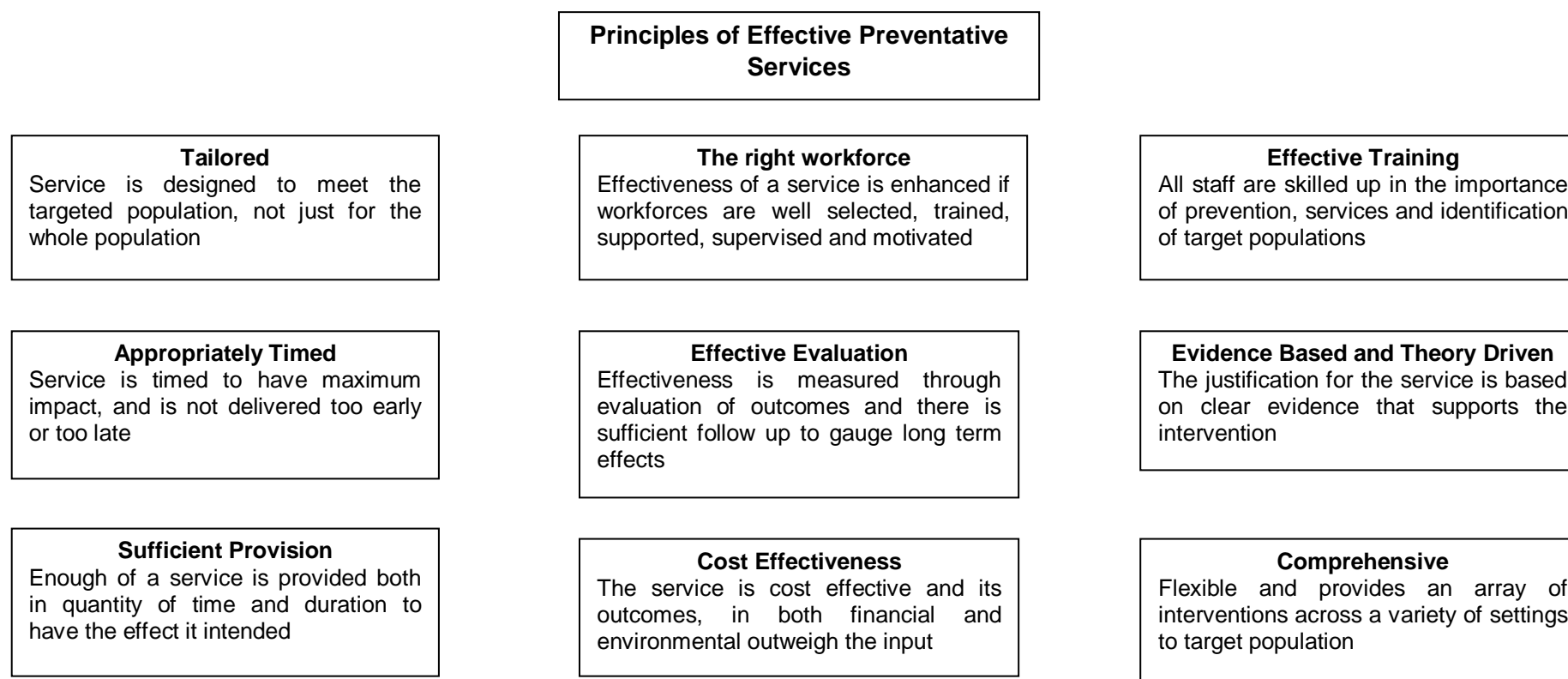
- *The Way Ahead – five years of improvement 2008-2013*
- *Ageing Well Strategy 2008, currently being updated*
- *Carers Strategy – Carers at the Heart of 21<sup>st</sup> Century Families and Communities in Devon (2009-2010)*
- *Joint commissioning strategy for people with Dementia 2009*
- *Devon Rural Health & Wellbeing Strategy 2010*
- *Market position statement 2010*
- *Mental Health & Wellbeing Promotion Strategy 2010*
- *Reablement and rehabilitation statement 2010*
- *Supporting Self Care and Self Management Strategy 2010*

## Principles of Effective Preventive Services

(as identified in the South West Joint Improvement Partnership toolkit 2010)

Principles that have been gathered from those services that have proven to be effective may help commissioners select, modify or create more effective services in Devon. The diagram below sets out a number of principles which research and best practice suggest, if in place, gives the service the best possible chance of success.

*What works in prevention – Principles of effective prevention programmes, Narkin et al American Psychologist 2003*



### The National and Local Policy Context

- 1.1 A number of strategies and policy directives have contributed to the development of this strategy. The main ones include:

**A Vision for Adult Social Care: *capable communities and active citizens*** (Department of Health, November 2010)

- 1.2 The document sets out a vision which focuses on breaking down barriers between health and social care funding and creating more personalised preventative services. It is supported by the partnership agreement, 'Think Local, Act Personal' (Department of Health November 2010) which emphasises the need to work on personalisation, using a community based approach to develop services with local communities and other service providers.

**Transparency in Outcomes: a framework for adult social care** (Department of Health, November 2010)

- 1.3 This document sets out an enabling framework for people to achieve outcomes from services which really matter to them.

**Putting People First Programme (A shared vision and commitment to the transformation of Adult Social Care)** (Department of Health 2009)

- 1.4 The 'Making a strategic shift towards prevention and early intervention (Department of Health October 2008) document provided key messages which include:

- there is growing evidence about the effectiveness of preventive approaches
- invest rather than spend and develop a balanced portfolio of investment across the full range of possible interventions
- develop a whole system approach which extends well beyond health and social care is likely to be most effective

**The Way Ahead - five years of improvement 2008 – 2013** (Devon Primary Care Trust and Devon County Council 2008)

- 1.5 This document set out the local vision for health and social care in Devon with objectives to:

- health as good as it can be – prevention and early intervention
- care as local as possible and as specialised as necessary
- the best possible treatment – that is continuously improving
- the right support for people – with complex needs
- the most effective use of resources – for maximum impact
- a say and an influence – promoting partnerships in care

**Transforming Community Services** (Department of Health November 2010)

- 1.6 This national programme is designed to provide more personalised care closer to home through the separation of the commissioner and provider functions of Primary Care Trusts. Establishment of new community focused organisations to provide more choice for patients and a stronger role in the transfer of care and treatment from hospital settings.

**The initial work from the Way Ahead strategy is informing the Transforming Community Services agenda. This reinforces the shift in services from the acute to the primary care and community services sector.**

**Rural Health & Wellbeing Strategy** (NHS Devon 2010)

- 1.7 The Rural Health and Wellbeing Strategy sets out Devon's vision to improve the overall health, wellbeing and quality of life of all people living in rural areas, with a focus on reducing inequalities in health and reducing inequities in health and social care provision.

**Ageing Well in Devon** (Devon County Council and Devon Primary Care Trust 2008)

- 1.8 Ageing Well is a joint statement of health and wellbeing strategy which identifies four aims to be achieved for older people in Devon. These are:

- physical, mental and emotional wellbeing
- improved quality of life
- making a positive contribution
- attaining economic wellbeing

This document is currently being reviewed and updated.

**Devon Mental Health & Wellbeing Promotion Strategy** (Devon County Council and NHS Devon 2010)

- 1.9 The aim of this strategy is to improve the mental wellbeing of all people in Devon. This will be achieved by creating flourishing and connected communities through the promotion of wellbeing and resilience and the reduction of inequalities. It also seeks to improve the quality and accessibility of services for people with poor mental health.

**Carers at the heart of 21<sup>st</sup> Century Families and Communities in Devon (NHS Devon and Devon County Council 2009)**

- 1.10 This strategy sets a commissioning framework for carer support in Devon with the overall vision that:

Carers in Devon will be able to maintain a balance between caring responsibilities and a life outside of caring and that the person they care for will receive the best possible support

**Joint Commissioning Strategy for people with dementia in Devon** (Devon County Council and NHS Devon 2009)

1.11 The three key areas of focus for this strategy are based on:

- raising awareness
- early diagnosis and intervention
- living well with dementia

**Supporting Self care and Self Management Strategy** (Devon County Council and NHS Devon)

1.12 This strategy seeks to improve the patient experience and prevent further escalating costs. This will be achieved by enabling people with long term conditions to manage their health better; the provision of fully integrated support and services; redesigning health and social care provision to embed the principles of self care.

