Prevention in Adult Social Care: venturing upstream - the route less travelled

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1. Introduction

This paper argues that there is a missing narrative in debates about the sustainability of social care for older people. There should be more emphasis on what can be done to support healthy ageing in communities and populations in order to reduce demand for social care. Fifteen years on from the 'Wanless report' on social care[1], to what extent have we responded to the recommendations to promote public health and provide low level services to delay the onset of needs? Have we created the conditions for healthy ageing, where we are encouraged and supported to live independently as we age? How much projected future need could be prevented through action upstream on behavioural risk factors, on boosting community connections and providing supportive environments? To what extent does the current evidence meet the needs of local authorities, and help them with their investment in prevention?

This paper calls for greater clarity in how prevention is conceptualised and mobilised, and for the stronger adoption of population level approaches. It makes a case for public health teams to collaborate more closely with adult social care on population needs assessments, better data and intelligence, and use of evidence to help promote healthy ageing and reduce demand for adult social care. It sets out what the research agenda could look like going forward.

2. Meeting the social care needs of older people

In March 2021, the National Audit Office[2] warned of a 57% increase in adults aged 65 and over requiring care by 2038 compared with 2018 in England, and they reported that already there are high levels of unpaid care and unmet need. The models on which this projection was based[3] assume the prevalence rates of disability in old age by age group and gender remain unchanged. In these models, numbers of disabled older people are predicted to rise from 3.5 million in 2018 to 5.2 million in 2038; while numbers of severely disabled people would rise from 1.7 million to 2.5 million in the same time period.

The crisis is well documented and receives significant press attention, yet a crucial part of the debate is missing.

Even at today's levels of demand, we know that the current system cannot meet the quantum of need presented. In 2006, Derek Wanless' work on social care[1] models and sustainability of services, pondered the costs of providing social care for older people in England in 20 years' time, given demographic, economic, social and health trends driving demand, and considered how sustainable solutions might be found. This

[1] Wanless D (2006) Securing good care for older people: taking a long term view, King's Fund https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/securing-good-care-for-older-people-wanless-2006.pdf

[2] National Audit Office (2021) The Adult Social Care Market in England https://www.nao.org.uk/wp-content/uploads/2021/03/The-adult-social-care-market-in-England.pdf

[3] Hu B, Hancock R & Wittenberg R (2020) projections of adult social care demand and expenditure 2018 to 2038, LSE, Care Policy and Evaluation Centre https://www.lse.ac.uk/cpec/assets/documents/cpec-working-paper-7.pdf

work had a strong interest in 'public health and low-level services preventing or delaying the need for social care services by reducing people's dependency, disability and ill health'.

The impact of the pandemic on older populations may make things worse. During the pandemic, many older people were advised to 'shield' or stay at home, which has had an impact on their levels of physical activity[4], particularly in more socioeconomically deprived communities. The confidence of older people to re-engage in society has also been affected, and the recent report by Public Health England[5] has predicted that without further action, there is likely to be a significant increase in falls, which will place further demand on adult social care services.

Earlier attempts to address growing social care need include the Care Act (2014) elements of which were intended to support improvements in older people's independence and wellbeing. The Care Act tasked local authorities with providing or arranging services that help prevent people developing needs for care, and to support or delay people deteriorating such that they would need ongoing care and support. There are questions about the extent to which local authorities have been able to address these responsibilities[6]. Indeed, such efforts have been described as being hampered by insufficient resources, by a lack of clarity about what constitutes primary prevention and by a paucity of evidence about the best prevention programmes in which to invest. Tightening of budgets may have, paradoxically, compromised the implementation of the prevention duty. Further pressure on the ability of local authorities to deliver under the Care Act has come from the COVID-19 pandemic, which has placed additional demands on local authorities to protect the health and improving the wellbeing of their local population, whilst delivering vital services to vulnerable populations.

Build Back Better, the government's plan for health and social care[7] proposes incentives for integration and prevention, a long-term perspective, and using existing partnerships across NHS, social care providers and others to ensure they are working to deliver more effective care in people's own homes and support in the communities they live in. This has been followed by the Government's White Paper 'People at the heart of care'[8], published on 1 December 2021, which committed £5.4 billion to a range of improvements, including housing and workforce support.

