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*Concern*



# Healthy Ageing Evidence Review



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*This evidence review is part of a series produced by Age UK, in order to provide evidence to underpin decision-making for people involved in commissioning, service development, fundraising and influencing.*

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## Key messages

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- The overwhelming evidence on the spiralling health costs of an ageing population provide strong arguments for funding preventive approaches.
- Programmes that promote preventive approaches, such as the Partnerships for Older People Projects (POPPs) have been evaluated as being effective and cost-efficient.
- Health promotion services that are effective are often providing more than just activities and information – they involve adopting approaches that can change people’s behaviours.
- In general, peer mentoring can be very effective and cost-effective.
- Volunteering has benefits not only for society but for older volunteers, who often gain or regain a sense of usefulness and purpose.
- The lay health educator model (the Senior Health Mentor) has been effective in improving healthy behaviours and reaching hard-to-reach groups, and has the potential to be sustained as a low-cost model.
- There will be increasing pressure on costs and funding for services in the next five years, regardless of which politicians are in power.
- The **fit as a fiddle** programme includes a significant range of healthy ageing initiatives. There is still the opportunity to study it more closely for the purposes of future service development.
- International examples of Japan’s ‘Hureai Kippu’, or ‘Health Care Currency’ time-banking scheme and the US’s retirement campuses provide stimulating ideas as to how we might extend our active ageing strategy with suitable partners.

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# 1 Policy context

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The last ten years of government policy have included repeated commitments to achieving the goal of healthy ageing. The gap between policy aspiration and practical implementation has nevertheless remained, and could be considered to have widened during this period.

## Early national standards

*The National Service Framework for Older People*<sup>1</sup> sets an aim of extending the healthy life expectancy of older people, with a national standard that ‘the health and well-being of older people is promoted through a coordinated programme of action led by the NHS with support from councils’. By 2010, however, although the measure of healthy life expectancy at age 65 remains in the performance management system for the NHS, it is classified as a tier 3 priority, which means that it is one of a number that primary care trusts can choose to prioritise locally – or not (*The Operating Framework for the NHS in England 2010/11*).<sup>2</sup>

The National Service Framework (NSF) included the evidence base for a wide range of health promotion activities for older people with the strongest evidence found for increased physical activity, improved diet and nutrition, and immunisation programmes for influenza. It also emphasised the importance of older people being able to access whole population health promotion activities (such as smoking cessation) and the benefits of a much wider range of initiatives to improve health and well-being, for example, tackling poverty through benefits advice and support.

*Better Health in Old Age*<sup>3</sup> presented a very positive picture of progress against the NSF standard, but by 2006 this had been tempered somewhat. *A New Ambition for Old Age*<sup>4</sup> set out the next steps needed to implement the NSF, emphasising the economic case for high uptake of health promotion activities among older people and promising more opportunities for older people to increase their levels of physical, mental and social activities.

## White papers and reviews

A series of white papers and reviews on health have been published over the period. In 2004, *Choosing Health*<sup>5</sup> placed the emphasis on enabling individuals to make healthy choices and removing barriers for particular communities, including older people. The strongest message was that, with the exception of children and young people, the role of government was to enable healthy lifestyles, rather than to intervene. In 2006, *Our Health, Our Care, Our Say*<sup>6</sup> repeated the aims for promoting health and well-being in old age as: higher levels of physical activity; reducing barriers; and increasing uptake of evidence-based disease-prevention programmes.

Lord Darzi’s NHS Review in 2009 emphasised that building an NHS for the future demands a focus on helping people to stay healthy as well as treating them when they are sick. It committed to offering health checks to everyone aged between 40 and 74 over a two-year period (*High Quality Care for All*<sup>7</sup>). The Review stressed the importance of investment in prevention in the context of the economic downturn.

## More recently

The impossible challenge of running the NHS from the centre and the charge of too many top-down targets have led the Department of Health to redefine its role as setting an overall direction and supporting local delivery. Policy has often been framed as guidance which local NHS organisations can use or not as they see fit. It remains to be seen whether this is a sustainable approach in a period of severe financial restrictions.

The *Prevention Package for Older People*<sup>8</sup> was published as a series of resources to support PCTs in prioritising and commissioning services that promote the health, well-being and independence of older people. Resources published to date include those on falls, foot care, hearing services, intermediate care and discharge from hospital. Further resources have been promised on depression, continence and arthritis.

A continued focus on the health benefits of physical activity for older people can be found in commissioning guidance (*Let's Get Moving*<sup>9</sup>), and in the annual report of the Chief Medical Officer (*On the State of Public Health*<sup>10</sup>).

## Looking ahead

There is relatively little to distinguish between Labour and Conservative proposals for health after the election. At the end of 2009 the Government published a hastily prepared white paper (*NHS 2010–2015: From good to great*<sup>11</sup>) that promised a focus on prevention and helping people to stay healthy, linking this to the need for greater efficiency and productivity. In draft policies to date, the Conservative party has promised to change the Department of Health to a Department of Public Health, focusing much more on the prevention of disease than just on cure, and to provide separate public health funding to local authorities.