**Reablement and Rehabilitation Statement** (Devon County Council 2010)

1.13 Key points are:

- reablement is one of a range of community-based Social Care and Healthcare services that are provided in Local Authority areas across England
- the NHS Operating Framework document (2010/2011) identified that Reablement and support services following hospital discharge would be key priorities
- there is a need for hospitals to work with GPs and Councils to develop such services to improve patient outcomes and reduce emergency hospital re-admissions
- detail on plans to support hospital discharge and Reablement have been scoped and steps identified in the recent joint Devon County Council/NHS Devon paper

**Market Position Statement** (Devon County Council 2010)

1.14 Main points are:

- an interim document has been produced to clarify for providers the direction of travel for the future commissioning of social care
- the future operating model will work to support people to help themselves, in line with the principles of Putting People First

**Long-Term Limiting Conditions Strategy**

1.15 There is recognition of the value of a single Long - Term Limiting Conditions Strategy across the Health and Social Care community. Work will be undertaken shortly to produce this document.

## **Devon Prevention Strategy: Promoting Independence and Wellbeing Review of Evidence**

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### **1. Introduction**

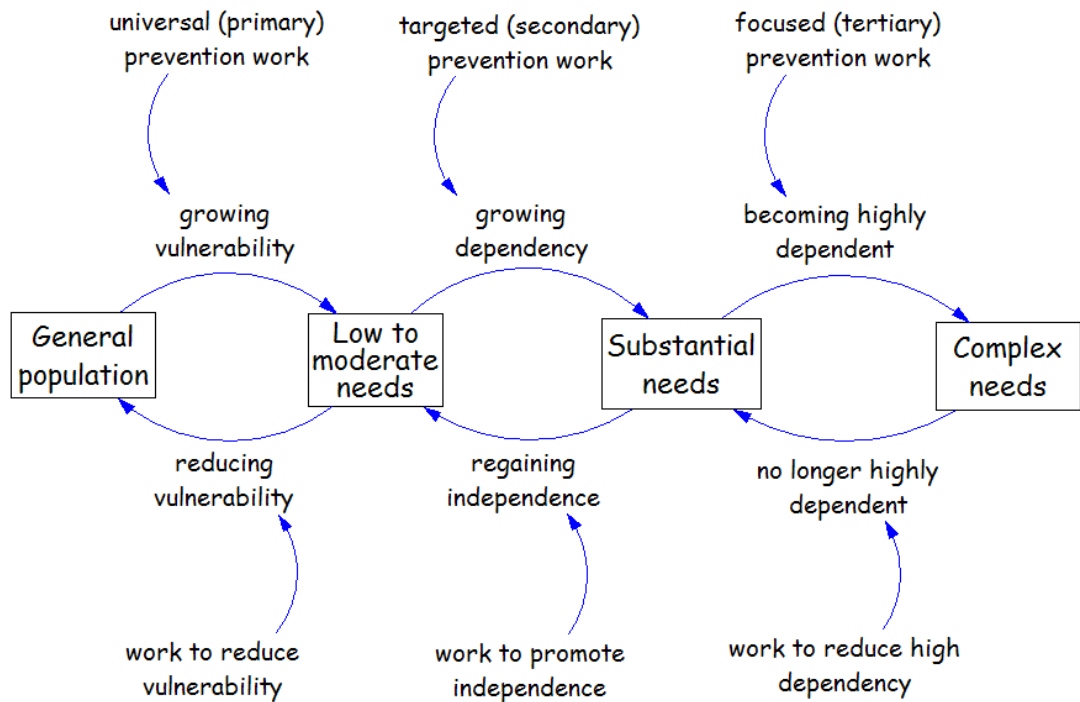
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- 1.1 The document is part of the Prevention and Wellbeing Workstream of the Devon Health Economy Transformation Programme. The aim of the document is to scope activities likely to be of greatest benefit in improving quality and performance in the Devon Health Economy, particularly in relation to the care of older people
- 1.2 In line with the definitions set out in the Devon County Council and NHS Devon Prevention and Wellbeing Joint Strategy (Brown, 2010), prevention is defined here as services or programmes that prevent or delay people needing health or social care support, and wellbeing is defined as services or programmes that improve the overall health and wellbeing of the individual or family and thus prevent or delay people needing health or social care support.
- 1.3 Part of the motivation for this work is a recognition that current spending within the Devon Health Economy is directed more towards institutional care, and thus less towards care in the home, than has been achieved elsewhere. Residential care is an expensive way of providing services that can often be provided at lower cost in other settings – or that could have been obviated in the first place by the implementation of upstream interventions.
- 1.4 The Department of Health’s “Putting People First” document on use of resources in adults social care (Department of Health, 2009d) identifies a number of factors that influence residential care spend: high costs for a small number of people; large numbers admitted; the eligibility criteria used; the need to make use of an existing supply of places; and self-funders who subsequently become the responsibility of the local authority.
- 1.5 A subsidiary aim of this document is thus to identify means of effective early intervention and prevention which can redirect the flow of current spending and halt, or at least slow, the potential growth in future spending that will otherwise accompany the demographic shifts described in Section 1. The objective here is to do this, not by directly addressing the residential-care system directly (for example, by altering eligibility criteria), but by shifting the distribution of need in the population downwards, leading to lower numbers admitted and fewer individuals with very high levels of need.
- 1.6 Figure 1.1 depicts a system-level overview of transitions between stages of dependence. These stages (general population, low to moderate needs, substantial needs, complex needs) are depicted in boxes, with the flows into



and out of them depicted as the arrows joining them. The factors potentially affecting these flows are located at the top part of the diagram (for factors potentially preventing flow towards reduced independence) and the bottom part of the diagram (for factors potentially promoting regaining of independence). A fuller version of this diagram, with possible interventions that might shift the indicated flows, appears below.

**Figure 1.1: System-level overview of flows between different stages of dependence**



- 1.7 There are three sections to this document. The first section sets the scene, describing anticipated shifts in the population structure of Devon that highlight the importance of this work and comparing the current situation in Devon to that in comparable other areas.
- 1.8 The second section summarises evidence on effectiveness and potential cost savings for interventions potentially forming part of the Prevention Workstream of the Devon Health Economy Transformation Programme. The interventions included are: community mentoring; social care reablement; falls prevention; intermediate care; telecare; volunteering; extra-care housing. Details of strategies on intelligent progress towards prevention for key areas of public health activity – stopping smoking, obesity, alcohol, and psychological therapies – are also described.
- 1.9 The final section proposes a strategy that would combine the most effective and cost-effective elements from the second section in order to improve quality and performance around prevention and wellbeing for older people in the Devon Health Economy.

## 2. Overview: current situation and future projections

- 2.1 Like the overall population of England, the population of Devon is ageing. The population of Devon recorded by the most recent National Census in 2001 was 705,880. Of this number, 147,823 (21.0%) were aged 65 or older, and 20,953 (3.0%) were aged 85 or older. The population projection for 2031 is 868,606, of which 249,886 (28.9%) will be 65 or older and 45,966 (5.3 %) will be 85 or older.
- 2.2 The details of this shift in population structure are shown in Table 1 (figures from Devon County Council population projections). The final column of this table also highlights the change in size of each age-specific population segment in Devon from 2001 to 2031. The number of children aged 0 to 14 will increase only slightly over this period, by less than 2%. The rise in the number of young adults and adults of working age will be higher (between 10 and 20%). It is in older adults, however, that the biggest rises will be seen: the number of 65 to 85 year-olds is projected to rise by more than 60% and the number of people aged 85 and older will more than double, rising by almost 119%.

