

Putting **People First**
Transforming Adult Social Care

Making a strategic shift towards prevention and early intervention

Key messages for decision makers

October 2008



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Contact Details	Helen Wiggins Social Care Policy & Innovation - System Reform 8E25 Quarry House Quarry Hill, Leeds LS2 7UE 0113 2546486
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Authors: Guy Robertson, with support from Raj Kaur, Angela Glew, Nick Marcangelo and the 29 POPP sites

This booklet is aimed at supporting key decision makers and commissioners across health and social care to invest with confidence in a balanced range of effective preventative approaches for older people.

The information presented in this paper is based on current learning from the emerging local and national evaluations of the Department of Health's **Partnerships for Older People Projects (POPP) programme** and other initiatives.

Putting People First and Social Care Transformation

Making a strategic shift towards prevention and early intervention is one of the central objectives of Putting People First, and the Social Care Reform Grant provides resources to facilitate this kind of transformation.

The transformation of social care, as indicated in the Putting People First concordat and the Local Authority Circular Transforming Social Care, sets out a clear direction – i.e. *"to make... a strategic shift towards early intervention and prevention, the cornerstone of public services."*

The vision for adult social care for the next decade and beyond is laid out in Putting People First. At its heart are four main themes:

- Facilitating access to universal services
- Building social capital within local communities
- Making a strategic shift to prevention and early intervention
- Ensuring people have greater choice and control over meeting their needs

These themes are not discrete or separate, but rather they are interdependent. Therefore, whilst this document focuses on prevention and early intervention, it also highlights the themes of promoting access to universal services, developing social capital, and delivering choice and control.



Defining Prevention

The term prevention can be understood in many different ways. The following framework is helpful as it has a broad focus. It identifies three categories:

- **Primary prevention/promoting wellbeing:** this is aimed at people who have little or no particular social care needs or symptoms

of illness. The focus is therefore on maintaining independence and good health and promoting wellbeing.