It is likely that these commitments to prevention and public health will be severely tested when the inevitable reductions in acute hospital services start to bite, whichever party is in government.

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## 2 Definition of healthy ageing

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The World Health Organization (WHO) defines **health** as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’.<sup>12</sup>

**Healthy ageing** is a concept promoted by WHO, that considers the ability of people of all ages to live a healthy, safe and socially inclusive lifestyle. It recognises the factors beyond health and social care that have a major effect on health and well-being, and the contribution that must be made by all sectors with an influence on the determinants of health. It also embraces a life course approach to health that recognises the impact that early life experiences have on the way in which population groups age.<sup>13</sup>

*The Case for Healthy Ageing: Why it needs to be made*<sup>14</sup> describes healthy ageing in the following way:

**Healthy ageing** may be considered as the promotion of healthy living and the prevention and management of illness and disability associated with ageing. Ageing can be thought of as an accumulation of changes over the life course that increases frailty. If we can design and execute effective interventions to prevent or delay the onset of chronic disease and increase healthy life expectancy, there will be social, economic and health dividends for us all. There is an appreciation that the locus of responsibility for the prevention and management of many chronic diseases lies with the individual through their behaviour and the recognition that a range of factors – socio-economic, environmental and cultural – influences this behaviour.

This points to one of the key challenges for the preventive approach – it is not just about providing good information and services. Crucially, it is about persuading people of the healthy ageing argument. Only when we have managed this will they adapt or change their behaviour to adopt a healthy approach.

Although this review looks at healthy ageing, much of the research we refer to relates to well-being. And indeed the quest for well-being is the key area of overlap with the other evidence reviews, as discussed above. We see this relationship as acutely relevant in that good health is both a component of wellbeing as well as a contributor to it. The Institute for Public Policy Research (IPPR, 2009)<sup>15</sup> adapts Nazroo<sup>16</sup> to identify five essential elements of well-being as:

- resilience
- independence
- health
- income and wealth
- having a role and having time.

We can see that health is one of these elements. But it is also clear that poor health will have a detrimental effect on attaining the other four – most obviously in the cases of independence, resilience and having a role.



A related and useful terminology is used by the Partnerships for Older People Projects (POPPs).<sup>17</sup> The programme assessed its impact on improving the quality of life using the Health-Related Quality of Life (HRQoL) 'domains': mobility, self-care, usual activities, pain/discomfort and anxiety/depression. With both, the focus is on outcomes and we can see a similar focus when we consider Age Concern's adoption of the seven outcomes in the social care Green Paper, *Independence, Well-being and Choice*.<sup>18</sup> These are:

- improved health and emotional well-being
- improved quality of life
- making a positive contribution
- increased choice and control
- freedom from discrimination or harassment
- economic well-being
- maintaining personal dignity and respect.

And closely related to these are the five areas that make up the Services Debate framework for developing services. These were developed from the results of the staff and partner questionnaire and the subsequent workshop:

- living independently
- having fun and keeping well
- coping in challenging times
- being in control
- participating and contributing.

So we can see there are a number of different ways to 'cut the cake'. But ultimately we are talking about the same ingredients interacting with each other to realise a wider more positive state of the human condition that we aspire for everyone to reach. And which we believe we can influence through providing services (and convincing arguments) that promote healthy ageing.

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## 3 The need for healthy ageing services

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WHO's Active Ageing Policy Framework<sup>19</sup> points out that despite the best efforts in health promotion and disease prevention, people are at increasing risk of developing diseases as they age. The following provides a précis of their analysis of particular risk areas.

**Smoking** – not only does this increase the risk for diseases such as lung cancer, it is also negatively related to factors that may lead to important losses in functional capacity. For example, smoking accelerates the rate of decline of bone density, muscular strength and respiratory function.

**Poor oral health** – primarily dental caries, periodontal diseases, tooth loss and oral cancer cause other systemic health problems. They create a financial burden for individuals and society and can reduce self-confidence and quality of life. Studies show that poor oral health is associated with malnutrition and therefore increased risks for various non-communicable diseases (NCDs).

**Alcohol** – while older people tend to drink less than younger people, metabolism changes that accompany ageing increase their susceptibility to alcohol-related diseases, including malnutrition and liver, gastric and pancreatic diseases. Older people also have greater risks for alcohol-related falls and injuries, as well as the potential hazards associated with mixing alcohol and medications.

**Nutrition** – eating and food security problems include both under-nutrition (mostly, but not exclusively, in the least-developed countries) and excess energy intake. In older people, malnutrition can be caused by limited access to food, socio-economic hardships, a lack of information and knowledge about nutrition, poor food choices (e.g. eating high-fat foods), disease and the use of medications, tooth loss, social isolation, cognitive or physical disabilities that inhibit one's ability to buy foods and prepare them, emergency situations and a lack of physical activity. Excess energy intake greatly increases the risk for obesity, chronic diseases and disabilities as people grow older. Insufficient calcium and vitamin D is associated with a loss of bone density in older age and consequently an increase in painful, costly and debilitating bone fractures, especially in older women.