**Table 1: Projected population in Devon by age group 2001 to 2031**

Age group	Year							2031 population as % of 2001 population
	2001	2006	2011	2016	2021	2026	2031	
0-14	118929	117341	113803	113909	116293	119599	121084	<b>101.8</b>
15-29	111930	124839	134773	135411	131760	127793	127385	<b>113.8</b>
30-44	138701	139498	131631	131140	139644	149267	149652	<b>107.9</b>
45-64	188197	204365	215451	218986	222244	220695	220599	<b>117.2</b>
65-84	126870	132272	145421	165622	179233	192568	203920	<b>160.7</b>
85+	20953	22592	25889	28903	32264	37195	45966	<b>219.4</b>
<b>Total</b>	<b>705580</b>	<b>740907</b>	<b>766967</b>	<b>793972</b>	<b>821438</b>	<b>847115</b>	<b>868606</b>	<b>123.1</b>

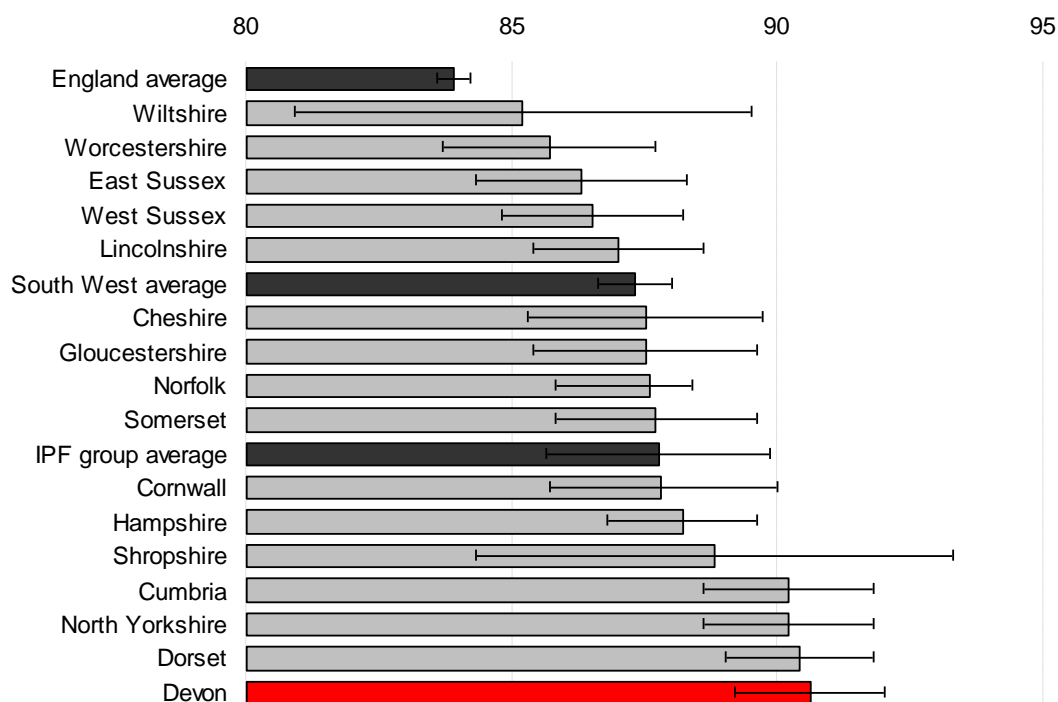
Source: Devon County Council population projections

- 2.3 Some parts of Devon already have populations with an age distribution that resembles what we expect to see across the county in 20 years' time. For example, in East Devon 4.5% of the population is currently aged 85 and older – more than twice the national average of 2.2%, and 4<sup>th</sup> highest out of 408 districts in England and Wales (Office for National Statistics, 2010)
- 2.4 A number of data sources are available that allow us to compare the overall situation of older people in Devon with those in comparable areas.

## Satisfaction with home and neighbourhood

- 2.5 Information recorded as part of National Indicator 138 indicates older people in Devon had average levels of satisfaction with home and neighbourhood, higher than the levels of Institute of Public Finance (IPF) comparator areas, as shown in Figure 2.1. These figures may conceal areas with higher or lower levels of satisfaction and it is not possible to identify specific causes of this variation.

**Figure 2: NI 138: People aged 65 and over who are satisfied with both home and neighbourhood (%) in Devon and IPF comparators, 2008 data**



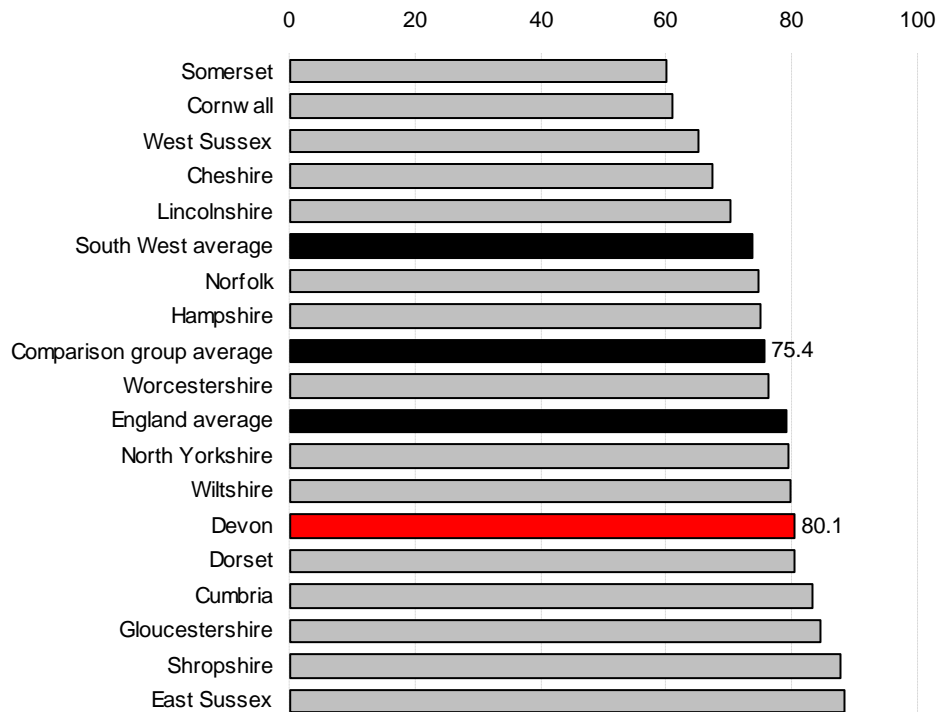
## Independence achieved through rehabilitation or intermediate care

- 2.6 The benefit to individuals from intermediate care and rehabilitation following a hospital episode is measured by National Indicator 125, “Achieving independence for older people through rehabilitation/ intermediate care”. The indicator is intended to capture the joint work of social services and health staff and services commissioned by joint teams, and the key element is that both the health and social care needs of the individual have been assessed.

The measure is designed to follow the individual and not differentiate between social care and NHS funding boundaries. Formally, the measure is the proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing bed for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting) who are at home or in extra care housing or an adult placement scheme setting three months after the date of their discharge from hospital.

Figure 3 shows the performance of Devon and other authorities in the IPF (Institute of Public Finance) comparator group on this indicator for 2008-09.

