What works to help Older People stay happy and well at home for longer?

Summary Report

**IMPACT Facilitator Project 2023/24 (Northern Ireland)**

University of Ulster / Southern HSC Trust Adult Community Services

Orla Fitzsimons, November 2024

IMPACT is a UK centre for implementing evidence in adult social care, with the vision that ‘good support isn’t just about ‘services’ – it’s about having a life.’ In pursuit of this, the key objectives for the centre are to enable practical improvements on the ground and make a crucial contribution to longer-term cultural change.

IMPACT Facilitators are focused on supporting bottom-up change. They work within a local organisation leading an evidence-informed Theory of Change project. Findings and outcomes are shared for replication across the sector.

# Project Background

The Southern HSC Trust has a workforce of 14,887 and provides health and social care services to a population of 383,541 adults and children, from the council areas of Armagh City, Banbridge and Craigavon: parts of the Newry Mourne and Down Council area and the Mid Ulster Council area. The Southern HSC Trust provides health and social care services to the residents of these areas, and to others who travel in, at a cost of nearly £2.6 million each day.  This remit includes areas of deprivation and rural areas, and there are inequalities in health and life expectancy by locality (Southern HSC Trust Corporate Plan 2023/2024).

In Northern Ireland, the population aged 65 and over, increased from 13% in 1997 to 17.5% in 2022 (NISRA, 2022). By 2028, one in five people in Northern Ireland are expected to be over the age of 65, with the population ageing at a faster rate than other areas of the UK (Age Northern Ireland, 2021). By 2039 the population aged 65+ will have increased by 74%, with growing complexity of need *(DoH NI (2016) Health and Wellbeing 2026:Delivering Together,p7).* This represents an increasing challenge in terms of the demands on health and social care services in Northern Ireland, and to the current and future wellbeing and independence of older people living at home and in their communities.Longevity is something to be celebrated and represents significant advances in healthcare, however, the increase in the older population unavoidably increases the resource required for support.

# Pre-Project Evidence

## What did the evidence tell us?

The initial evidence review found that, whilst everyone ages, there is a range of considerations which effect the likelihood of someone facing challenges to living well in their own home. For instance, ageing is more closely associated with experiences and situational factors (such as retirement or death of a partner) than chronological age, and socioeconomic factors such as poverty impact considerably on the ability for individuals to remain well at home. This suggests a benefit to targeted and bespoke approaches to supporting older people in their own home.

As well as noting the importance of personalised approaches to keeping individuals well at home, the review identified common challenges. Loneliness was often reported, with social support (including that provided by carers) noted as a factor that allowed people to stay happy and well at home for longer. Social prescribing was raised as a potential option to improve social connections. Additional systemic improvements suggested included better links between health and social care, including GPs and health outreach visits, as well as preventive visits focused on collaborative planning.

The review also noted that there was a lack of consistent understanding amongst policymakers and those who commission services about ‘prevention’: the initial language proposed for this project. There was a lack of clarity around what it means, what the aims are, and what its success looks like. It was observed that those who hold a budget for prevention are often unclear on the evidence and how it should be effectively used, to produce the most benefit. The concept of ‘prevention’ whilst represented in legislation remained elusive in practice.

The full IMPACT Evidence Review conducted prior to the start of the project can be read here:

https://impact.bham.ac.uk/our-projects/facilitators/preventative-approaches-for-older-people/

# Project Engagement

## What did we do in the Southern HSC Trust?

Along with the host organisation, a local Theory of Change was developed and following project aims agreed:

* Gain a wide range of perspectives of older people and their family carers; and staff who provide services for them, on what would be preventative and support them in their own homes and communities
* Suggest evidence-informed ways of increasing preventative approaches

The main activities were

**Gathering the views** of older people, their family carers and Southern HSC Trust staff and managers providing services to older people, as well as local community and voluntary organisations staff, volunteers and managers, providing services to older people to gain their views. Everyone was asked the same questions:

* What do you think works well in helping older people stay happy and well at home for longer?
* What do you think are the main issues in older people staying happy and well at home for longer?
* What do you feel can and should change, to help older people stay happy and well at home for longer?