**Medications** – because older people often have chronic health problems, they are more likely than younger people to need and use medications – traditional, over-the-counter and prescribed. Medications are sometimes over-prescribed to older people (especially to older women) who have insurance or the means to pay for these drugs. Adverse drug-related reactions and falls associated with medication use (especially sleeping pills and tranquilisers) are significant causes of personal suffering and costly, preventable hospital admissions.<sup>20</sup>

**Adherence** – it is estimated that in developed countries adherence to long-term therapy averages only 50 per cent. In developing countries the rates are even lower. Such poor adherence severely compromises the effectiveness of treatments and has dramatic quality of life and economic implications for public health. Without a system that addresses the influences on adherence, advances in biomedical technology will fail to realise their potential to reduce the burden of chronic disease.<sup>21</sup>

**Psychological factors** – including intelligence and cognitive capacity (for example, the ability to solve these problems and adapt to change and loss) are strong predictors of active ageing and longevity.<sup>22</sup> Often, declines in cognitive functioning are triggered by disuse (lack of practice), illness (such as depression), behavioural factors (such as the use of alcohol and medications), psychological factors (such as lack of motivation, low expectations and lack of confidence), and social factors (such as loneliness and isolation), rather than ageing per se.

**Physical environments** – older people who live in an unsafe environment or areas with multiple physical barriers are less likely to get out and therefore more prone to isolation, depression, reduced fitness and increased mobility problems. Hazards in the physical environment can lead to debilitating and painful injuries among older people. Injuries from falls, fires and traffic collisions are the most common.

**Vision** – worldwide, there are currently 180 million people with visual disability, up to 45 million of whom are blind. Most of these are older people, as visual impairment and blindness increase sharply with age. Overall, approximately 4 per cent of people aged 60 years and above are thought to be blind. The major age-related causes of blindness and visual disability include cataracts (nearly 50 per cent of all blindness), glaucoma, macular degeneration and diabetic retinopathy.<sup>23</sup> In all countries, corrective lenses and cataract surgery should be accessible and affordable for older people who need them.

**Hearing impairment** – leads to one of the most widespread disabilities, particularly in older people. It is estimated that worldwide over 50 per cent of people aged 65+ have some degree of hearing loss.<sup>24</sup> Hearing loss can cause difficulties with communication. This, in turn can lead to frustration, low self-esteem, withdrawal and social isolation.<sup>25,26</sup>

*The Case for Healthy Ageing*<sup>27</sup> sets out the challenges we are facing as follows.

It is estimated that by 2018 there will be in the UK:

- nearly 7 million older people who cannot walk up one flight of stairs without resting
- 1.5 million older people who cannot see well enough to recognise a friend across a road
- over 4 million people with major hearing problems
- up to a third of a million people aged 75+ with dual sensory loss
- over a million people aged 75+ who find it very difficult to get to their local hospital
- a third of a million people who have difficulty bathing
- nearly a million people with dementia.

*Improving Care and Saving Money*<sup>28</sup> adds that:

- Approximately 1.26 million adults receive local authority-funded social care now.
- Over 1.7 million more adults are expected to need care and support in 20 years' time.
- In the next 20 years, the number of people over 85 in England will double, and those over 100 will quadruple.
- A fifth of the population of England is over 60, and older people make up the largest single group of patients using the NHS.
- Older people in the UK use three-and-a-half times the amount of hospital care of those aged under 65, and almost two-thirds of general and acute hospital beds are in use by people over 65 (much of this provision is for people in the last 12 months of their lives).

- Older people currently account for nearly 60 per cent of the £16.1 billion gross current social care expenditure by local authorities, and despite a recent downward trend, those aged over 65 still account for approximately 40 per cent of all hospital bed days, with 65 per cent of NHS spend being on those aged over 65.
- Injury due to falls is the leading cause of mortality in older people aged over 75 in the UK.

The rationale for FAAF<sup>29</sup> comes at this from a slightly different angle, noting the challenges around activity and diet (and older men).

1. By 2020, over half of adults in the UK will be over 50 years of age. The persistent trend that the 'older you are, the less you participate' (*A Vision for 2020*, Sport England, 2004), has huge significance for society as a whole, particularly in terms of bringing together older people with younger, more active generations. The challenge is immense. Only 17 per cent of men and 13 per cent of women aged 65–74 take sufficient exercise to meet the international guidelines of half an hour's exercise of 'moderate intensity' on at least five days a week. For those aged 75 and over, this falls to 8 per cent of men and 3 per cent of women.
2. There is also a growing prevalence of obesity in society through poor diet, from which older people are not immune. The main contributing factors are lack of motivation, bad eating habits, fatalism, and health, dependency or disability problems, with falls being a major cause of disability and a leading cause of death for the over-75s. Conversely, disease and illness can also be common causes of under-nutrition. This picture is complicated by the difficulties certain groups have in choosing to eat healthy food due to frailty and availability.

3. Research has also shown that it is difficult to engage older men in health issues: in line with notions of masculinity, older men tend to tough out illness and they are less likely than women to seek help for problems such as depression (*Working with Older Men – a review of Age Concern services*, Age Concern, 2006).