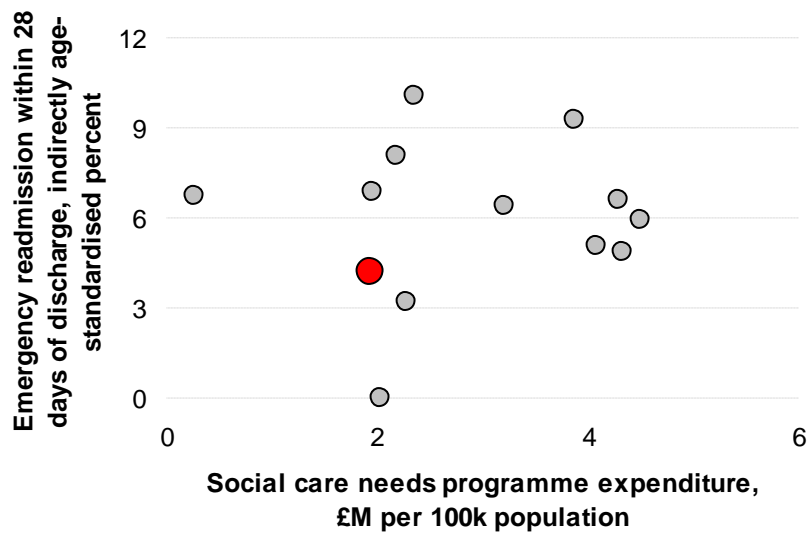
**Figure 3: NI 125 - Achieving independence for older people through rehabilitation and intermediate care (%) in Devon and IPF comparators, 2008-09**



### Readmission following hospital discharge

- 2.7 Compared to other Primary Care Trusts in the Government Office South West (GOSW) area, NHS Devon has relatively low levels of emergency readmissions within 28 days of hospital discharge: 4.19% compared to a GOSW area average of 5.95%. NHS Programme expenditure on social care needs was also relatively low: £1.93 million per 100,000 unadjusted population compared to a GOSW average of £2.87. Figure 4 summarises these figures in GOSW PCTs for Financial Year 2007-08.

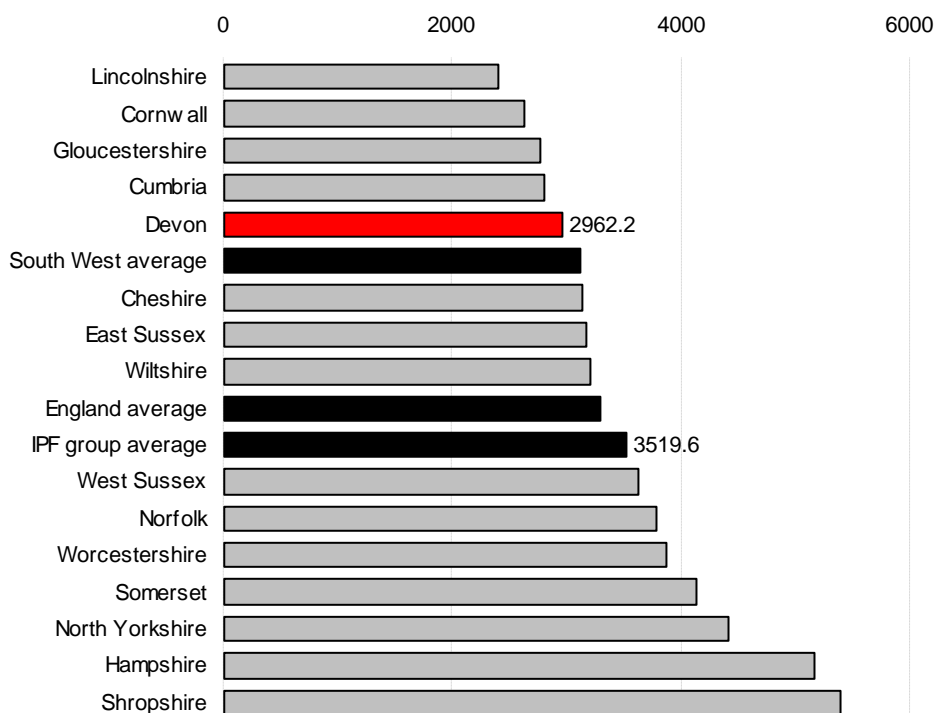
**Figure 4: Emergency readmissions within 28 days of discharge in relation to social care needs expenditure (NHS programme budget), in Devon (larger red marker) and other GOSW Primary Care Trusts**



**Support for independent living through social services**

2.8 National Indicator 136 measures the proportion of people supported to live independently through social services. Figure 5 shows the proportions recorded under this indicator in Devon and in IPF comparator areas. Levels for Devon are lower than the average for this comparator group, suggesting fewer people in Devon are being supported to live independently than in similar areas, but these figures are not adjusted for age or other potentially relevant factors and this indicator does not differentiate vulnerable adults from older people.

**Figure 5: NI136 (VSC03) - People supported to live independently through social services (per 100,000 of the population) in Devon and comparators, 2008-09**



**Projected growth in numbers of people with long-term limiting conditions**

- 2.9 The ageing population in Devon described above has major implications for the population burden of disability. In the 2001 Census, 17.6% of the population of England and Wales reported having a long-term limiting condition. Based on overall population growth alone we would expect the number of people in Devon with long-term limiting conditions to grow from an estimated 138,000 in 2011 to around 157,000 in 2031 – in other words a rise of 13%, in line with population growth of the same amount.
- 2.10 If, however, we take into account the anticipated shifts in population structure related to ageing, we can anticipate the number of people in Devon with long-term limiting conditions to grow from an estimated 169,000 in 2011 to around 215,000 in 2031 – in other words a rise of 27%, and a far higher overall total.
- 2.11 This level of population disability is far beyond the capacity of current social and health care provision. If no preparations were made, it is likely such an enormous burden of care would overwhelm care providers entirely. The importance of engaging with appropriate and effective prevention work now, to reduce as much as possible the impact of such a shift, becomes clear when seen in this light.

**Projected growth in prevalence of dementia**

- 2.12 Dementia prevalence and incidence increased markedly with age once people are aged 65. Pooled data from European studies show dementia is more common in men than in women and approximately doubles in prevalence with every five years' increase in age, from a prevalence of 0.4%

in both men and women in those aged 60 to 64 to 22.1% in men and 30.8% in women aged 90 and older (Alzheimer's Disease International, 2008). The same data showed an exponential rise in dementia incidence with age from 2.4 per 1000 per year in people aged 65 to 69, to 70.2 per 1,000 per year in people aged 90 and older (Quoted in van der Flier and Schelten, 2005).

- 2.13 Estimates calculated by applying these figures to Devon, and taking into account the projected population change described above, are shown in Table 2. Compared to 2006 levels, the prevalence of dementia in 2031 is likely to be 78% higher. An alternative set of calculations of future dementia prevalence, with similar results, is contained in Devon County Council's and NHS Devon's Joint Commissioning Strategy for people with dementia in Devon (Richards, 2009).

**Table 2: Estimates of current and future dementia prevalence for Devon based on likely population growth**

	2006	2011	2016	2021	2026	2031
60 to 64	202	231	211	226	249	247
65 to 69	530	651	743	685	734	805
70 to 74	1,069	1,155	1,422	1,626	1,506	1,618
75 to 79	1,809	1,835	2,015	2,495	2,859	2,669
80 to 84	2,915	2,979	3,111	3,477	4,339	4,986
85+	5,196	5,953	6,645	7,416	8,549	10,565
Total	11,720	12,804	14,147	15,924	18,235	20,891
<i>Increase*</i>	-	9.3%	20.7%	35.9%	55.6%	78.2%

\* Increase relative to estimated prevalence in 2006

Source: Devon County Council population projections and Alzheimer's Disease International (2008) estimates of dementia prevalence by age group

- 2.14 The anticipated shift in the age-structure of Devon's population in the next few years will have an effect on Devon's care burden markedly higher than that which would be associated with a simple rise in population. The numbers of people with limiting long-term conditions and with dementia are predicted to grow rapidly, and imply marked rises in the level of dependency within the population.
- 2.15 It is possible that some of this predicted rise in dependency can be offset by effective preventive work now. Some of this may involve universal, or primary, prevention and some may involve targeted, or secondary, prevention. The rest of this document describes some preventive measures that have been proposed, and assesses their potential effectiveness and impact on costs.

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### **3. Scoping of evidence for interventions**

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3.1 Evidence for the following interventions is assessed as follows:

- community mentoring
- social care reablement
- falls prevention
- intermediate care
- telecare
- volunteering
- extra-care housing
- intelligent progress towards prevention

3.2 For each intervention, a brief description is given followed by a brief review of existing evidence on effectiveness and cost. A summary concludes each section and grades the quality of evidence available for each intervention according to the system for grading evidence used by NICE, the National Institute for Health and Clinical Excellence (see Appendix 1). The July 2010 Health White Paper “Equity and Excellence” stated that the role of NICE will expand to cover the development of quality standards for social care.