Between March and June, 2024, 120 people participated either in group or individual meetings, online using Microsoft Teams, in person or via telephone:

* Older People – (n=61; 51 in group discussions in support groups and 10 individual telephone conversations)
* Family Carers of Older People (n= 8; 5 in a carers support group meeting and 3 individual telephone conversations)
* SHSCT staff and managers working with older people and family carers – (n= 41)
* Community and Voluntary Sector staff, managers and volunteers working with older people and family carers, in the SHSCT geographical area (n= 10)

**Sharing the findings and making recommendations:** Towards the end of the project, two co-production events were arranged by the project Facilitator in Newry and in Armagh to bring together older people, family carers and staff in local SHSCT services for older people, and local community and voluntary organisations.

A group of people sitting around a table

Description automatically generated

The aims of these events were to:

* Share with the wider community what older people, their family carers, staff and volunteers in local services had said during the engagement process in relation to what is important to them about helping older people to stay happy and well at home for longer.
* Discuss ‘what works’ in helping older people stay happy and well at home for longer based on the project findings,
* Discuss how we can work together with the SHSCT and other local agencies, local communities and services, to promote and develop ‘what works’, ‘why does it work’ and ‘for whom does it work’,
* Discuss what factors might help all project stakeholders to work together, to do this.

A total of 22 people attended these events.

**How the coproduction event worked**

The IMPACT Facilitator shared the themes of what all four stakeholder groups had said during the project. Attendees at the two coproduction events were then invited to discuss what had been said to date, using a summary document of the project findings called the ‘We Believe Workbook’ (Dewing et al 2014). Attendees were supported during the discussion, by a nominated ‘table facilitator’ who guided the discussion, recorded notes on what people were saying and then shared key points with the room. The event concluded with the IMPACT Facilitator summarising what had been said from the flip chart record, and inviting final comments.

# Project Outcomes

Conversations with the four groups of stakeholders produced insights which were categorised into key themes. These were: social connections, physical wellbeing, practical support, support for carers and service delivery. Each theme will be considered in more detail in the following sections. Those who attended the coproduction events supported the findings and offered observations that powerfully summarised the core issues. These observations have been included at the end of each key theme.

# Social Connections

The importance of social connection was a key theme in the conversations, and people sought to avoid loneliness through retaining or building relationships that gave a sense of belonging. All stakeholders spoke about the value of a ‘community of caring’ and being with people who treated each other with care and compassion. This need for connection was noted across all services: between staff and older people, but also between carers, between staff, and between older people.

Older people emphasised the importance of social connections for their wellbeing. A clear preference for in-person connection was expressed, or if impractical, for conversations on the telephone. Many centred connections with friends and family:

*“my daughter makes my dinner most nights and seeing her every day is really important to me.”*

For others, organised groups provided this social connection, and some older people spoke about the joy of an expanding and changing social circle:

*“Networking with others is really important to me – and fun!”*

*‘Really look forward to this group. Only £2 collected each week and I get a chat with everyone – we love listening to each other’s tales of woe!’*

As well as noting the benefits of their group, this older person raised cost as an important issue. For some, cost presented a barrier to accessing groups. With tight budgets for many, even a nominal fee could be prohibitive to being able to access a group. As well as groups, others benefitted from social connections with volunteers at support services:

*“I use the Good Morning service and that is really great, getting to chat to someone every day when I can’t get here to this group.”*

The Good Morning service was also valued by professionals, especially where an in-person service is unavailable or inaccessible. Many older people found themselves in these circumstances, where they felt unable to get the social connection that they wanted within their community. One explained:

*“I want to be connected more to my community, but this has been a problem as day centres/respite centres locally can’t cater for all my needs unfortunately, so I’m stuck in the house all the time.”*

Staff members noted that for some, this can result in what they described as ‘inappropriate contact’ with medical professionals: where older people make appointments with professionals such as GPs for conversation, as an attempt to alleviate loneliness. This suggests a need to enhance the offer of voluntary and other community-based groups; something that those participating in the coproduction events strongly agreed with. This is discussed further under the Service Delivery theme.