We seek to help with such ambitions around prevention, including those enshrined in the Care Act 2014, challenging the seemingly inherent view that as a society we are doing all we can to enable us to age well and function independently into later life, and that predicted levels of disability are inevitable.

3. Identification of needs and access to social care

The NHS is, as we all know, a universal service and free at the point of access. Those who plan health care services are naturally interested in seeing the population stay as healthy as possible. This is inherently a 'good thing' of course, but it will also translate into less demand for scarce resource.

The dynamic is different in adult social care. It is not a universal service and tends not to take a 'whole population' view. Whereas every member of a population can be seen – in theory at least – to be an NHS patient by virtue of their registration with a general practice, not everyone 65 and older is a social care

[4] Age UK (2021) Impact of COVID-19 on older people's mental and physical health: one year on https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/coronavirus/impact-of-covid-19-on-older-peoples-health_one-year-on.pdf

[5] Public Health England (2021) Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1010501/HEMT_Wider_Impacts_Falls.pdf

[6] Marczac J, Wistow G & Fernandez JL (2019) Evaluating social care prevention in England: challenges and opportunities, Journal of Long Term Care

[7] HM Government (2021) Build Back better, our plan for health and social care https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1015736/Build_Back_Better-_Our_Plan_for_Health_and_Social_Care.pdf

[8] HM Government (2021) people at the heart of care: adult social care reform white paper https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper

service user. Becoming one requires an application to be made to have your needs assessed and a means-tested decision made regarding access.

In any population, there will be a number of people who struggle on their own, lack a social support network, or anyone to advocate on their behalf, and do not seek help from social care.

Even if we focus solely on those who **do** come forward to express their needs, too few people get support. A recent briefing on the value of investing in social care[9] reports that 120,000 new requests for support were made between 2015/16 and 2019/20, yet the total number of people actually receiving publicly funded long-term care over that period fell by 3,000. The paper suggests that local authorities have not had sufficient funding to keep pace with growing demand, indicating that a growing number of people were not getting the care they needed, were relying on family or friends, or were going without entirely. The authors argue that social care can enable people to live independent and fulfilling lives, but too few people have access to it.

In addition, adult social care access is not uniform across local authorities. It has been suggested that there is a 'postcode lottery' in terms of availability and access to home-based care, for example. A recent IPPR report[10] points to the proportion of care provided at home as varying considerably across different councils, from as low as 46% in Barnsley to as high as 84% in Hammersmith and Fulham.

4. Preventive action in populations

'Prevention' is a contested term with no universally agreed definition, but it is a term that is frequently used. The Social Care Institute for Excellence (SCIE)[11] defines prevention as three-fold:

Prevent – primary prevention/promoting wellbeing:	This approach should be applied to everyone, encompassing a range of services, facilities and resources that will help avoid the need for care and support developing. It could include information and advice, promoting healthy and active lifestyles, and reducing loneliness and isolation.
Reduce – secondary prevention/early intervention	This approach is targeted at individuals at risk of developing needs where support may slow this process or prevent other needs from developing. It could include carer support, falls prevention, housing adaptations or support to manage money.
Delay – tertiary prevention/formal intervention	The third approach is aimed at people with established complex health conditions, to minimise the effects, support them to regain skills and to reduce their needs wherever possible. This could include rehabilitation/reablement services, meeting a person's needs at home, and providing respite care, peer support, emotional support and stress management for carers.

Whilst these interpretations are helpful, we think they could go further to suggest a stronger population and community orientation.