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### **4. Community mentoring**

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Community mentoring is targeted at older people at risk of social isolation and loss of independence. The aim of the service is to promote social re-engagement through mentors who enable older people to make use of existing resources, engage with friendship or interest groups, and if necessary to respond to existing service provision.
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4.1 Community mentoring was developed by Devon County Council as part of local service redesign. Its precursor was developed by Upstream in Mid Devon. The Upstream service was evaluated by researchers from Peninsula Medical School through a pilot study followed up with an action research project. This evaluation found the intervention delivered clinically meaningful improvements in health with short-term benefits in psychological well-being and longer-term benefits in relation to depression, physical health, and perceived social support. (Greaves 2005). The evaluators noted that the intervention seemed to reverse anticipated downward trajectories in some aspects of participants’ health and wellbeing and suggested the approach justified future investigation. (Greaves 2006).

4.2 To follow on from the Upstream service, funding from the Department of Health Partnerships for Older Peoples’ Projects programme (POPPs) and the Department of Workforce and Pensions (Link Age Plus programme (LAP) enabled the implementation of community mentoring across Devon. The Devon Community Mentoring service offers face-to-face mentoring for older people (50 years of age and above) most at risk of social isolation. The service is provided by Age Concern Exeter (Link2), the Time for Life



Consortium (in the rest of the County and the Polish Project) and the Sahara Project for BME elders.

- 4.3 An evaluation of the service was conducted by a team from the Peninsula Medical School using a case-matched controlled design. (Dickens 2009) The evaluators found no evidence that the Community Mentoring service effectively improved individual outcomes after six months. They also failed to find evidence that the service provides is cost effective when compared to usual health and social care services. The evaluators noted that clients were satisfied with the service, suggesting good quality of care was provided, but that this is not a substitute for evidence of effectiveness or cost effectiveness. They acknowledged that there were limitations in the study design, specifically that the matching process was imperfect and led to uncertainties in interpretation and that issues of representativeness limited the generalizability of the findings. The evaluation did not include the Sahara Project.
- 4.4 The POPPs programme has been evaluated twice. A national evaluation estimated every £1 spent on the programme produced £1.20 benefit due to reductions in hospital emergency bed days. (Windle 2009). These figures came from assessment of all POPPs activity – covering 146 core local projects across 29 sites – so the figures and outcomes quoted cannot be ascribed to any individual project, making it hard to tell what works and what does not.
- 4.5 In the second evaluation a team based at the Nuffield Trust studied eight POPPs projects using a person-based risk-adjusted approach with matched controls. (Steventon 2011). They found no evidence of a reduction in emergency admission associated with these interventions, and in some cases an increase in admission in interventions in the intervention group compared to the control group – suggesting some projects were costing, rather than saving, money. The authors point out that they looked out only eight out of the 146 projects and that some of the others may have been more effective.

4.6 **Summary**

<i>Intervention</i>	<i>Level of evidence on effectiveness</i>	<i>Level of evidence on cost</i>
Upstream	3	-
Community Mentoring	2+	2+

*Recommendation:*

Evidence did not demonstrate the effectiveness and potential for cost-saving of Community Mentoring in the format it was in at the time the evaluation was completed.

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**5. Social care reablement**

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Reablement involves services for people with poor physical or mental health that help them accommodate their illness by learning or relearning the skills necessary for daily living (CSIP 2007 quoted in Allen and Glasby 2010). It is different from rehabilitation, which involves services for people with poor

physical or mental health to help them get better.

- 5.1 Reablement is an approach to home care services that aims to help people become independent in activities, such as practical tasks and activities of daily living, in which they had previously become dependent. Reablement typically takes the form of either discharge services, in which case clients are predominantly those discharged from hospital, or intake services, in which case they are provided to clients who meet Fair Access to Care (FACS) eligibility and are referred for home care. The 2009 Green Paper on future options for adult social care, *Shaping the Future of Care Together*, affirmed the national policy commitment to reablement. (DH 2009c)
- 5.2 The Department of Health commissioned two studies of reablement, one retrospective and one prospective. The retrospective study was intended to assess whether the short-term benefits of reablement services that had previously been found (e.g. Lewin 2006) were maintained over a longer period. (Newbrunner 2008) Focusing on four Councils with Adult Social Services Responsibilities (CASSRs), the researchers used routine data on clients who received homecare re-ablement in 2004-05 and assessed the level of social care services they used over the following two years, 2005-06 and 2006/07. They found evidence of good outcomes in all four sites but acknowledged that the study lacked baseline data and a comparison group, so it was not possible for them to conclude whether the patterns of service use they reported were a direct result of reablement. The researchers did not report any findings in relation to the costs of the services provided.
- 5.3 A prospective study of reablement services across a number of local authority areas is currently underway. Although the study is not yet complete a two-part interim report was published in 2009. (Jones 2009). The interim report found reablement had short-term benefits in relation to social care outcomes, dependency levels, self-reported health-related quality of life, and self-reported health. The authors point out that these findings were based on incomplete data and were not compared to any other service so it is not possible to attribute outcomes to reablement services. The final report (due October 2010) will include comparative analysis with standard home-care services and cover the full follow-up period. The interim report gave details of the average costs of reablement provision (between £1500 and £2000 per service user) but did not report on cost-effectiveness or make any comparisons with other services.
- 5.4 Devon County Council internal documentation (Reablement PDD v0.1) estimates potential savings for reablement using a predictive model produced by Care Services Efficiency Delivery (CSED) plus results from a similar local authority. Those entering the service are taken to have needs which are substantial or critical, according to standard FACS (Fair access to care services) criteria. Assuming a throughput of 2,348 people per year in an intake reablement service savings, derived from reductions in care hours required, are estimated at £947,696 in the first year and £4,044,992 in the second year. Total direct project costs are estimated at £193,000 and transition costs at £229,000. No sensitivity analyses were conducted around these estimates and the source of the figures on which estimates of savings were based is not stated.
- 5.5 In an overview of the need for social care reform, Glasby and colleagues comment that there have been promising results in pilot studies of

reablement.(Glasby 2010) They suggest a cautious approach is needed, however, because (a) up to a quarter of individuals do not complete the reablement phase (CSED 2009); (b) reports on costs of reablement services have given details of savings but little information on the costs of providing the service; and (c) there are dynamics around the timing of reablement relating to who benefits, and for how long, that have not yet been analyzed – the unexplored issue being that reablement is likely to delay, rather than prevent, the need for more costly forms of care. (Newbronner 2007)

## 5.6 **Summary**

<i>Intervention</i>	<i>Level of evidence on effectiveness</i>	<i>Level of evidence on cost</i>
Social care reablement	2-	2-

*Recommendation:* Making decisions about local spending on reablement may be easier when national studies of effectiveness and cost-benefit have been completed.

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## **6. Falls prevention**

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Falls prevention involves interventions or packages of interventions intended to reduce falls and fall-related harm. The prevention may be primary (intended to prevent falls and fall-related harm in those who have never fallen) or secondary (intended to prevent further falls and related harm in those who have previously fallen).

6.1 Falls and fall-related fractures have a significant impact on health and social care costs as well as on individuals. The 2009 Department of Health guide to effective interventions identifies four objectives:

- improve patient outcomes and improve efficiency of care after hip fractures through compliance with core standards
- respond to a first fracture and prevent the second – through fracture liaison services in acute and primary care settings
- early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries
- prevent frailty, promote bone health and reduce accidents – through encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards

6.2 The National Hip Fracture Database Preliminary National Report (NHFD 2009) identified “widespread shortcomings in the provision of acute care and the availability of the resources needed to initiate the secondary prevention of fragility fractures.” Areas of concern included common failures for patients to undergo surgery within 24 or 48 hours from presentation at A&E, which is linked to morbidity and mortality rates; only 58% of patients receiving preoperative geriatric assessment; 40% of patients leaving hospital without an

adequate assessment of their osteoporosis and 56% without a falls assessment.