Co-production event participants stressed the need for older people to feel they belonged to their communities, to be connected and to experience real relationships and feel valued as a person. Some shared their experiences of feeling they were not respected by paid health and social care staff and called for a culture shift in behaviour and attitude, although this was not the experience of all present. Group members also suggested that societal and cultural views that informed policy and practice had to be challenged if older people were to stay happier and healthier for longer at home. For example, one person reflected that in other countries the assumption about moving into a care home once your needs got to a certain level was not prevalent:

“*The idea of ‘nursing homes’ [is] rarely considered as someone ages; they are cared for until the end of their lives at home by their family”*

Others reflected this, sharing their observations that where older people experience being viewed as a ‘burden’ or feel ‘invisible’ they may not wish to ‘bother’ services and professionals. This indicates a need to address ageism within communities, services and culturally across Northern Ireland. Reflecting the initial findings, the group preferred in-person rather than online contact and meetings to improve the participation of older people, not only in decisions about their own needs and support but also in the development of local and regional services.

# **Physical wellbeing**

Maintaining physical health was discussed by all stake holders as a key aspect of prevention: what people could do for themselves and being able to access services when they needed to.

## Physical activity

This was a priority area for practitioners:

*“Helping older people to remain physically active is crucial and goes hand in hand with being socially connected” [Promoting Wellbeing Team worker].*

Groups and programmes focused on activity were appreciated by some older people

*“I tried the Strength and Balance training which I found out about through this group, and that was really fun. I do the exercises every day now at home.”*

This structure and guidance was experienced as a helpful way to increase older people’s engagement with physical activity, as well as providing a sense of individual accomplishment.

## Accessing healthcare

Conversations revealed the importance of healthcare, in terms of keeping well and preventing deterioration, but also difficulty in accessing services. One older person explained they attempted to access maintenance healthcare and experienced:

*“Long waiting times and for me, things tend to get worse when I have to wait. That means I can’t get out and about as much as I’d like, and I get depressed at times.”*

Here, this older person explains the importance of preventative and ongoing healthcare, as well as highlighting the negative impact that a lack of access to these services can have through reducing opportunities for ‘getting out and about’ which can include both physical activity and social connection. A staff member also reflected this, noting the importance of ongoing healthcare as a form of early intervention. They shared that they valued *“access to foot care and opticians as early intervention approaches” [MDT staff]*

Professionals noted in conversation that where access to these kinds of physical care services were unavailable or older people did not know how to access it, this could result in an over-reliance on GP services, where other services would be more appropriate. This in turn contributes to challenges of accessing appointments.

As well as support with ongoing physical health, conversations highlighted the importance of mental health and services that support wellbeing. One older person said:

*“My mental health isn’t great either, and no one seems to be interested in helping me with that”*

Professionals reflected that this may be heightened by an outcomes-based culture. They reflected the lack of value placed on services where outcomes can be more challenging to evidence, such as mental health, health promotion and wellbeing awareness, and their impression was that these were low priority for decision makers compared to physical health.

Alongside this lack of clarity about where and how older people and carers could access the range of allied health services, there was concern about being able to see a GP when one was needed. The conversations revealed that older people had an awareness of how busy GPs are. One older person shared their experience:

*“Talking to GP’s is really hard. Getting an appointment and having to wait weeks when I do get one. I really avoid having to call my GP if I don’t really have to because it’s so stressful, especially when you aren’t feeling well.”*

As well as challenges with getting appointments, and processes for securing appointments that are difficult to navigate, professionals also noted that online or telephone appointments can be a barrier to some people and prevent them from accessing healthcare. As a result, individuals can end up only accessing healthcare in an emergency and requiring much greater care and support. Here, the range of relationships to healthcare is highlighted: from attending for a chat, to avoiding when there is a pressing medical need.