Primary prevention: we agree with SCIE's definition of primary prevention being applied to everyone, but the concept would be strengthened by adopting a community asset-based approach, rather than solely focusing on individuals. A community asset approach includes improving outdoor spaces and buildings, transportation, housing, social inclusion, and civic participation and employment. In its priorities for local government report[12] the Centre for Ageing Better proposes four priorities for change: creating opportunities for fulfilling work for older people; enabling safe and accessible homes; promoting healthy ageing; and

[9] Health Foundation, King's Fund & Nuffield Trust (2021) The value of investing in social care https://www.kingsfund.org.uk/sites/default/files/2021-10/value-investing-social-care-briefing.pdf

[10] IPPR (2021) Home care postcode lottery https://www.ippr.org/news-and-media/press-releases/home-care-postcode-lottery-80-000-care-home-residents-could-be-receiving-social-care-in-their-own-homes

[11] Social Care Institute for Excellence (2021) Prevention in social care, https://www.scie.org.uk/prevention/social-care#definition

[12] Centre for Ageing Better (2021) Priorities for local government https://ageing-better.org.uk/sites/default/files/2021-04/Priorities-for-local-government.pdf

keeping older people connected. The report states that local authorities are 'at the heart of supporting local communities to thrive and enabling people to remain healthy and active well into their later lives'.

'Age Friendly Communities' are one example of an intervention that also has the benefit of cutting across the 3 types of prevention. There are over 50 cities and communities aiming to become age friendly in the UK, all at different stages of development and focusing on different priorities on the basis of community needs. Manchester was one of the first cities to embark on the journey to becoming Age Friendly, and this includes taking action in the eight domains of the age friendly communities framework[13].

Secondary prevention: as the table above suggests, in any population there will be a cohort of individuals who are 'on the cusp' of needing social care. Ideally, we would be able to identify and target this group to offer support to enhance and maintain their wellbeing.

Unpaid carers represent one group 'on the cusp' and often with unmet needs. The burden of social care needs that are not met by the public sector often fall to family members, whose own health and wellbeing can suffer[14], creating another cycle of needs. Unpaid carers often give up their jobs to provide care, which in turn creates financial insecurity in later life. This economic impact creates a domino effect of need, potentially leading to escalation and more intensive interventions for the care recipient when the carer's health deteriorates.

Local authorities could identify relevant data streams and use intelligence across their services to ensure that they identify and offer support to certain population groups, at the right time. For example, when an older person applies for support due to fuel poverty, they could be offered other support as well, such as social prescribing or information about activities or groups in their neighbourhood.

There are already examples of this approach in some localities. For instance, the Wokingham Adult Social Care Strategy[15] aims to prevent, reduce and delay need for formal care and support, by providing (amongst other things) support for carers, use of technology and adaptations.

There are also examples of national strategies supporting local action, e.g. the Loneliness Annual Report 2021[16] highlights a £750m charity funding package, and local case studies including 'Rural Coffee Connect' in Leicestershire and Rutland which target isolated people in rural areas and connects them to people in their local community.

These examples represent a proactive approach that seeks to support the individual before a crisis occurs, via diverse agencies that connect people to their local community to address issues such as loneliness and isolation. There is a need for these models of good practice to be shared and scaled-up for greater impact across the country, to reduce demand and enable the benefits to be accelerated and maximised.

Tertiary prevention: Tertiary prevention applies to populations who are in receipt of care because they have disabilities. Some tertiary prevention is focused on people with complex health needs; whilst other types of tertiary prevention focus on those with existing social needs.

The objective is rehabilitation and reablement, thereby halting or slowing the progression of need and regaining as much independence as possible. For people with complex health conditions, this population is likely to also have social care needs e.g. with mobility, washing, shopping. It is important to note that the

[13] World Health Organisation (accessed 2021) The WHO Age Friendly Cities Framework https://www.who.int/news/item/01-10-2007-new-guide-on-building-age-friendly-cities

[14] Public Health England (2021) Caring as a social determinant of health: a review of the evidence, https://www.gov.uk/government/publications/caring-as-a-social-determinant-of-health-review-of-evidence

[15] Wokingham Borough Council (2020) Adult Social Care Strategy 2020-2025 Plans, policies and strategies - Wokingham Borough Council accessed 26th November 2021

[16] Department for Digital, Culture, Media & Sport (2021) Loneliness Annual Report https://www.gov.uk/government/publications/loneliness-annual-report-the-second-year/loneliness-annual-report-january-2021

percentage of people aged 65 or more with 4 or more complex health conditions is expected to grow by 60% by 2035[17], and this will likely have an impact on future demand for support.