6.3 Of Devon's 160,600 people aged 65 and older we would expect that in one year:

- 55,200 will fall
- 23,900 will fall twice or more
  
- 7,800 fallers will attend A&E or MIU, and a similar number will call an ambulance
  
- 3,900 will have a fracture, and of these 1280 will have a hip fracture. (Extrapolated from figures in DH 2009a) Based on NICE guidelines and population modelling, in a population the size of Devon's, 25,000 people should receive a falls assessment and a further 12,500 will potentially require a brief screening of gait and balance.(Extrapolated from figures in DH 2009b)

6.4 Department of Health guidance draws attention to the importance of effective prevention in post-menopausal women. In a population the size of Devon's we would expect there to be (a) over 128,000 post-menopausal women; (b) 40,600 post-menopausal women with undiagnosed osteoporosis; (c) 16,100 post-menopausal women with a previous fracture of any kind; (d) 2100 post-menopausal women with a new fracture each year. (Extrapolated from figures in DH 2009c). The guidance states that although groups c and d make up only 14% of the population of older women it is in these groups that 50% of hip fractures occur. The guidance proposes a fracture liaison service that would identify members of these groups in primary care and through hospital-based fracture

6.5 An economic evaluation summarizes the main findings of an economic model on the impact of a fracture liaison service.(DH 2009b) This evaluation suggests that for a population the size of Devon over a five-year period a total saving of £635,923 NHS acute and community services and local authority social care costs could be expected. Additional revenue costs in year one and to cover drug therapy for five years would cost the NHS £512,271. Of the total saving, £464,205 would be saved by NHS acute care, £156,148 by social care, and £15,571 by NHS community services. (Extrapolated from figures in DH 2009a; note that simple linear extrapolation of costings may not provide accurate estimates.)

## 6.6 **Summary**

<i>Intervention</i>	<i>Level of evidence on effectiveness</i>	<i>Level of evidence on cost</i>
Fracture liaison service	2++	2++

### *Recommendation:*

According to Department of Health estimates, the introduction of a fracture liaison service has the potential to save to save around £120,000 over a five-year period. A locally enhanced Falls Service is in place and may already capture some of these savings.

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## **7. Intermediate care**

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Intermediate care is provided to individuals who would otherwise face long hospital stays or be referred to in-patient care inappropriately. It involves individualised care intended to maximise independence and enable individuals to live in their own homes. Intermediate care involves a single comprehensive assessment framework and cross-professional working and information sharing. It should be provided for six weeks at most. (Adapted from DH 2001)

- 7.1 Intermediate care was introduced in response to the National Beds Inquiry (DH 2000), which identified that around 20% of bed-days in acute care were being used by older people. Intermediate care was intended to prevent avoidable admissions, enable earlier discharge from acute care, and delay the start of long-term care. The Department of Health, which invested heavily in intermediate care, was criticized (e.g. Pencheon 2002) for introducing a programme that was poorly evaluated and understood. To address this issue, the Department of Health initiated a three-part, £1.2 million evaluation programme.
- 7.2 One part of the Department of Health-sponsored evaluation was a survey of intermediate-care co-ordinators. The results of the survey showed that intermediate care was being developed and delivered not as a single contained package of care but as a “constellation of complementary services” (Martin 2004). The policy was put into practice in a diverse way which led to a unevenness of provision and of quality,(Martin 2007) and which made it difficult to evaluate the effectiveness of the programme.
- 7.3 A separately conducted part of the Department of Health evaluation identified that intermediate care took the form of “an umbrella of different services that offer opportunities to reduce the pressure on acute secondary care, to promote and maintain independence and to reduce admissions to long-term institutional care” (Godfrey 2005, p.440) The researchers who conducted this element of the evaluation reported there was wide variation in relation to the costs of intermediate care because of the variety in personal circumstances, personal preferences, and care pathways. The configuration of different service inputs in relation to each other also contributed to differences in overall costs. Overall, there was wide variation in the allocation of resources and costs incurred by programs identified as part of intermediate care. This made it difficult to give any simple answer to the question of whether intermediate care works for older people. (Godfrey 2005, p.506)
- 7.4 The third part of the Department of Health evaluation included a health-economic component.(ICNET 2006) The report on this part of the evaluation concluded two key considerations for intermediate care: first, which patients are selected: patients with greater clinical need show the largest benefits but incur the highest episode costs. Second, which types of intermediate care were most valuable: admission avoidance might be more worthwhile than discharge support but discharge support services had, in practice, received more resources. The authors of the report highlighted the need for community-based intermediate care services to be integrated with other community services as part of a whole-system approach.

7.5 A number of trials of intermediate care have also been conducted. These indicate intermediate care is associated with equivalent (Young 2005) or better outcomes (Garåsen 2008; Green 2005) for older people and unblocked beds.(Crotty 2005) No improvement in cost-effectiveness has been reported for intermediate care in comparison to standard care.(O'Reilly 2008; O'Reilly 2006; Walsh 2005; Griffiths 2001)

7.6 A successful intermediate care system is likely to include the following features:

- clarity over whether the main aim of the service is reducing admissions or avoiding delayed transfers, or at least over the extent to which resources are applied to each. (If intermediate care is intended to support discharge, need for referral to intermediate care must be identified as early as possible following admission)
- a single point of access/referral
- daily screening of referrals
- a whole-systems approach with involvement of GPs, staff from acute hospitals, staff from community hospitals, and social care staff
- multi-disciplinary teams that include physiotherapists, occupational therapists, nurses, doctors, social workers, and carers

7.7 Evidence from research and from the Islington REACH Intermediate Care Team suggests a whole-systems approach to intermediate care is necessary for success. Glasby and colleagues (2008) suggest the best way forward may be to focus more on providing the resources needed to achieve the aims of intermediate care and to focus on the whole system rather than just on one part of it.

7.8 Within such a whole-systems approach to intermediate care, there are two key sets of relationships. First, the relationship between health and social care must proceed along the lines demonstrated in the Islington model, with systems in place to enable shared staffing, shared financing, and shared reporting in operation across multidisciplinary teams. Second, the relationship between intermediate care and acute services has been shown to be crucial in attempts to address delayed discharge and rising emergency admissions. Finding the best way of making this a positive relationship is likely to be crucial.(Glasby 2008)

7.9 **Summary**

<i>Intervention</i>	<i>Level of evidence on effectiveness</i>	<i>Level of evidence on cost</i>
Intermediate care	2+	2-

*Recommendation:*

Specific forms of intermediate care have the potential to be beneficial when aligned with other elements of the care system. Ongoing monitoring and evaluation of outcomes and costs are needed.

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## 8. Telecare

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Telecare was defined in the Our Health Our Care Our Say (DH 2006) White Paper as “a combination of equipment monitoring and response that can help individuals to remain independent at home. It can include basic community alarm services able to respond in an emergency and provide regular contact by telephone as well as detectors which detect factors such as falls fire or gas and trigger a warning to a response centre. Telecare can work in a preventative or monitoring mode for example through monitoring signs which can provide early warning of deterioration prompting a response from family or professionals. Telecare can also provide safety and security by protecting against bogus callers and burglary.” Telecare differs from telehealth, which has a narrower focus on clinical symptoms and information.