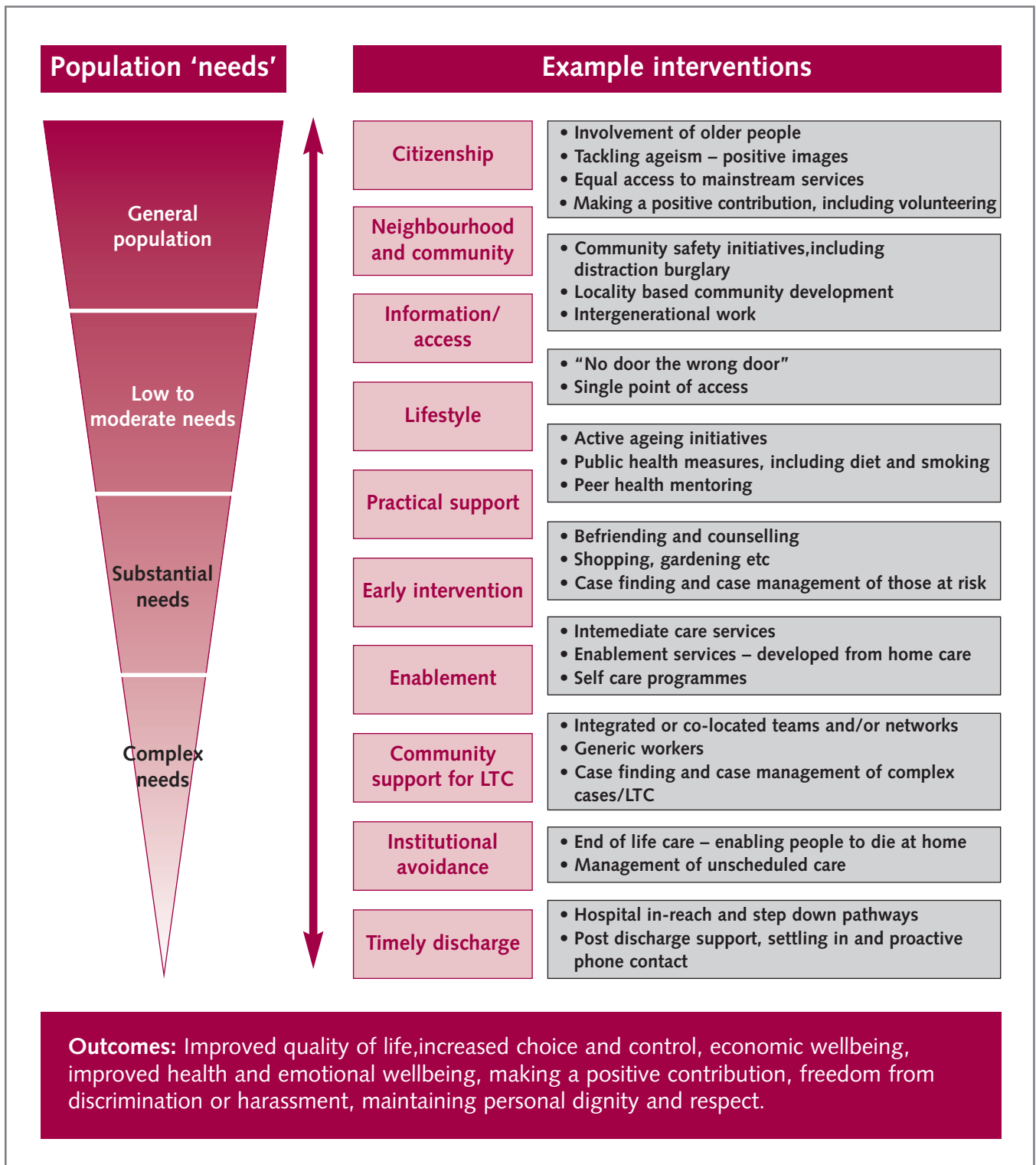
Interventions include combatting ageism, providing universal access to good quality information, supporting safer neighbourhoods, promoting health and active lifestyles, delivering practical services etc

- **Secondary prevention/early intervention:** this aims to identify people at risk and to halt or slow down any deterioration, and actively seek to improve their situation.

Interventions include screening and case finding to identify individuals at risk of specific health conditions or events (such as strokes, or falls) or those who have existing low level social care needs

- **Tertiary prevention:** this is aimed at minimising disability or deterioration from established health conditions or complex social care needs. The focus here is on maximising people's functioning and independence through interventions such as rehabilitation/enablement services and joint case management of people with complex needs.

Interventions are required across all three categories of prevention in order to deliver the wellbeing outcomes which older people across the full spectrum of need aspire to. This is demonstrated in the following diagram:



NB it is important to remember that even those with complex needs will want to make use of many of the 'lower level' interventions.

Evidence for prevention

The National Evaluation of the **Partnerships for Older People Projects (POPP) programme**, along with the individual local evaluations of the 29 pilot sites is producing a growing body of evidence that preventative approaches improve the quality of life of older people and are value for money. The evidence indicates that:

- POPP sites appear to be having a significant effect on reducing NHS hospital emergency bed day use when compared with non-POPP sites. For every £1 spent on preventative initiatives, £0.73p will be saved on emergency hospital bed days. The difference between where investments are made and where the benefits (i.e. savings) arise emphasises the need for close working between health and social care
- The savings effect seems to be most pronounced where interventions are specifically focussed on 'hospital avoidance' (e.g. intermediate care/rapid response, hospital in-reach etc), although the effect has also been discernable even where interventions have been focussed on improving people's quality of life (e.g. befriending, peer support, practical assistance etc)
- Preventative interventions can reduce demand for local authority funded social care support, particularly long term care placements .e.g very significant reductions in supported long term care packages associated with intensive support in the community for older people with mental health problems; and large reductions in home care packages from re-ablement services
- Changes in the use of a range of services used by people after a POPP intervention have been identified, resulting in a mean net cost reduction of £410 per person. This is attributed to:
 - Statistically significant reductions in hospital overnight stays (from a mean of 8 prior to intervention to 6.4 post)
 - Slight increases in GP appointments and contacts with practice nurses
 - Reductions in home care, but increases in community meals, social workers and community nurse contact
- Some preventative work can however lead to an increase in activity – i.e. by seeking out and making contact with people who had previously been unknown (though there is evidence that intervening earlier can avoid or delay the need for more costly responses at a later date)