One example of tertiary prevention relating to a medical condition is where an individual has experienced a severe stroke and consequently needs social care support with activities of daily living until they are able to reacquire their skills/abilities. The intervention may be short or longer term.

Another example of tertiary prevention related to social care need is where an isolated older person has recently been bereaved, and as a result no longer has their family carer. The person may reside in a rural area with poor transport, and have previously received support for their physical and mental wellbeing. However, following the bereavement, a mental health crisis occurs and social care tertiary prevention is needed to help them regain the confidence to re-engage in their community.

5. Solutions and opportunities

We argue that there should be greater emphasis on what can be done to support healthy ageing in communities and populations in order to reduce demand for social care. There are of course efforts underway, particularly under the banner of Age Friendly Communities but we see much greater potential under three broad headings:

- Exploring and acting on primary prevention
- Strengthening collaborations; and
- Meeting evidence needs.

Exploring and acting on primary prevention

There need to be system level strategic debates around what we mean by 'prevention' and where the opportunities are. We focus on 'debate' here because if we are talking about different things the prevention agenda can become stuck. To arrive at a shared view – and strategy – we need to discuss the different perspectives and interpretations that exist across the system of health and social care. We have explored some examples above but recognise we are only scratching the surface, and richer thinking will come from health and social care planners on the ground.

The development of Integrated Care Systems (ICSs) is timely for this work. These geographically-based partnerships will bring together providers and commissioners of NHS services with local authorities and other local partners to plan, co-ordinate and commission health and care services. They are part of a fundamental shift in the way the health and care system is organised and legislation will put them on a statutory footing from April 2022.

There is an opportunity for ICSs to drive a consistent view to prevention, through the commissioning of services and population approaches. ICSs will have precisely the right people around the table, with their collective need to ensure sustainability of the health and social care system. Those bodies can provide the platform for these debates and the strategic muscle to make things happen, identifying and protecting existing community assets, and mobilising resources to create the conditions at population level which support wellbeing and health.

Strengthening collaborations

Adoption of population level approaches will be facilitated if public health professionals and adult social care professionals work more closely.

[17] HM Government (2021) Integration and innovation: working together to improve health and social care for all, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960549/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-print-version.pdf

Research undertaken by the University of Birmingham based on a national survey[18] found that the potential synergies 'between social care and public health prevention activity are not always being realised within local authorities' and that this sometimes reflected '…different priorities and ways of conceptualising prevention'. Recommendations included the need for 'a more consistent shared approach to promoting the capacity and capability of communities, families, networks and individuals – which has the potential to deliver benefit in relation to both care and health needs'.

There is a clear opportunity to get better at collaboration. There are already examples of adult social care teams working closely with public Health teams; indeed, in some areas, the Director of Public Health also has responsibility for social care.

There are opportunities for joining up public health interventions with a primary prevention approach for social care, to address behavioural risk factors such as lack of physical activity, with a community asset based approach, e.g. through locally-based walking and cycling schemes and access to green spaces, all of which promote the health of the older population by enhancing mobility and independence.

Public health approaches can help inform population approaches to wellbeing now and in planning for the future. For example, a better understanding of predicted care needs at population level, based on improved data analysis, will help local areas plan their current and future service provision.

An enhanced ability to anticipate social care demand creates opportunity to intervene proactively to provide the necessary interventions both to support people to maintain their wellbeing (through primary prevention programmes such as Age Friendly Communities) and to support people on the cusp of needing social care, through secondary prevention such as better social support, community connections, physical activity interventions.

Meeting evidence needs

When compared with evidence on effective preventive *healthcare* interventions that demonstrate return on investment, evidence for preventive social care interventions has not been plentiful. In January 2020, Public Health England[19] described cost-effective interventions that were shown to produce a return on investment across health and social care for older adults. This was able to cite only a small number interventions where the financial benefit accrued to social care, such as dementia nursing homes and a 'help at home' scheme. This latter intervention was in a single geographical area and authors noted that further work was needed to confirm whether the savings could be generalised. Other interventions including befriending and home care reablement provided wider social benefit across the system.