- 8.1 Three recent systematic reviews of the evidence for telecare have been conducted. The first examined the effects of using telecommunications technology to monitor vital signs, home safety, and security, or to provide information and support.(Barlow 2007) The authors found the best evidence for telecare interventions related to automated vital signs monitoring (for reducing health service use) and telephone follow-up by nurses (for improving clinical indicators and reducing health service use) but found little evidence to support or refute the effectiveness of home safety and security alert. They found no good evidence for the cost-effectiveness of any of these interventions.
- 8.2 The second review assessed the literature on home telecare for elderly people with chronic diseases.(Botsis 2008a) The authors identified 54 relevant studies and reported good levels of patient and health-care professional satisfaction with telecare, although patients preferred a combination of home telecare and conventional health-care delivery. The authors concluded that although telecare was associated with benefits there were important organizational, ethical, legal, design, usability and other considerations requiring resolution prior to widespread implementation. In a subsequent commentary, the same authors identified the potential of telecare but highlighted the lack of rigorous evaluation of interventions from a range of perspectives: clinical, technical, and in terms of cost-effectiveness. (Botsis 2008b)
- 8.3 The third review was a Cochrane Review published in 2008 and called “Smart home technologies for health and social care support”.(Martin 2008) This explored the effectiveness of smart home technologies as an intervention for adults with physical disability, cognitive impairment, or learning disability who lived at home in a community setting. The authors searched for randomised controlled trials, quasi-experimental studies, controlled before-and-after studies and interrupted time series analyses. The interventions considered were social alarms, electronic assistive devices, telecare social alert platforms, environmental control systems, automated home environments, and ‘ubiquitous homes’. The outcomes considered were any objective measure that records an impact on a participant’s quality of life, healthcare professional workload, economic outcomes, costs to healthcare provider or costs to participant. Measures of service satisfaction, device satisfaction and healthcare professional attitudes or satisfaction were also included. The review team failed to find any studies which met the inclusion criteria and

concluded there is a lack of evidence to support or refute the use of smart home technologies in health and social care.

8.4 North Yorkshire County Council has invested in telecare and estimates that, in 2009, the provision of telecare to vulnerable people reduced overall care needs by 877 weeks, saving £2,789,000.(CSED 2010a) Full costings for the provision and monitoring of telecare were not reported, nor were outcomes. As part of a Councillor Pledge, Essex County Council dedicated £4 million to telecare equipment and support in 2009/10. Part of this investment funded a free telecare service for new users aged 85 and over, later reduced to 80 and over. After the first year a service fee of between £1.50 and £5.50 is charged; for mainstream telecare provision this fee is charged after twelve weeks. Essex County Council no longer offers free telecare to everyone aged 80 and over because of doubts whether this universal provision provides cost-benefit. (CSED 2010b)

8.5 The Scottish Joint Improvement Team is supporting the development and enhancement of telecare services in Scotland through a national programme running from 2006 to 2011. The programme provides funds for Telecare developments to health and social care partnership through a £20 million development fund. An evaluation of the impact of Telecare developments on informal carers (Jarrod 2009) concluded that carers were generally positive about telecare and its impact on their lives and those they cared. It also highlighted a need for good information and communication about telecare, both among users and professionals, and for a review of charges for telecare – which were commonly being applied or considered – to ensure equity and consistency. A broader evaluation of the Telecare Development Programme (Beale 2009) in its first phase (2006 to 2008) described the programme as having made “a promising start” but identified a shortage of good data about the programme and the need to promote a culture of evaluation if the practical and economic cost and benefits of the programme were to be assessed.

8.6 **Summary**

<i>Intervention</i>	<i>Level of evidence on effectiveness</i>	<i>Level of evidence on cost</i>
Telecare	1+	1+

*Recommendation:*

Some forms of telecare in vulnerable groups have been shown to be effective but better data on long-term outcomes and on cost-benefit are needed to support local implementation.

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**9. Volunteering**

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Volunteering involves working without payment, typically towards some social, political, or cultural cause.
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9.1 The Department of Health strategic document “Volunteering: involving people and communities in delivering and developing health and social care services” (DH 2010) put forward a case for leaders, partners and commissioners across health and social care “to consider when and how volunteering might support the achievement of local priorities for individuals



and communities, and where strategic investment might be justified to support this”.

- 9.2 In older people, there is evidence that volunteering for at least two hours per week slows age-related decline in self-reported health, functioning, and mental health, and improves mortality rates.(Lum 2005) A meta-analysis showed that volunteering improved older people’s sense of wellbeing,(Wheeler 1998) and one study found this positive effect was not moderated by levels of social integration, gender, or race/ethnicity.(Morrow-Howell 2003) Analysis intended to account for selection bias and study drop-out bias suggested formal volunteering has a beneficial effect on depression but informal helping does not.(Li 2005) Some studies have indicated that intensive volunteering as part of the US Experience Corps programme, which places older people in elementary schools to help children with reading or other skills, can improve physical activity levels (Tan 2006) and physical performance in older adults in fair health.(Barron 2009) The benefits of volunteering vary in relation to factors such as perceived level of involvement, quality of training and support, and stipends more than in relation to individual differences but benefits were likely to be highest in older people with lower socioeconomic status. (Tang 2010; Morrow-Howell 2009)
- 9.3 Volunteering England commissioned a systematic review to ascertain the health effects of volunteering on individual volunteers and health service users. The authors reviewed 87 articles that met their inclusion criteria and found evidence that volunteering decreases mortality and improves self-rated health, mental health, life satisfaction, social support and interaction, healthy behaviours, the ability to cope with illness, and levels of functional impairment.(Casiday 2008) Although each of these studies found volunteers make a valuable and cost-effective contribution, the methodology used in each case was rudimentary, making the findings difficult to generalize.
- 9.4 Economic analyses of individual interventions have been conducted. For example, a cost-effectiveness analysis of the Experience Corps programme took a conservative approach and found the cost per QALY for older people was around \$205,000.(Frick 2004) This figure did not take into account the benefits received from the programme by the schools or young people.
- 9.5 Attempts to place a monetary value on volunteering in relation to the benefits delivered by volunteers have used the Volunteer Investment and Value Audit (VIVA) approach or the Social Return on Investment, developed by the Cabinet Office but there is no evidence about the cost-effectiveness of volunteering for health or social care. The authors of the Volunteering England review stressed the difficulty of generalizing about volunteering because interventions are highly context dependent and aspects of a programme such as the way volunteers are trained and managed are likely to play an important role.(Casiday 2008)

9.6 **Summary**

<i>Intervention</i>	<i>Level of evidence on effectiveness</i>	<i>Level of evidence on cost</i>
Volunteering	2++	2--

*Recommendation:*

Volunteering covers a wide range of activities so costs and outcomes vary widely but some interventions have good potential. Further scoping of individual programmes is needed ahead of commissioning decisions.

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## **10. Extra-care housing**

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Extra-care housing is an extension of sheltered housing that aims to meet the housing, care and support needs of older people, while helping them to maintain their independence in their own private accommodation. The qualifying age for entry may be below 65 years but most entrants are older than this. Extra-care housing offers support and care to residents for 24 hours a day, and has been viewed as a possible alternative to moving into a care home. (DH 2005)

- 10.1 The case for extra-care housing was set out in the 2005 Green Paper, "Independence, Well-Being and Choice".(DH 2005). The Department of Health's Extra-Care Housing Fund Initiative was implemented across 15 sites from 2004 to 2006, and the Personal Social Services Research Unit (PSSRU) at the University of Kent was funded to evaluate the programme.
- 10.2 The PSSRU found that, across the 15 sites, extra-care housing can provide an environment that supports social well-being for older people.(Callaghan 2009) A more detailed analysis of the Bradford extra-care housing project included assessment of different cost components as well as of social- and health-care outcomes and quality of life.(Bäumker 2010, Bäumker 2008). Estimated costs per person per week, including the broad cost components of health care, social care, accommodation, and living expenses, were an average of £380 before individuals moved into extra-care housing and £470 afterwards. The cost increase came mainly from higher costs of accommodation, social care and support, while health care costs were lower.
- 10.3 The PSSRU evaluation thus found a decline in health-care costs, including a decline in admissions, and an increase in quality of life. Overall costs increased by an average of £90 per week.
- 10.4 **Summary**

<i>Intervention</i>	<i>Level of evidence on effectiveness</i>	<i>Level of evidence on cost</i>
Extra-care housing	2+	2+

*Recommendation:*

Extra-care housing can lead to improved individual wellbeing at a higher cost. Modelling of cost-benefit is needed to determine whether this represents value for money.