- Across the range of interventions piloted within POPP, validated user feedback demonstrates that there has been a significant improvement in people's reported quality of life
- Analysis of relevant data shows that improvements in quality of life are 'cost effective' – i.e. the costs of the interventions compared to the gains in quality of life years, are well below the thresholds used by the National Institute of Clinical Excellence to assess whether gains are worth the cost
- The great majority of interventions funded through the 2year POPP grant indicate that they have been, or are in the process of being, sustained through mainstream commissioning processes. New investment from Primary Care Trusts to sustain the preventative work has been substantial. This experience provides very significant learning for the use of the time-limited Social Care Reform Grant
- Partnership working and a truly 'whole systems' approach can attract investment from sources beyond health and social care, in particular from the Fire Service, Culture and Leisure, Housing, Public Health, Supporting People etc.

Case Studies

The rigour applied within the POPP programme has meant that evidence of the effectiveness of preventative approaches has been forthcoming. The following case studies are examples of how effective interventions have been delivered in practice:

Case Study 1

Bradford POPP – Health in Mind

Is a re-design programme of services for older people with mental health problems. Two of the four elements of the programme are considered:

Community Involvement Project – aimed at improving capacity within the voluntary and community sector to support older people with, or at risk of developing mental health problems. This was delivered by a programme of funding for well-being activities, a network of Mental Health Cafes and the development of a community involvement team.

Findings¹:

- Significant increase in the capacity of voluntary and community organisations to support older people with mental health problems
- A significant reduction in depression amongst participants alongside reported improvements with respect to social inclusion and wellbeing.

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

Findings¹:

- 26% of users were prevented from being admitted to a care home
- In a further 13% of users admission to hospital was prevented or delayed
- 15% were supported to be discharged from hospital earlier than would otherwise have been the case
- There was a 29% reduction in the number of home care hours immediately after intervention, levelling out at a 26% reduction one month later
- When operating at full capacity the Intensive Support Teams are projected to produce net savings of around £550k per annum.

*With regard to the overall programme – "...the economic evaluation gives a positive Net Present Value (NPV) of £602017 and an Internal Rate of Return (IRR) of 8.5% over an assumed operational period of ten years. This suggests that the programme can provide good value for money as long as the projected outcomes are achieved."*¹

Case Study 2

East Sussex POPP – Independence First

Represents a mixed portfolio of partnership and prevention projects aimed at having a broad based impact on the local health and social care economy, with a particular focus on:

- Promoting independence
- Developing and testing a range of targeted preventative interventions
- Modernising clinical and social care services
- Creating an organisational culture of 'whole systems' solutions

This was achieved through 12 service initiatives:

- Rapid response team (PCT-led)
- Paramedic practitioners – alternative to ambulance response
- Intensive community support team for older people with mental health problems
- Memory assessment and support team
- Medicines management
- Navigator service for signposting and practical support for people with moderate needs
- ICES Direct – telephone advice and assessment for simple aids
- Falls prevention team
- Hospital duty social care assessment team – rapid assessment to avoid hospital admission
- Enhanced response team – rapid and out of hours access to home care
- County connect – first contact signposting service
- Bathing advice and information service.