Similar to many other areas of research prompted and driven by the COVID-19 pandemic, there has been an explosion of fast-paced public health research activity both nationally and internationally[20]. This has become better co-ordinated due to active engagement and steer from research funding bodies and a range of research collaborations. An example of this activity is the collaborative research across local health and social care systems spearheaded by the NIHR Applied Research Collaborations (ARCs), the NIHR Schools for Public Health Research and Social Care Research, the NIHR Policy Research Units and the others such as the Health Foundation. Much of the research has focussed on understanding and attempting to mitigate the impact of COVID-19 on high risk population groups, in particular older people and those in high risk social care settings, such as care homes; and with an increasing appreciation of the wider impact of the COVID-19 pandemic on other vulnerable population groups and social care and occupational settings.

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[18] Tew J et al (2020) Implementing the Care Act 2014: Building social resources to prevent, reduce or delay needs for care and support in adult social care in England, https://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/publications/prp-prevention-pdf-121219-acc.pdf

[19] PHE (2020) The older adults' NHS and social care return on investment tool: final report https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/860613/Older_adults_NHS_and_social_care_return_on_investment_tool_-_Final_report.pdf

[20] Oyebode O, Ramsay SE, Brayne C. Public health research in the UK to understand and mitigate the impact of COVID-19 and COVID-19 response measures. J Epidemiol Community Health. 2021 Mar 1;75(3):209-12.

Whilst to date the focus has been on mitigating the impacts of the pandemic, this successful alignment of academic endeavour could provide the momentum and the opportunity for a focus on primary prevention in adult social care, addressing the issues brought to light by Marczac and colleagues[6], and providing some focus on return on investment. Research could inform how prevention is conceptualised between and within local authorities, focus on how to improve collaboration between adult social care and health, and address the evidence gaps on how to effectively invest in primary prevention at the system level. The recent move toward the establishment of NIHR Health Determinant Research Collaborations based in local authorities is particularly welcome[21]. More research is needed to identify how best to promote healthy ageing and reduce prevalence, and mitigate the impact of disease and disability[22] [23].

6. Conclusion

In this paper we have pointed to a missing narrative in debates about the sustainability of social care for older people. We argue that there should be more emphasis on what can be done 'upstream' to support healthy ageing in communities and populations in order to reduce demand for social care.

We have set out some thoughts about the potential for 'venturing upstream' to stop people falling in the river (to draw on an often-quoted parable) and we have made some suggestions for action to be taken at a system level.

Our motivations in writing this paper are not only about the need to reduce demand for social care – although this is very important. We believe we should be supporting healthy ageing anyway, because preventing disability and dependency is good for everyone, and will help all achieve the most fulfilling and independent lives possible. We leave you with a quote from Hu and colleagues writing in 2020[3]:

'Due to population ageing, social care expenditure will continue to rise rapidly in the following decades … [therefore] promoting healthy ageing and other measures which seek to ensure that the prevalence rates of diseases do not follow recent trends or at least that their disabling effects are mitigated [will be essential]. The existing literature stresses that the prevention of chronic illness, disability and dependency plays a crucial role in the improvement of older people's quality of life and subjective wellbeing. Our analyses show that there is also a strong economic case for the prevention of disability and dependency: a reduction in the future prevalence of disability leads to a parallel decrease in care needs, which helps to address the financial challenges in the social care sector'.

[21] NIHR (accessed 2022) Health Determinants Research Collaboration https://www.nihr.ac.uk/documents/health-determinant-research-collaboration-hdrc-expression-of-interest-eoi-guidance-notes/28513

[22] Kingston A, Wohland P, Wittenberg R, Robinson L, Brayne C, Matthews FE, Jagger C, Green E, Gao L, Barnes R (2017) Is late life dependency increasing or not? A comparison of the Cognitive Function and Ageing Studies (CFAS), The Lancet, 390, 10103, 1676–1684

[23] World Health Organization (2017) Global Strategy and Action Plan on Ageing and Health, World Health Organization, Geneva. www.who.int/ageing/WHOGSAP-2017.pdf?ua=1