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## **11. Intelligent progress towards prevention**

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- 11.1 A set of strategies for "intelligent progress towards prevention" within the Devon Health Economy has been put forward based on existing evidence of effectiveness. Each strategy is based on three elements: effective

commissioning, anticipation of changes in demand, and prevention. The emphasis of the work done was to establish where there was good evidence on effectiveness and on costs, with a particular emphasis on identifying areas with potential for good return on investment.

- 11.2 The strategies in place so far cover stopping smoking, obesity, alcohol, and psychological therapies.
- 11.3 *Stopping smoking.* The intelligent progress towards prevention strategy on stopping smoking (Tolley 2009a) identifies excellent evidence for the effectiveness of preventive strategies and potential savings of up to £1 million.
- 11.4 *Obesity.* The intelligent progress towards prevention strategy on obesity (Tolley 2009b) identifies weak evidence of effectiveness and a reduction in costs related to prescriptions for obesity drugs and surgery as well. The Foresight report on obesity estimated the direct and indirect costs to the NHS of obesity and overweight to be £4.2 billion and growing. (Government Office for Science 2007)
- 11.5 *Alcohol.* The intelligent progress towards prevention strategy on alcohol (Tolley 2009c) identifies excellent evidence of effectiveness and potential savings of over £1 million.
- 11.6 *Psychological therapies.* The intelligent progress towards prevention strategy on psychological therapies (Tolley 2009d) identifies excellent evidence of effectiveness and potential savings of over £1 million.
- 11.7 Some aspects of each of these strategies have already been implemented within the Devon Health Economy but scope remains to fully engage with the approaches described and realise further savings.

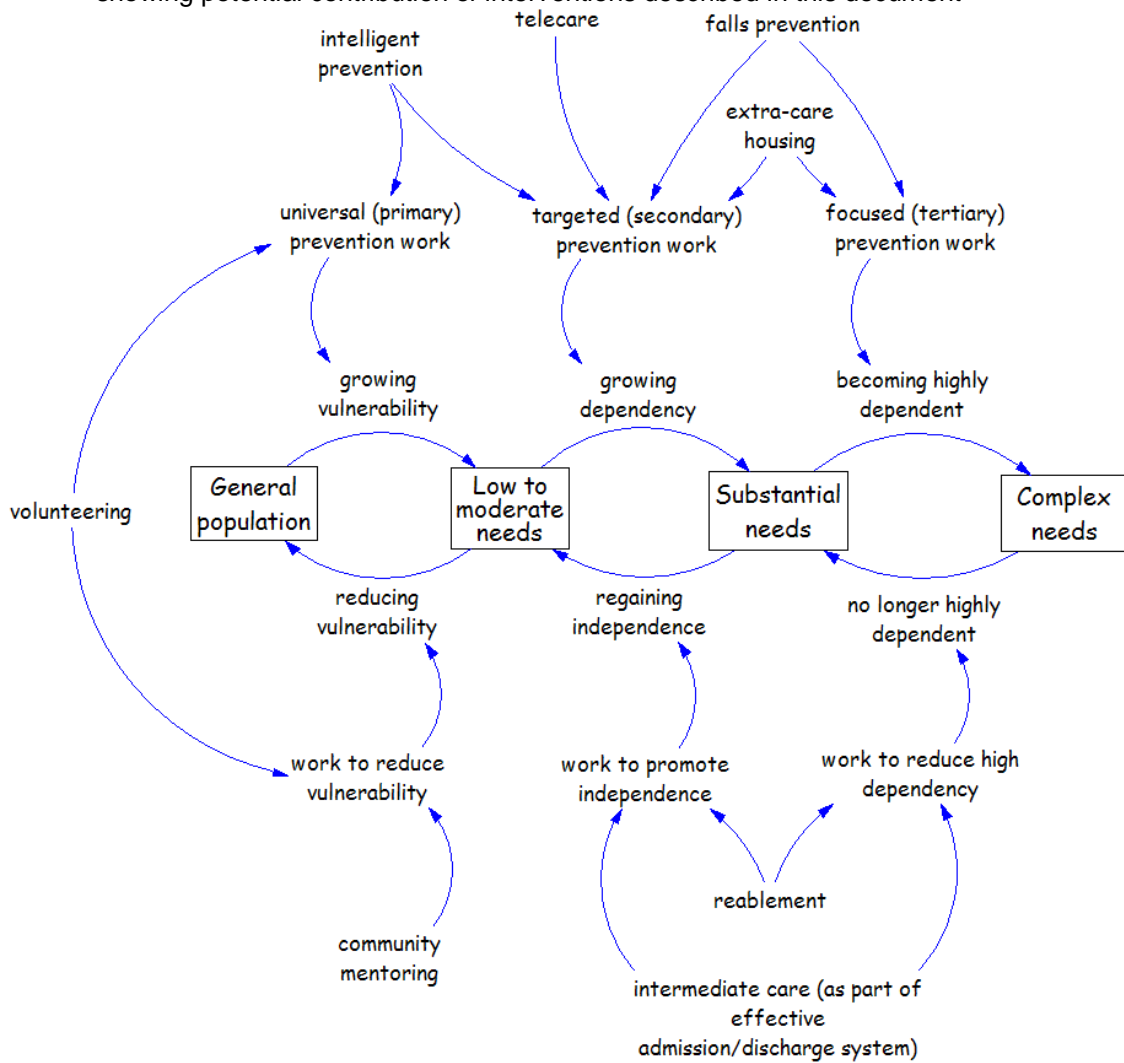
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## **12. Summary: costs and benefits of identified interventions**

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- 12.1 This section summarizes the evidence on effectiveness and costs in relation to the interventions described above in relation to their capacity to improve quality and performance around prevention and wellbeing for older people in the Devon Health Economy.
- 12.2 Figure 12.1 presents a system-level overview of the preventive measures described here in relation to their potential effects on the transitions between stages of dependence. The factors potentially affecting the flows between stages are located at the top part of the diagram (for factors potentially preventing flow towards reduced independence) and the bottom part of the diagram (for factors potentially promoting regaining of independence). The interventions explored in this document are shown with arrows indicating to which part of the early intervention and prevention system they relate.

Figure 12.1. System-level overview of flows between different stages of dependence showing potential contribution of interventions described in this document



12.3 Table 12.1 summarizes the strength of evidence and likelihood of benefit associated with each of the interventions described above.

Table 12.1. Summary of evidence on interventions

	Likelihood intervention will deliver desired outcomes	Likelihood intervention represents value for money
Volunteering (specific projects)	+++	++
Community mentoring	--	--
Falls & fractures prevention	+++	++
Smoking cessation	+++	+++
Alcohol abuse reduction	+++	+++
Psychological therapies	+++	+++
Social care reablement	?	?
Extra-care housing	+	+
Telecare	?	?
Intermediate care (including all essential elements)	++	?

Note: “+++” represents the highest level of evidence, “--” represents the lowest level of evidence, and “?” represents uncertainty/insufficient evidence

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### **13. Appendix 1: reviewing and grading the evidence**

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- 13.1 Evidence relating to clinical effectiveness was reviewed and graded using the hierarchical system presented in table 2.2. This system reflects the susceptibility to bias inherent in particular study designs and is the same as the system used by NICE, the National Institute of Health and Clinical Excellence
- 13.2 In assessing the quality of the evidence, NICE recommends each study is given a quality rating coded as “++”, “+” or “-”. The highest possible evidence level (EL) is a well-conducted systematic review or meta-analysis of RCTs (EL = 1++) or an individual RCT (EL = 1+). Studies of poor quality are rated as “-”. NICE recommends studies rated as “-” should not be used as a basis for making a recommendation although they can be used to inform recommendations.

Table 13.1. Levels of evidence for intervention studies

<i>Level</i>	<i>Source of evidence</i>
1++	High-quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias
1+	Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1-	Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
2++	High-quality systematic reviews of case-control or cohort studies; high-quality case-control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal
2+	Well-conducted case-control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal
2-	Case-control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal
3	Non-analytical studies (for example case reports, case series)
4	Expert opinion, formal consensus

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## 14. References

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