Achievements²:

- Overall net financial return on investment for the whole programme was between 15-35%. This was largely attributable to reduced health service activity
- Data from pre and post intervention surveys show that:
 - older people's quality of life had improved
 - they were less likely to have used hospital services for an emergency or overnight stay in the previous three months
 - they were likely to make better use of community and outpatient services
 - they were more knowledgeable and confident about any health condition they might have and how to manage it – i.e. they had greater choice and control
 - people still had their long term health conditions but they were able to cope better and were less likely to face acute crisis because of failed care arrangements
- Sustainability has been achieved for the overwhelming majority of the programme, through significant investment from the PCT as well as from Adult Social Care
- Data from a large scale survey of older people repeated in 2008 after a three year gap (i.e. pre and post – POPP) showed very significant improvements in the views of older people about a wide range of aspects of health and social care provision. They felt that health and social care staff worked together better, felt more involved and were happier with the services provided for them.

Case Study 3

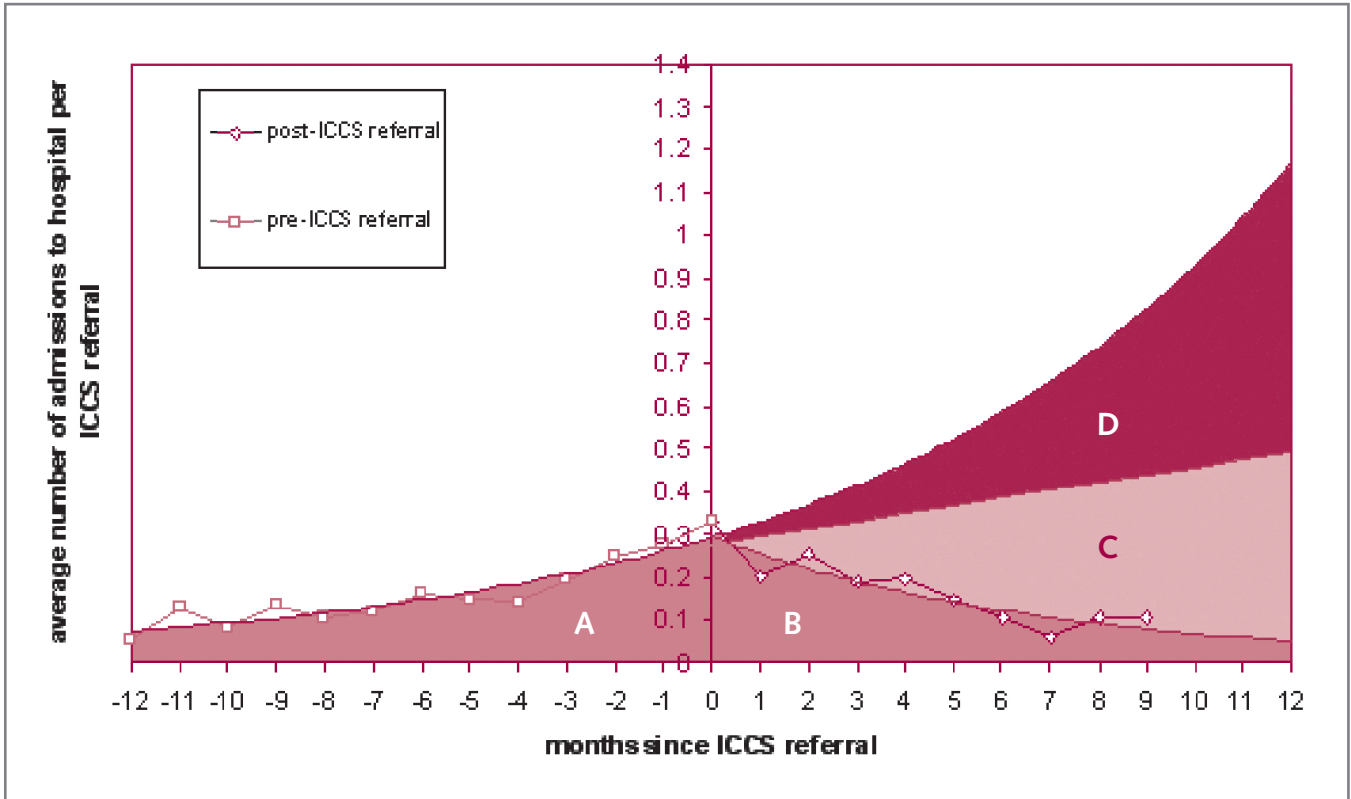
Brent POPP – Integrated Care Co-ordination Service (ICCS)