IPPR's *Older People and Wellbeing*<sup>30</sup> noted that:

- There are 1 million socially isolated older people and this number is projected to rise to 2.2 million in the next 15 years.
- The risk of depression as a result of crime can persist over a long period of time.<sup>31</sup>
- The physical fabric of the environment is a big concern.<sup>32</sup>
- The urban environment can have intensely bad neighbourhoods and negative impacts on well-being, but conversely, having a community role (and feeling able to influence the environment) decreases depressive symptoms.<sup>33</sup>
- Older people, though, are more worried about traffic than teenagers, crime and drugs.<sup>34</sup>
- The quality of older people's housing is very important as they are particularly likely to spend long periods of time at home.<sup>35</sup> It is estimated that 2.2 million households with a person over 60 live in unfit housing.<sup>36</sup>
- Living alone is an obvious risk factor. There is a greater proportion of older men living alone now, but women still predominate (75 or over).
- Age discrimination excludes older people from a wide range of services, public places, community life, leisure activities, employment, mainstream culture, media and public debate.

The above headline statistics show overall figures for older people, as well as the occasional insight into the situation of particular groups.

Any deeper analysis for service development would benefit from identifying particular groups and assessing the research relating specifically to them. The IPPR<sup>37</sup> says that certain groups are most at risk from poor emotional well-being – the poorest, the very old, some BME groups, those most isolated, in worse physical health, and those without an active social or community life. Poor health affects over a quarter of all people over 75, making that group particularly vulnerable to depression, social isolation and exclusion.

Stresses associated with poverty are: making ends meet; poor housing; the wider physical environment; fear of crime; poor physical health – these are greater the more deprived you are, and are associated with poor emotional well-being.

Events and transitions in life that can trigger poor mental well-being include: poor physical health; bereavement; retirement; divorce; illness of a close partner; taking on caring roles. These are often associated with a first episode of depression<sup>38</sup> but can be mitigated by the support structures people have, such as family and friends.

***Fitter older adults have better cognitive function, with even gentle exercise helping to reduce stress, ease depression and anxiety, and enhance mental well-being.***





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## 4 What kind of factors and approaches address these issues?

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*At Least Five a Week*<sup>39</sup> references a wide body of evidence on the beneficial effects of physical activity for older adults on well-being and quality of life:

**Mobility** – people with higher levels of lifestyle physical activity and sport are more likely to maintain mobility.

**Muscle strength** – regular strength training using external weights or body weight has been shown to be highly effective in increasing or preserving muscle strength, even into very old age. The increase in muscle strength is accompanied by improvements in functional mobility, such as walking speed.

**Falls** – exercise programmes, particularly strength training, have been shown to be highly effective in reducing subsequent incidence of falls among older people. In programmes combining strength, balance and endurance training, the risk of falls was reduced by 10 per cent; programmes with balance training alone reduced the risk by 25 per cent; and tai chi reduced the risk by 47 per cent.

**Bone health** – physical activity can produce a beneficial bone response in all adult ages, although old bone responds more slowly than young bone.

**Emotional well-being** – physical activity can help improve the emotional and mental well-being of older people. Physical activity is associated with reduced symptoms of depression. It can also reduce anxiety in older people and enhance mood, even where there is no evident improvement in fitness. Rehabilitation programmes that incorporate physical activity have had a positive effect on the emotional functioning and mental health of older people.

### **Enhancement of cognitive function –**

there is limited evidence that physical activity can improve at least some aspects of cognitive function among older people. Better cognitive performance in older age – particularly in those tasks that are attention demanding and rapid – is associated with increased aerobic fitness, physical activity and sport participation.

### **Prevention of cognitive impairment –**

physical activity may offer some protection against problems of serious cognitive impairment in old age. Two prospective studies show that high levels of physical activity reduce the risk of cognitive impairment – Alzheimer’s disease and dementia. One of these studies, with women aged 65-plus, indicated that those with a greater physical activity level at baseline were less likely to experience cognitive decline during the six to eight years of follow-up.

**Self-efficacy** – physical activity programmes that aim to increase self-efficacy through a cognitive-behavioural approach have been successful in changing behaviour. This work is important because there is strong evidence that initial low self-efficacy for physical activity is one of the most important determinants of functional decline with chronic knee pain, of risk of falling, and of future engagement in physical activities.

**Physical symptoms** – positive effects on fatigue and energy have been shown in patients with heart failure and chronic obstructive pulmonary disease, and in healthy older people. For every six to ten older people attending a cardiac rehabilitation programme, at least one will have a meaningful improvement in health-related quality of life.



**Social functioning** – remaining physically active in older age may offer opportunities for maintaining independence. Daily routines involving walking to local shops may mean less reliance on others while at the same time promoting social and community interaction

*The Case for Healthy Ageing*<sup>40</sup> recommends a range of areas where there are opportunities to improve healthy ageing. These are quite broad, not just detailing service priorities but identifying opportunities to influence provision:

- advice on the review of prescribed medicines
- foot care, especially simple nail-cutting services
- increase the take-up of physical activity, as it can reduce coronary heart disease, certain types of cancers and diabetes, prevent post-menopausal osteoporosis and osteoporotic fractures, reduce accidental falls, and increase social participation – we need accessible, affordable and well-managed opportunities for individuals and groups, that are properly signposted
- vision – we need regular eye tests; the cost of glasses and transport have been identified as barriers
- incontinence – affects 3 to 5 million people, and can ruin a person's life if not properly treated, isolating them at home
- dental care – services need to be more flexible and we must ensure that services are properly targeted at where they are needed
- nutrition / malnutrition – a mix of health promotion and improved hospital services
- hearing – we need better audiology services
- falls and osteoporosis – better falls services and assessments
- health trainers – operating health promotion campaigns, ideally employing older people as peer mentors
- mid-life health check – a lifecheck tool for the over-60s
- vascular checks – better screening
- screening programmes – especially flu and breast cancer.