Prominent media narratives around healthcare, have also impacted on how older people perceive services. One older person said:

“*I don’t really call the doctor much, thankfully, but I am a bit worried about if I need to see her, whether I could get an appointment”*

Another reflected these fears, saying:

*“It’s really scary to think about the ambulance waiting times. I have heard some really scary stories from people.”*

Conversations with professionals also reflected that these fears are common, and other concerns include how crowded Accident and Emergency departments can be. Professionals shared that some older people believe ‘hospitals are places people go to die’, perhaps exacerbated by news coverage, and this has a negative impact on their engagement with healthcare. Further conversations reflected a belief that it is difficult to get back out of hospital once you are admitted. One older person shared their experience of disconnection between the hospital and their social care provider:

*“I felt rushed out of hospital when I fell last time, my son was told if I didn’t go home now, I would lose the care package completely. Even though my needs had greatly increased when in hospital, my mobility needs especially, the Trust couldn’t provide any extra nights or daytime calls because they had no staff.”*

Professionals noted that these fears lead to some older people refusing to go to hospital when recommended by a GP. This could result in their condition worsening and the need to get an emergency ambulance. In turn this can lead to a longer wait for discharge as their needs might have become more complex but there remain limited staff to provide the required support at home. This again highlights the vital importance of accessible, easy to navigate and trusted ongoing community health services. Allied to this is the need to build relationships between medical professionals and older people which can facilitate earlier and preventative responses. Other challenges highlighted here will be discussed in more detail in the section around ‘service delivery’.

# **Practical Support**

Staying at home is important to many people as they grow older. It was noted that if people do not feel safe at home, a feeling of vulnerability can arise. One older person shared:

*“I get nervous at night sometimes now, never used to. This is out in the middle of the country, nothing has happened to me, but I have a friend who was burgled a few months ago. She wasn’t at home thank god but she has trouble sleeping now and her son has to stay with her a lot.”*

Practical approaches to supporting a feeling of safety and comfort were highlighted in conversations with health and social care professionals and community-based volunteers. These needs were noted as particularly prominent for older people who live alone or in very rural areas, lack family support locally or have particularly complex needs. For some older people practical support starts with heating and maintaining their home:

*“[it is] the economics of living on your own: heating my house has been a problem with oil and everything going up. I worry about that a lot.”*

*“[It can be a challenge] getting honesty from tradespeople when you need something fixed around the house, I think they see an old lady living alone and can put up their prices and sometimes don’t do a good enough job because sure I’m an ‘old fogey’ and won’t complain.”*

Professionals also reflected the value of trusted and reliable tradespeople. They also expressed concern about older people’s basic needs that might not be met and how they affect health and wellbeing. When asked what would help, they said:

*“Vital home comforts – heating, clothing, good food, energy and not having to worry about these things day to day.” [Access and Information Team worker]*

*“Practical support such as help with online banking” [Community and Voluntary service manager]*

Professionals also noted ways which might help, including medicine safety, for example using pill pockets, and support around accident and fall prevention. Another key tool was regular fire safety check. One person shared the impact:

*“this group got me a fire safety check at home, and now I am a lot happier being in the house on my own.”*

## Community Transport

Disability or challenges in mobility were noted to substantially contribute to challenges with maintaining regular social interaction, and accessing services, especially in rural areas. Community transport was highlighted by professionals and volunteers as ‘vital’ in keeping older people happy and well at home for longer. Whilst essential, community and voluntary groups noted challenges in developing a network of volunteer drivers to cover all areas of the Trust. Consistent funding was suggested as solution to achieve the coverage needed.

Participants at the co-production event from the community and voluntary sector suggested that money to support practical preventive services had reduced over time, and the recent UK government cut in winter fuel payments was a big concern. Additionally, competition amongst community groups for limited funding was perceived as creating a culture of competition rather than collaboration and harming innovation. It was also suggested that the community and voluntary sector were perceived as leading on prevention, impacting progress towards implementing prevention measures across statutory health and social services.