This is a 'holistic' service targeted at older people over 65 who may be at risk of avoidable hospital admission, premature admission to institutional care, or simply causing concern due to medical, physical, emotional or social issues. It achieved this by undertaking assessments and then co-ordinating a range of interventions responding to identified needs – operating across health, social care and other organisational boundaries as required. Interventions included odd jobs around the home, assistance with moving into more appropriate accommodation, benefits and pensions advice or referrals to health and social care providers, podiatrists, occupational therapists etc.

Findings³:

- Overall the ICCS is extremely cost effective in reducing hospital A&E attendances, admissions to hospital and hospital bed-days
- The development of savings builds up over time due to the continuing accrual of savings after the ICCS has closed the case
- Assuming no other sources of savings, the ICCS would break even (i.e. savings minus costs), if it prevented 5-6 bed days per client per year – in fact it saves between 14 and 29 bed-days
- It also results in 2-6 fewer admissions and 3-7 fewer A&E attendances
- There is a dramatic reduction in falls. In the first month of service 21% of people experienced a fall – this reduced to 4% of cases by the fifth month
- More people were helped to live at home but no measurable effect on admissions to nursing and residential care was found
- The impact on hospital activity was corroborated by other evidence

The graph below illustrates one of the core parts of the analysis – the actual and projected hospital admissions for ICCS clients:



The pattern of admissions pre and post ICCS intervention with fitted trend curves applied.

- Key:** A = actual admissions in previous 12months
 B = actual admissions 12 months post ICCS intervention
 C = prevented admissions based on constant growth assumptions resulting from ICCS intervention
 C+D = prevented admissions based on accelerated trend resulting from ICCS intervention)

Effective Interventions

Evidence suggests that the following interventions are key to generating a strategic shift towards prevention and early intervention. Much more information on each element is available in the **Resource Pack**.

Some of these interventions are new. Others are in existence in some shape or form in most authorities. What is significant about the learning from POPP is:

- The emerging **evaluation data to validate their effectiveness**
- The recognition of **the need for a balanced portfolio of investment across the full range of interventions** in order to promote older people's independence and wellbeing.

It needs to be remembered that the starting point for any service redesign should be engagement with older people.

Age proofing existing mainstream services

It is essential that older people have good access to universal services. The design of these services needs to recognise the barriers to inclusion that currently exist for disabled and older people.

To achieve this it is important to⁴:

- Involve older people in planning from the outset
- Design core services that older people can use
- Use existing resources wisely to improve access to services and overcome barriers to inclusion
- Tailor mainstream services for older age groups

Providing information for all

All older people, including those who can fund their own care, need to have access to good quality information and help with how to navigate complex public services. This is fundamental to ensuring that older people have choice and control over how they maintain their independence and wellbeing. Whilst there is clearly a need for good quality and well publicised websites, telephone contact centres, leaflets etc, the evidence suggests that there is a huge amount to be gained from:

- Actively seeking out people who could benefit from information and advice and delivering this face to face through older people acting as 'navigators', '**wayfinders**' or '**village agents**'

- Supporting staff to deliver a system where “no door is the wrong door” for older people. The simple ‘**First Contact Checklist**’ is a particularly effective and inexpensive system which enables front line staff who come into contact with older people to ask about and respond to a simple set of 10 questions which cover the common issues relevant to older people. The results are passed to the contact centre who arrange any referrals.