The rationale for FAAF,<sup>41</sup> and the WHO's Active Ageing Policy Framework<sup>42</sup> draw out the following points on activity, diet and the physical environment. The rationale for FAAF follows this, but also stresses the important links between physical activity and mental well-being:

We are now recognising the important role that appropriate exercise and nutrition can play in promoting healthy ageing and reducing the decline that accompanies ageing (e.g. improvement of cardiovascular function, the reduction of risk of several diseases, increase in life expectancy, improved muscle and bone strength, leading to a lesser risk of falling).



Similarly, evidence shows that fitter older adults have better cognitive function, with even gentle exercise helping to reduce stress, ease depression and anxiety, and enhance mental well-being.<sup>43</sup> Indeed, a comprehensive review on mental health promotion for older people<sup>44</sup> shows that most enhanced and positive mental well-being comes from participating in physical activity. Rather than considering older people to be past the point of reaping these benefits, research concludes that there is no section of the population in which it is more worthwhile and necessary to promote physical activity.<sup>45</sup>

The WHO Active Ageing Policy Framework says:

Participation in regular, moderate physical activity can delay functional declines. It can reduce the onset of chronic diseases in both healthy and chronically ill older people. For example, regular moderate physical activity reduces the risk of cardiac death by 20–25 per cent among people with established heart disease (Merz and Forrester, 1997). It can also substantially reduce the severity of disabilities associated with heart disease and other chronic illnesses (US Preventive Services Task Force, 1996). Active living improves mental health and often promotes social contacts. Being active can help older people remain as independent as possible for a long period of time. It can also reduce the risk of falls. There are thus important economic benefits when older people are physically active. Medical costs are substantially lower for older people who are active (WHO, 1998).

Despite all of these benefits, high proportions of older people in most countries lead sedentary lives. Populations with low incomes, ethnic minorities and older people with disabilities are the most likely to be inactive.

Policies and programmes should encourage inactive people to become more active as they age and to provide them with opportunities to do so. It is particularly important to provide safe areas for walking and to support culturally-appropriate community activities that stimulate physical activity and are organised and led by older people themselves. Professional advice to ‘go from doing nothing to doing something’ and physical rehabilitation programmes that help older people recover from mobility problems are both effective and cost-efficient.

The Institute for Public Policy Research (IPPR) broadens out the picture, adding the wider elements of education and learning and social and community participation. In its *Older People and Wellbeing*,<sup>46</sup> IPPR argues:

Education and learning is a significant indicator of emotional wellbeing in later life (but community-based funding is highly limited). Taking on an active grand-parenting role can be good for wellbeing (but not suitable for all). The most important factors underlying good mental health and wellbeing are social and community participation – many older people say the most important thing is to feel wanted and needed by others (Lee 2006).

The IPPR and FAAF have plenty to say about volunteering. It is associated with increased life satisfaction and is important for charities that depend upon it.

With many people, the point of retirement is a critical phase. It can result in loss of status and too much unfilled time on people’s hands. Volunteering can help older people find a role outside their home and family. Community Service Volunteers (CSV)<sup>47</sup> has described the benefits that volunteering brings with it:

1. A sense of purpose – volunteering made them feel useful and needed once more.
2. A sense of achievement.
3. A structure to life – volunteering provides activities within a meaningful framework.
4. Social benefits – several of those interviewed welcomed the chance they now had of meeting new people and extending friendship circles.

There are, however, barriers to taking part, such as people's skills and fears. Volunteering rates fall as we get older and start falling off from when we retire.<sup>48</sup> The IPPR<sup>49</sup> suggests that we need to take a fresh approach, especially with the over-75s. It identifies 75 as an age where people's well-being has peaked and generally starts to decline quite rapidly.

**Personal resilience** – self-esteem is a powerful predictor of low-level depression. Good social support and an active social life can lessen the effect of low self-esteem.

**Religion** – it gives many a sense of purpose and a social network.

**Respect** – feeling valued and respected contributes to good mental health. It can be fostered through older people's active contribution and participation in schools and other groups. Lack of respect is linked to feelings of being excluded from the mainstream of society.

The rationale for FAAF<sup>50</sup> looked at two important reports. These sought the views of older people directly and evaluated findings on their knowledge, attitudes and preferences regarding their choice of healthy lifestyles.

1. *Promoting Mental Health and Well-being in Later Life*, the first report of the independent UK Inquiry into Mental Health and Well-being in Later Life (Age Concern and the Mental Health Foundation, 2006) showed there are five main factors that impact on older people's mental health and well-being: discrimination; participation in meaningful activity; relationships; physical health; and poverty.