# **Support for Carers**

The Trust has a range of community-based support in place for carers, including provision of peer support and a wide range of other health and wellbeing support. These are delivered through a contract with the Clanrye group. However, despite this provision, all stakeholder groups reported feeling that carers were under-supported. One professional captured this, saying:

*“Unpaid carers and volunteers are vital and get very little recognition and support”*

Practical issues reported included inadequate carers allowance and challenges faced by carers who worked. Since the conversations took place, there has been a small increase in the Autumn 2024 UK Government budget. As well as ongoing practical issues, the conversations revealed carers felt unsupported when they reached out for help, and some felt this was exacerbated through there being no statutory duty to provide this care. One family carer reflected the experiences of many when they said there was: “No one to turn to when I need help”.

Another carer shared their experience, saying:

“*[the person we were caring for] needed us to fight for her for so long, that we didn’t get a chance to fight for ourselves, and why was it we needed to fight anyway? We are all people, we just haven’t been treated like a family of people, ever.”*

A particular issue highlighted by family carers was challenges in accessing short breaks. This experienced lack of respite led to them feeling unable to provide the care that the older person needed, or that they wanted to give:

*“My Dad needs me to be at my best when caring for him, I can’t do that because he needs so much support now, 24/7 and I haven’t had any sort of a break for over 4 years now. There is just me”.*

Staff, managers and volunteers working with older people and local community and voluntary organisations, reflected that supporting family carers is vital to helping older people to stay happy and well at home for longer:

“*Carers need access to support services that they have been assessed as needing during Carers Assessments, as well as when they reach out for help”.*

Here, there were multiple conversations that suggested the Carers’ assessment process needs to be reviewed to maximise its usefulness. Similarly, a Southern Trust wellbeing worker noted the value in reframing the work of carers as prevention through*:*

*“Looking at carers aged 50+ as an early intervention for them as older people themselves.’*

Professionals noted the importance of groups where carers can ‘*connect with other carers for support’.* Others noted the importance of targeted support for carers based on need, and their own support needs as they age. In particular, they highlighted the need for:

*“Targeted support for carers aged 60+ especially parent carers in this age group, as they have been caring for their child all their adult life. Also, for carers of people over 75+ with complex needs or increasing frailty.”* [SHSCT Promoting Wellbeing Worker]

This theme highlights the need to revisit the processes around the Carers’ Assessment in terms of giving the carer the information they need and being linked into support that is currently available. Additionally, there was a view that if a support need is identified then the Northern Ireland Assembly should consider making it a duty to provide that support. The co-production events also emphasised the limited resources such as respite care, direct support for the cared for person and the challenges around paid employment whilst also being a carer. At the same time the events noted the need to not focus on the needs of carers alone and overlook those older people who do not have family or others locally to give support. Participants also advised a range of different types of support for carers could be developed, including developing peer support alongside support groups. Finally, that there is no support for carers at times of crisis and emergencies, and that this needed to change.

# Service Delivery

The final core theme identified in the conversations was service delivery. One older person succinctly explained their vision for service delivery saying:

*“I need to be asked what I want and listened to and given support when I ask for it.”*

Unfortunately, this was not the experience for most. Family carers revealed difficulty accessing information on services for the older person they care for, and difficulty in accessing health and social care support both for themselves and for their loved ones. One older person shared an example of challenges in navigating health and social care services system, saying:

“*My sister has been in hospital for a long time and needs help when she gets out, but she has had to wait a long time to get the help in place. Her daughter is brilliant talking with social workers and everything. I’m worried though if I had to do that, whether I would be able to manage all that*.”

A family carer also reflected some challenges around finding information. They said:

*“I am not sure what help is out there for me or mum. I don’t seem to have any time to look anything up as regards help, I just get on with it, it’s non-stop.”*

All stakeholders noted the value of good communication, including sensory support services for older people.