Building capacity in local neighbourhoods

Community development approaches, focused on older people within particular neighbourhoods, have been shown to be effective in enhancing quality of life and facilitating older people’s access to information and services. The ‘**Sure Start for Older People**’ model outlined by the Social Exclusion Unit is relevant here as it combines the notion of joining up access to services and information, with a focus on community development as a means of working with older people to identify and determine their own local priorities. This kind of approach also supports older people to make a positive contribution. Building community capacity through this kind of volunteering is important, particularly in the face of a rapidly ageing population.

Services to promote wellbeing

A **comprehensive range** of wellbeing services might include:

- Activities to address **social isolation** – e.g. befriending and luncheon clubs
- **Practical help** with things like shopping, gardening, minor repairs and adaptations in the home etc
- **Healthy living advice** and support – e.g. exercise classes, diet advice, risky lifestyle issues awareness etc
- **Inter-generational** initiatives
- **Community safety** – fire safety, anti-social behaviour, victim support, crime prevention etc
- **Housing choices and improvements**
- **Transport** and other forms of getting out and about.

Many of these will be provided by the voluntary and community sector. Only a minority of these are likely to be funded through social care – resources from the leisure services, community development, supporting people programme, public health, community safety partnerships, housing etc are most likely to be providing the majority of the resources.

The delivery and sustainability of these services requires a focussed approach with particular attention needing to be paid to relationships with the voluntary and community sector.

A pathway for those not eligible for ongoing social care support

Wherever eligibility thresholds are set there will always be people who approach social services but who are not subsequently deemed to be eligible for ongoing social care support. The Commission for Social Care Inspection has highlighted that where such individuals are signposted to other sources of help, it is important that there is appropriate follow up to consider whether an individual's outcomes have been achieved. One way of addressing this is to have a pathway for these people, including self funders, which refers them directly into a form of case co-ordination (see below) which provides a low level but holistic assessment of their needs, facilitates their access to mainstream and voluntary sector services, and then follows them up 3-6 months later to check their situation.

Case finding and case co-ordination

Case finding is the process of working pro-actively to identify people who could benefit from having access to information and/or services. It represents a marked departure from systems which just wait to receive referrals.

There are a number of methods used to identify people including screening questions, predictive tools and professional judgement. Case co-ordination is the term used to describe a time limited holistic approach to working with people with the objective of addressing their needs before they trigger a crisis or rapid deterioration.

The key characteristics are:

- That it undertakes a holistic assessment of people's needs (going beyond just health and social care issues)
- Facilitates their access to universal and/or voluntary sector services
- Follows people up 3-6 months later to check whether their outcomes are satisfactory.

Case co-ordination can be targeted at different levels of 'need'. It has been found to be most effective when explicitly targeted at those people who straddle the boundary of being eligible for services, and at those experiencing significant life events (e.g. bereavement, onset of disability, becoming a carer etc). This works best where there is strong engagement with local GP's and information sharing with A&E and the ambulance services. Evaluation results from projects targeted in this way show impressive results in reducing falls, emergency bed day usage (from admissions and lengths of stay), and A&E attendances (see Case Study 3 above).

Re-ablement

Enablement services appear to be able to make significant reductions in the number of older people requiring ongoing social care support. Recent research⁵ has demonstrated the significant financial and quality of life gains which can be achieved from a more rehabilitative and therapeutic intervention at the point of referral to social care. It found that about 40% of older people were not requiring homecare support 2 years after re-ablement, and of those that had required a homecare package, on average 45% of these people either maintained their lower care package following homecare re-ablement or even continued to reduce their package 2 years later. In many authorities progress is being achieved through the re-commissioning of home care services. Connections with intermediate care services and housing are very important.