- Older people feel that being able to make contributions to society (and being recognised for them) is good for their mental well-being. Volunteering was identified as a key way of making contributions and participating in society.
- Older people also identify physical activity and maintaining a good diet as the key components of physical health which can have positive impact on their mental well-being.
- The Inquiry report concluded local-level action will make the most difference, and recommended that healthy ageing programmes should be established to encourage older people to take advantage of opportunities for meaningful activity, social interaction and physical activity. Specifically, the Inquiry recommended that such active ageing programmes should promote mental as well as physical health and well-being in their design, delivery and evaluation.

2. *As Fit as Butchers' Dogs?*, the report on healthy lifestyle choice and older people (National Consumer Council and Age Concern, 2006) showed that:

- older people feel that a positive outlook and zest for life is a key factor of health, both in terms of physical and mental well-being
- supportive contact with others is critical for both physical and mental health
- there is a lot of scope for better publicity of facilities that exist and support to provide 'routes' for older people
- information about what is available is not reaching all those who would be interested.

Some groups need more intervention than others, particularly those who present attitudinal barriers.

There is also a strong case made for the contribution towards healthy ageing of National Falls Awareness Days (NFAD) and their successors, National Falls Awareness Weeks (NFAW) in the annual evaluations and in Don't Mention the F-word.<sup>51</sup> The effectiveness of a tailored exercise programme devised by Dawn Skelton and her team on preventing falls and the dramatic negative effects of falls on the future health and well-being on older people are highlighted in the annual awareness campaign.

The series of NFAD and NFAW reports outlines the scope of the national awareness campaign which aims to reduce the human and financial cost of falls (4 million bed-days in English hospitals every year and a cost to the economy of at least £1.7 billion annually).

In recent years, the awareness campaign has focused public attention across the country on falls in the home (stairs), in the street (pavements) and on buses. As an element in the original NFAD scheme, the Minority Ethnic Elders Falls Prevention (MEEFP) programme played a significant part in spreading the message of falls prevention and targeted exercise to previously hard-to-reach groups of older people.<sup>52</sup>

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## 5 Services delivered and their effectiveness

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The major service evaluations for this evidence review are as follows.

### **Ageing Well Programme Final Evaluation Report<sup>53</sup>**

This was an innovative programme that ran and expanded from about 1993 to 2007. It enabled older people to become involved in local initiatives designed to improve physical, social and emotional health and well-being.

It was delivered via volunteers and co-ordinators at local level. Many volunteers trained as Senior Health Mentors, following the model used successfully in the USA of the 'lay health promotion' model. The training programme consisted of eight core sessions of about 75 minutes' duration each. There was also a core training pack that volunteers could refer to and build on, but this wasn't used as much as was anticipated. Programme activities were far-reaching, from leaflet and verbal advice about healthy living to a variety of forms of exercise and social activities. Clients were charged for taking part in some activities. The results of the evaluation questionnaire suggested that a majority of the clients would be willing to pay fees to take part.

The programme demonstrated benefits for participants and volunteers, but primarily through the recording of qualitative feedback rather than any quantitative analysis of health improvements against baseline positions. The evaluation did not include a cost-benefit analysis, although the evaluators recommended this for further research.

Many of the health challenges that are identified here were addressed and an innovative peer-to-peer approach was used in an attempt to increase the uptake and response to its messages over traditional 'professional' sources. However, this did lead to some uncertainty as to the status and role of the mentors, who, it seems, were often uncomfortable with the formal title of Senior Health Mentor and tended to refer to themselves just as volunteers.

Age Concern updated the training pack for volunteers in 2009. The role is now described as Health Mentor. Many of the current FAAF projects are using this approach.

### **Health Trainers and Health Trainer Champions**

In 2004, *Choosing Health*,<sup>54</sup> the public health white paper, introduced NHS Health Trainers to provide advice, motivation and practical support to individuals in their local communities. Health Trainers reach out to people who are in circumstances that put them at a greater risk of poor health. They often come from, or are knowledgeable about, the communities they work with. In most cases, Health Trainers work from locally based services which offer outreach support from a wide range of local community venues.

Health Trainers work with clients on a one-to-one basis to assess their health and lifestyle risks. They have facilitated behaviour change, providing motivation and practical support to individuals in their local communities, since 2006.

Health Trainer Champions work with Health Trainers by providing clients with information and signposting them to the NHS and other community services that will help them to live healthier lifestyles and access the support they need.



More than 3,000 trainers and champions have been trained and they have seen more than 60,000 clients. While the final evaluation is not due until October 2010, there have been a number of studies of the programme along the way. Key findings included:

- Peer education is a successful technique in providing information and facilitating behaviour change in a culturally competent way.
- The use of lay workers can also be a sustainable model when funding for a project ends.

Multi-level interventions are likely to have the most significant impact on health inequalities.<sup>55</sup>

### **Prevention in Practice<sup>5</sup>**

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This publication contains 24 case studies of services that demonstrate the advantages of taking a pro-active approach in tackling the issues faced by many older people. Many of these examples refer to health services that both provide a much-appreciated service to older people, often in their homes, as well as preventing those same people from being significantly debilitated or put into a spiral of declining health by the lack of a small but essential service.