One of the coproduction events discussed the need also to consider how information is given, as there can be range of information sheets available but what some people need is the human contact of someone spending time with them to talk through information and options. For some, this human contact is provided by Access and Information service staff as part of their role. However, the experiences of the group suggest many were not accessing this support, possibly indicating a lack of information about the service, how to access it, or another accessibility challenges.

In conversation, one manager reflected on further challenges in raising awareness, highlighting that a balance was required between promoting services and managing expectations. They noted the need to:

*“Manage expectations of everyone [and identify] needs vs wants; of older people, of carers, of staff including service commissioners. Prevention cannot solely be the role of frontline workers.”* [SHSCT Manager]

This quote underlines the tensions between communities who want more services and the availability of finite resources. It also indicates that moving towards a preventative approach needs to be a trust wide initiative and cannot be something that individual workers or services are pursuing unsupported: something that was strongly supported by those at the coproduction events.

The following are improvements to service delivery offered by those who took part. These were around proactive engagement and planning, partnership working and the use of link workers. These three sub-themes will be discussed in turn here.

## Proactive Engagement and Planning

Many of the people who gave their views noted health and social care tends to be reactive, and much energy is taken up in responding to crisis, rather than prevention and early intervention. It was suggested this was more costly than managing preventable crises and deterioration in health and wellbeing, plus additional stress for older people and carers. Proactive Trust-wide planning and engagement with older people and their carers were highlighted by them as a clear route forward in helping people live well at home for longer. Emphasis was placed on listening to older people and taking their views on board. In one conversation, an experience was shared which highlights how this perceived lack of engagement feels from an older person:

*“People in the Trust need to understand that I am not living at home to be awkward. It’s where I want to be, and I need a lot of help to stay at home which they are not planning or giving me. I feel like I and my family are just forgotten about and left to get on with it because I am at home now for years and can’t get anyone to listen to me and my family about what I need and want to stay here. It’s really upsetting and difficult when you are just invisible”*

Staff, volunteers and managers, also spoke about need to listen and act on the voices of older people not just on a one-to-one basis but also in the planning of services. Planning on an individual level but also systemically requires good communication within and between organisations and teams, and across agencies. Staff and volunteers spoke of preventative work that was collaborative, with clear, shared goals, and how this, in their view, works well in supporting the autonomy and independence of older people, in their homes and communities. One person mentioned the potential role of Council Age Friendly Officers in local collaborations:

*“Close links with Council Age Friendly Officers - very beneficial in co-ordinating wellbeing activities”. [Promoting Wellbeing Team worker]*

There was a recognised need for earlier contact with older people and carers:

*“Agility and flexibility of statutory services to identify and address needs of older people and their family carers earlier.” [Community and voluntary service manager]*

A core consideration was education and awareness raising long before crises arise. Initiatives were suggested to begin conversations and invite people to consider and plan for getting older. For example, building on ‘Positive Ageing Month’ activities in partnership with local councils.

## Partnership Working

Good examples of partnership working were noted by staff who were in multidisciplinary teams, but they also stated that the approach was not yet universal across the SHSCT leading to what some Trust staff described as a *‘postcode lottery’* of provision. It was acknowledged this could aggravate pre-existing health inequalitiesand that the *‘Stop Start’ government in NI’* has also contributed to this.

GPs were considered by some to be ideally placed to signpost on to the Access and Information Team, or other appropriate workers based with GPs, but it was noted the ideal model would proactively engage people even earlier through wider community initiatives. Such initiatives as noted above by older people and carers should be person to person as well as online. They were looking for people in their own area to open the door to services and this would require local/community partnerships:

*“partnership working and collaborative leadership between SHSCT, local councils, and community and voluntary sector is vital.” [Community and Voluntary service manager]*

## Link workers

The idea of a link worker, or what others might call community navigator or key worker, was raised by a range of people as way to address the stressful experiences older people and carers shared:

*“All the waiting and chasing for basic things like my wheelchair and other services needs to stop. I am too unwell and my family are too stressed out to be making constant phone calls to find out what’s happening, there needs to be one person in charge of all my care at home, who can go and do that for us and pull everything together, I’m sick of hearing, ‘that’s not my job”*

*“If there was a one stop person, you know, for my dad or for me, who knows all about what help he can get or what is out there? Who would come to us and ask us what we need help with and could point us in the right direction, that would be great. I am so knackered all the time, just getting through the day ... I have no energy to go and look for that myself. “*

As well as the costs of time and wellbeing, and potential for people to not receive the support they need, it was noted that these poor experiences can damage trust in health and social care services as a whole, and mean people are less likely to seek support until they are in crisis.

Professionals also recognised the value of this type of role:

*“community advocate or navigator for older people who takes an holistic, person centred needs based approach, e.g. the Community Navigator role in the mPower project was highly valued by both staff and isolated older people and created real changes and benefits”. [Promoting Wellbeing Team Manager]*

Staff in both sectors spoke of evidence that both multidisciplinary teams based in GP practices, and a Community Navigator role which was piloted as part of the mPower project (Terje et al. 2022) in the SHSCT could be a way forward. A key finding of mPower that is also reflected by older people and carer above is the importance of human contact: ‘Community Navigators visited people in their own home, spent an adequate amount of time with them on each visit, and demonstrated genuine engagement and caring in interactions with them’ (Terje et al 2022:7). Staff who mentioned these approaches were keen to see these evidence-based approaches to prevention locally rolled out across the SHSCT. For example:

*“Clear, consistent and easy access to the services older people choose to meet their needs, including GP services. This only happens with good information and support with for example a ‘community navigator’ role to help older people and carers find out what is available and get access to their chosen services.” [Service Manager]*

Professionals also stressed that link workers needed to be able to provide information on whatever older people and carers might need, not just a specific topic. Again, this would require the whole range of services in that area to be open and encouraging of such a role. To help with this another suggestion was for community hubs across the SHSCT and councils.

Participants at the coproduction events supported the idea of link workers or community navigator. They also recommended that support whether for the older person or their carers needed to be much more flexible in the day e.g., domiciliary care packages/hours and times of visits. Allied to this was that whilst direct payments are being promoted as improving choice, they are hard to obtain and manage for older people and carers.

Participants at the coproduction events agreed with the above findings and reflected that whilst their views had been sought many times before things did not seem to change in response. This led to the recommendation of more long-term coproduction, rather than just consultation, to allow partnerships and relationships to be developed*.* This they suggested was not helped by the *“current cultures of competition”,* nor by the range of pilot schemes that appear and might be effective and then cease. It was suggested that those who valued them are part of the discussion in the councils and SHSCT of what should happen next.



# Recommendations for Service Development

This is presented in the form of a vision statement which was developed by the Facilitator after the coproduction events.

We believe that what works to help older people stay happy and well at home for longer is:

* **The promotion, fair funding and development of consistent and equitable opportunities for social connection, networks and partnerships,** that support older people, their family carers, staff and volunteers in older people’s and carers services,
* **The promotion, fair funding and development of consistent access to information about local services, within and across local councils, health and social care trusts, GP practices and local community and voluntary services,**
* **The promotion, fair funding and development of consistent community transport services** across the area,

We believe this will work to:

* promote and sustain older people’s independence and autonomy at home, as well as support older people’s, family carer’s, staff and volunteers, physical and emotional wellbeing, and
* will improve older people’s earlier and easier access to health, social care and other services and supports in their local communities.