Intermediate care

Comprehensive intermediate care services are vital to improving the outcomes for older people and reducing the demand on health and social care services. Key features include:

- rapid response to deal with crises in people's own homes and to avert emergency admission to hospital or care home
- in-reach into hospital to help facilitate timely discharge

- step down capacity so that decisions about older people's long term care and support needs are not made in an acute hospital bed
- services which meet the needs of older people with mental health problems

Joint health and social care approaches to managing long term conditions

People with complex health and social care needs, largely associated with long term conditions, benefit greatly from joint health and social care assessment and care management. As well as improving the outcomes for individuals the evidence strongly suggests that joint approaches reduce demand on both health and social care systems. The benefits are particularly strong where jointly delivered rapid and flexible response services targeted at older people with mental health needs are in place (see Case Study 1 above).

Support to care homes

Despite the shift to enabling more people to remain living in their own homes, care homes will always remain appropriate for, and the positive choice of a significant number of older people. There is now growing evidence of the effectiveness of working positively with this important part of the health and social care economy. Particular interventions include:

- Providing in reach nursing capacity to train and support better practice and decision making by care home staff, including end of life care.
- Promoting intermediate care rapid response services in-reaching into care homes
- Redefining the role of residential care by providing 'out-reach' services for the local community, and 'in-reach' from services that provide entertainment, exercise and inter-generational activities.

As well as improved quality of life benefits for older people it is also possible to reduce emergency admissions from care homes to hospital as well as reducing the progression from residential to nursing care home placements

Re-designing out of hours and/or crisis response services

Providing more co-ordinated out of hours response services which are less reliant on ambulance callouts is an important aspect of system improvement. This is becoming even more important given the expansion of telecare/telehealth services, which if they are to be most effective, need to offer an emergency response service for those without family or carers.

Case study evidence⁶ indicates that local authorities and their partners in health can achieve improved outcomes for individuals and bring increased efficiency and added capacity to the system where they have services that are:

- Integrated
- Jointly funded and managed
- Have a range of multi-disciplinary back-up services offering domiciliary and nursing support
- Have other response services in addition to the standard ambulance service
- Linked to intermediate care services

Further Information

Further information on all these interventions is available from the **Resource Pack**.

Omissions

There are a number of other important service development areas which are already covered well in other places, e.g:

- **Dementia**
- **Telecare**
- **Extra care housing**
- **Carers**

Making it happen

The experience of the POPP programme suggests that the following issues are key:

- **The involvement of older people** – this is vital to ensuring that changes and service developments meet the needs of the diverse population of older people. Older people need to be supported to become co-producers of service initiatives
- **A clear vision** – partners need to agree clear outcomes and how and when they are to be delivered. Local Area Agreements and other strategic commissioning processes are potential vehicles for implementation
- **Effective leadership** – which needs to extend to levels beyond that of chief officers and lead Members, to include frontline practitioners, middle managers, commissioners and back bench elected members
- **A whole system approach** – it is unlikely that significant progress can be made on promoting the independence and quality of life of older people without a partnership approach which engages a range of key stakeholders, extending wider than just health and social care.

Commissioning for strategic change

A robust commissioning approach is required in order to secure the resources and put in place the right interventions to produce a strategic shift towards prevention and early intervention.

The pilot programmes have provided learning in the following areas:

- **Resources** – the scale of investment required is variable and will largely depend on where local authority and health systems are starting from. Many of the elements can be implemented without significant additional resources; others will involve the reshaping of existing resources; and for others there is already 'new money' in the system (e.g. for carers, end of life care, minor repairs and equipment etc)
- **A good understanding of need and how the system is currently responding to it** – the Joint Strategic Needs Assessment and data from the National Indicator Set will be key to underpinning this work, supported for example by knowledge about the characteristics of hospital and/or care home admissions. This kind of intelligence is crucial to understanding what interventions need to be prioritised.