The value of the service is assessed not only through the words of the users but through their alignment to commissioning criteria and the targets they address, as well as, in some cases, comparisons with the much greater costs of not providing the service (i.e. the cost of hospital admissions).

This brings home the necessity of addressing a locally identified need and then providing a local solution (that meets the terms of the local commissioning practice/framework) to address it.

Examples of the services provided by Age Concerns include the following.

### **West Sussex Activity Centres**

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Failing day centres were transferred from the local authority to Age Concern. A range of activities and a hot meal are provided in a safe environment. In addition, formal and informal health support, such as chiropody and social support, are signposted to the client. Costs are supported by the Age Concern.

### **Oldham Community Café**

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The café provides affordable, good-quality food and acts as a hub for some other services, including learning opportunities. It is run as a social enterprise.

### **Gloucestershire Men in Sheds**

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Older men are encouraged into a group where they can use manual skills, knowledge and expertise to repair and refurbish hand tools in a social group, which is lottery-funded. The project came to a close in summer 2009 when funding ran out.



### Surrey Nordic Walking

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A **fit as a fiddle** project offering taster sessions and courses, and training people as walk leaders. It is claimed that there are greater health benefits than for ordinary walking groups; but there are some equipment costs.

### Age Concern Older Offenders' Project (ACOOP)

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Social care, advice and support to older offenders and their families, in prison, pending release and in the wider criminal justice system. The support group aims to improve general health and well-being, and reduce isolation.

### Supporting Older LGBT Communities in Central London

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This lottery-funded group holds regular social activities, offers telephone advice, befriending and signposting/referrals to agencies. It is intended to reduce social isolation, improve well-being, increase dignity and to enable people to participate in control of the services that are offered.

### Kingston Healthy Eating Lunches

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A one-year intergenerational project funded by the Department of Health, which promotes positive behaviours in young and old through a range of activities centred around a shared lunch.

### Sole Mates Footcare Service, Oxfordshire

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This affordable service is available in people's homes or at community venues, GP surgeries, etc. Funded by the county council and local primary care trusts, it provides a simple care service, mainly toenail-cutting, improving independence and mobility.

### Timebank, Gateshead

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Originally funded as part of a two-year LinkAge Plus project, this applies a model of mutual support. Participants use time and skills to benefit those around them and benefit from the help that others are able to give. Earned time-bank credits can then be cashed in for help and support.

### National Falls Awareness Days (NFAD) and Minority Ethnic Elders Falls Prevention Programme (MEEFP)

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A strong case has been made in the annual evaluations of the programmes (NFAD reports and the two MEEFP evaluations). A good summary of the advantages of raising awareness of falls is made in *Don't Mention the F-word* and *A Case for Healthy Ageing*.

The NFAD and MEEFP evaluations contain many small-scale examples of successful awareness-raising, but they are primarily a record of activity: specific programmes have not yet been assessed on a cost-benefit analysis basis.

There is scope for future research that not only gives a clearer picture of the national scale, but which could analyse and quantify the effect of awareness-raising in terms of lives saved, disability avoided, quality of life years gained, etc. It seems appropriate that, for one of the services that we believe saves lives and injury, there should be an evaluation that gives concrete proof of effectiveness.

### fit as a fiddle<sup>57</sup>

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In lieu of an evaluation of the programme, we summarise what the programme expects to accomplish. The Surrey Nordic Walking project described above in the ‘*Prevention in Practice*’ section is an FAAF-funded project.

The FAAF activities are intended to:

- enable more older people to participate in activity
- enhance the capacity of NHS bodies and local authorities to ensure that local facilities and services support healthy lifestyles and are accessible to older people of all ages; and promote, disseminate and target healthy-eating resources
- develop partnerships on a national and regional basis with health professionals, sports partnerships, public and private bodies to encourage working with older people to provide information, advice and support.

The programme can contribute towards the health and well-being of older people by:

- promoting independence and mobility
- engaging and consulting with older people
- improving and integrating local services for older people
- promoting social inclusion and addressing health inequalities
- developing strategic partnerships
- preventing ill-health, disease and disability
- preventing accidents among older people.

### Improving Care and Saving Money – Partnerships for Older People Projects (POPPs)<sup>58</sup>

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The evaluation argues that promoting independence of older people through a strategic shift to prevention and early intervention can produce better outcomes and efficiency for health and social care systems. The approach was designed to increase learning about how to promote older people’s independence, particularly through joint approaches to reducing their/our reliance on long-term institutional care and hospital admissions. The evaluation shows that better outcomes appear to be aligned with approaches which target the right people at the right time and provide personalised responses focused on *working with* the person rather than *doing for* them.

POPPs have increased the evidence base on the benefits of prevention, early intervention and integration by promoting joint approaches to independence in place of hospital or long-term institutional care.