We believe that this can be achieved by:

* **the promotion, fair funding and development of collaborative, evidence based, coproduction approaches to good communication,** within and across individual teams, older people’s services, organisations and agencies in both statutory and community and voluntary sectors serving the area
* **the promotion, fair funding and collaborative development** of proactive, effective and meaningful approaches, **to engaging as early as possible, with older people and their family carers, staff and volunteers,** in order **to identify and assess needs,** and **coproduce person and family centred plans for older people’s care at home,** now and in the future;
* **the promotion, fair funding and collaborative development of proactive engagement and planning systems, management and infrastructure** across agencies for older people’s services,

Factors we believe can help us achieve this are:

* listening to and recognising the strengths, expertise and assets of older people, family carers, local services existing networks, partnerships and relationships and the staff and volunteers working within them, at the earliest possible stage and continuing long term engagement.
* listening to the evidence of what works to help older people stay happy and well at home for longer, working collaboratively across teams and agencies to fund, implement and scale up approaches that have been proven to work
* listening more effectively to each other within and across agencies and teams, building the capacity of everyone to share information about what works, collaborate on promoting, funding and developing approaches to implementing what works in more areas, and with more older people

# What worked well on the Facilitator Project?

A core strength of this project is the large number of insights that have been captured, and the range of opportunities created for people with practice-based wisdom and knowledge built through lived experience to contribute and shape the project and outcomes. Before the project, the Facilitator had established professional links within the SHSCT and the local community and voluntary sector. This ongoing connection and understanding likely enabled effective identification and engagement of the stakeholder groups, teams and organisations crucial to the project. Having their support and buy-in early on was crucial in delivering the project successfully.

Another success was the decision to have a focussed 6-week exploration phase. This condensed period helped to raise awareness of the project across all stakeholder groups, build momentum for engagement and participation, and likely contributed to success in engaging with people and promoting discussion. Feedback collected during the project suggested that the project’s success was enabled through the facilitator’s flexibility, the creation and use of targeting communications and opportunities designed for each stakeholder group, and working to maximise comfort and support during each engagement.

# What did not work so well?

While there are considerable benefits in the project being hosted by such a large statutory organisation, access to the voices of frontline staff, family carers and older people themselves for the purposes of this project was initially a challenge. This is because there are many ‘layers’ of service leadership to navigate, to identify and engage with the key stakeholder groups for this project. For example, to speak to groups of older people in day centres run by the host organisation, the facilitator needed to register on the Registered Managers Visits list for the Trust and be introduced to management and staff of these facilities. This is of course, an important safeguarding formality which the host organisation has in place to protect older people and staff but is time-consuming. Future projects within large statutory organisations would benefit from planning for the time taken to navigate all the appropriate management structures and requirements here and considering early in the project who they need to meet, and what processes will need completing for this to happen on schedule.

# What impact have we made?

Through seeking out and amplifying the experiences of individuals from four stakeholder groups, it is hoped that the final report, recommendations and vision statement give a succinct, but representative view of experiences that people have around staying well at home for longer. Through inviting stakeholders into all stages of the process, including reflecting on the recommendations and initial findings, it is hoped that in the process of conducting this project the facilitator has emphasised to people that their opinions matter, and there is genuine desire to support them, for the people they support to stay well at home for longer. Through the coproduction process and events, the project has stimulated conversation with those in varying positions of power around future action. In a short-term project such as this, it is hoped that this is the start of ongoing work, and the impact will continue to grow, building on the work here.

# What opportunities are there for wider impact on policy and practice?

A key finding from the initial evidence review was around a lack of qualitative data exploring the impact of preventive approaches on older people. This report humanises conversations around, for example, loneliness, through using insights from the conversations with older people to illustrate the extent of the impact this has on daily lives. In this way the report helps to explain how fear or loneliness or a lack of transport can impact on an individual’s day to day life. It is hoped that this makes a powerful argument for implementation of some of the recommendations from the vision statement.

As well as providing a rich resource to contribute to discussions around helping people to stay happy and well, this report offers an alternative to the language of ‘prevention’. Within the evidence review there was a lack of clarity identified around prevention: what it means, what is being prevented, and how success is measured. During this project, the facilitator produced an alternative language of ‘being happy and well at home for longer’. It is hoped that offering this much more accessible language may inspire others to consider their understanding of prevention. The more accessible language allows for richer input from a diverse range of people, through presenting the issues in terms that are more easily understood, and easier to relate to personal circumstances.