- **Invest rather than spend** – the commitment of resources is best thought of in terms of an ‘investment’ framework. Different investments produce different returns – some produce significant net savings whereas others produce more modest savings but significant improvements in quality of life. What is required is a balanced ‘portfolio’ which promotes wellbeing as well as delivering financial savings
- **Use the levers and drivers** – there are a large number of policy drivers (including the forthcoming Comprehensive Area Assessment) which call for an increased focus on this agenda. Transforming Adult Social Care provides a clear policy direction as well as additional resources for prevention. There are also financial levers such as Practice Based Commissioning which have the potential to deliver progress
- **Engage partners** – promoting independence and wellbeing is not the sole responsibility of social care or health. There are a large number of other organisations with a role to play – and with money to invest, including - public health, regeneration, housing, community safety, leisure and cultural services, transport etc. Many service providers are also keen to embrace new ways of working and to be part of solving problems
- **Rigorous medium to long term business planning** – making a strategic shift doesn’t happen over night – it can only be addressed over the medium term (i.e. 3 to 5 or 10 years). Business planning must therefore be undertaken over this kind of horizon and it needs to be detailed and robust. Some of the lessons from authorities engaged in longer term commissioning are very **helpful**
- **Scrutinise the core spend** – mainstream expenditure warrants the same kind of scrutiny and calls for ‘evidence’ as that which is often demanded of preventative initiatives
- **Monitor performance and evaluate effectiveness** – resourcing ‘good ideas’ without paying attention to what they deliver is of little value. It is vital to develop evaluation frameworks which define what outcomes, deliverables and benefits are expected and then to monitor and manage performance carefully
- **Make best use of new money** – the **Social Care Reform Grant** should be used to provide the ‘bridge funding’ to facilitate whole system redesign and the strategic shift in resources. The experience from the POPP programme (which similarly had short term funding with an expectation of strategic change) suggests that the following discipline is useful. There are essentially two ways of using time limited resources:

- *Change management* – (e.g. project management, consultancy, reengineering, training etc). This investment should be carefully managed within the timescale of the funding availability
- *New capacity* – i.e. additional staff to deliver new or expanded services. There is a need to establish how the capacity will be resourced beyond the end of the grant (through savings, efficiencies, re-prioritisation of other resource, new resources etc)
- **Sustaining improvements** – the POPP programme has demonstrated that it is possible to sustain preventative approaches. Learning points include:
 - Work with PCT commissioners to re-profile growth monies for the acute sector with a view to changing the balance of resources which can be invested in primary and community care
 - Use evidence to de-commission or re-design existing services and use these resources to invest in prevention and early intervention
 - Engage with other partners with a common interest, in particular public health, supporting people, housing, culture and leisure services, and community safety
 - Build capacity within the local community – i.e. through promoting and supporting volunteering.

Summary and conclusion

This document provides a high level overview of the learning from the first two years of a three year programme. Further information from Partnerships for Older People Projects (POPP) will be made available throughout the coming year.

In summary the key messages are:

- Promoting the independence and quality of life of older people is a priority
- Older people need to be fully involved and supported to co-produce service development
- There is growing evidence about the effectiveness of preventative approaches
- Invest rather than spend – i.e. consider the different 'returns' that investment in particular interventions will deliver
- Develop a balanced portfolio of investment across the full range of possible interventions
- Pay particular attention to commissioning proactive ways of providing information and advice to older people, including those who can afford to fund their own care.
- Develop a whole system approach which extends well beyond health and social care is likely to be most effective
- The Social Care Reform Grant provides additional resources to support Councils' ability to make a strategic shift to prevention and early intervention

References

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Further information and support

National prevention and early intervention team:

Raj Kaur

Rajbant.Kaur@dh.gsi.gov.uk

Guy Robertson

Guy.Robertson@dh.gsi.gov.uk

Nick Marcangelo

Nicholas.Marcangelo@dh.gsi.gov.uk

Angela Glew

Angela.Glew@dh.gsi.gov.uk