The key messages are:

1. meeting people’s needs with a preventive approach can create efficiencies
2. efficiencies are available across the health and social care system
3. quality of life can be improved through preventive approaches
4. involving older people is important, especially in governance and evaluation
5. preventive services can be sustained (as they often win the argument – by demonstrating their cost benefit – for continuation funding)

- 6. health commissioners have made a significant contribution
- 7. there were a number of effective interventions
  - a. complex need projects were particularly successful
  - b. co-located teams with pro-active case co-ordination improved effectiveness.

Small-scale services providing practical help and emotional support can significantly improve the health and well-being of older people, alongside more sizeable services designed to avoid the need for hospital admission.

### Neighbourhood warden schemes

Neighbourhood warden schemes are particularly good at encouraging hard-to-reach older people to participate in activities such as exercise classes. Their personal and local knowledge enables wardens to assess needs and recommend appropriate activities.<sup>59</sup> These schemes are particularly useful for prevention, as they are able to provide early intervention.

### LinkAge Plus

The LinkAge Plus programme aimed to ‘test the limits of holistic working between central and local government and the voluntary and community sector to improve outcomes for older people, improving their quality of life and wellbeing.’<sup>60</sup> It did this by bringing together different forms of mutual help, services and support at the local level.

The programme started and finished with older people themselves, involving them through local groups and forums in planning and delivering provision.

A key principle was shifting the perception of ageing from one of dependency and decline to one of active citizenship, participation and independence.

The pilots showed that working in partnership, involving older people and delivering services that aim to give ‘that little bit of help’ with daily living can make a difference to the quality of life for older people in a cost-effective way.

Benefits from the LinkAge Plus approach fall into three main areas:

1. there are benefits to both taxpayers and older people from a holistic approach to service delivery, in which the voluntary and statutory sectors work together to improve access, remove duplication and overlap, and share resources
2. the approach has facilitated key services to help maintain independence and improve the well-being of older people, in a cost-effective manner
3. the pilots demonstrated that information and access to services can be improved through partnership working and through a range of innovative approaches to outreach as trialled by the pilots.

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## 6 Services in other countries

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McCormick and colleagues suggest that we move beyond the traditional healthy-ageing focus on healthcare and pensions, looking to innovative ideas and practice for healthy ageing. Looking at examples of practice internationally, four principal pillars of healthy ageing emerge:

- relationships
- work
- lifelong learning
- built environment.<sup>61</sup>

### Relationships

McCormick and colleagues argue that we need to move away from centralised programmes that deliver a service in isolation to enabling and harnessing everyday relationships. We should recognise that where relationships are built first, access to resources and services often follows.

An excellent example of this principle in practice is Japan's 'Hureai Kippu', or 'Health Care Currency' scheme, a time-bank scheme for care of older people. Volunteers earn credits (in hours), based on both the amount of time given and the arduousness of the task(s). Credits can later be used for oneself, or transferred (i.e. to an older relative living far away) to provide for one's own or one's relative's care in older age. It has been found that people prefer the scheme to paying for services because they build better relationships with carers. Users also prefer the scheme to relying on charities for services because reliance on charities makes them feel dependent.

### Work

Encouraging older persons to continue working is often valued for its role in closing the pension gap. However, continuing work (paid or unpaid) can also allow older people to maintain a sense of purpose, to maintain or create social relationships, and to engage in productive activities. It can ease the loneliness, isolation, and boredom that retirement sometimes brings.

An excellent example of this principle in practice is the United States' Experience Corps scheme. Operating in 23 cities, the Experience Corps is an intergenerational project that brings volunteers aged 55+ into primary schools for ten to 15 hours per week. Volunteers receive a \$100–300 stipend per month. The programme has been found to improve the physical and mental health of older persons, to provide a meaningful and valued activity, to provide cognitive and physical stimulation to older persons, and to enable social interaction across age groups. Both participation in and satisfaction with the programme are very high.

### Lifelong learning

The third pillar of healthy ageing is learning. Learning builds self-esteem and provides a sense of agency, while increasing social interaction and allowing the development of skills that may help one cope with life's challenges. Unfortunately, learning tends to be geared toward the young or to adults when it is occupationally related (for example, helping adults update skills to transition into or find a new job). A number of initiatives that bring learning to older adults have found that there are three essential elements to a successful programme. A communal learning environment, peer-to-peer teaching methods, and empowering older learners to participate rather than simply imparting knowledge to them are essential features of learning programmes for older persons.

## Built environment

Finally, the built environment is important to healthy ageing. We need to recognise that there are increasing numbers of older persons living alone, who may be less mobile. The built environment should connect older people to services, activities, and other people. The built environment should allow 'ageing in place' both by helping people to stay in their own homes and to move beyond them.

An innovative example of blending the built environment with older persons' needs can be found in the United States' University-Linked Retirement Communities. Fully inclusive retirement communities, where the older person exchanges their estate for a place in a community, are not new. Residents start out in a self-contained apartment, moving into assisted living units, skilled nursing centres, and/or a dedicated Alzheimer's wing, as necessary. What is innovative is building these retirement communities adjacent to major universities.

There are currently about 60 ULRCs in the US. By linking to universities, the communities encourage an active lifestyle, involving learning and intergenerational contact (while also providing benefits to the university such as student jobs and income from land leasing or sales).

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# Notes

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