All-Party Parliamentary Group on Primary Care and Public Health Inquiry

Delivering the Five Year Forward View: Behavioural change, information and signposting

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Name: Léa Renoux
Email: lea.renoux@ageuk.org.uk

Age UK
Tavis House
1-6 Tavistock Square
London WC1H 9NA
T 0800 169 80 80 **F** 020 3033 1000
E policy@ageuk.org.uk
www.ageuk.org.uk

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The All Party Parliamentary Group (APPG) on Primary Care and Public Health is seeking views on specific aspects of the NHS *Five Year Forward View* to accelerate positive behaviour change towards prevention and self-care. The NHS *Five Year Forward View* was published in October 2014 by health and care leaders in England, and sets out how the NHS needs to evolve over the next five years. This inquiry focuses on the further steps that may be taken to affect behaviour change and concentrates on information, support and signposting.

Key points and recommendations

- Accelerating behaviour change towards prevention requires lifelong approaches that focus on all levels, from the individual to the community to wider society.
- Individual-level behaviour change interventions should be personalised and targeted, including through risk-stratification tools, to have a maximum impact.
- Public health and prevention policies throughout the lifecourse are essential to a good and healthy later life. Changing people's perceptions of poor health as an inevitable part of ageing is key to inspiring healthy lifestyles and active ageing.
- Older people are more likely to respond positively to preventative/self-care strategies when they are actively engaged in their health. This requires a real shift in the NHS towards shared-decision making and supporting people to self-manage.
- Because older people are already in frequent contact with the NHS, there is a real opportunity to communicate messages about where and when to seek advice, and to empower them to self-manage their health. At the moment this is not happening.
- Support to self-manage doesn't have to come from a clinician, and may involve voluntary sector-led practical or wellbeing services delivered in the community.
- Public health materials should be targeted and insight-driven, using qualitative research and message testing with the target audience, i.e. the public, at key stages of the development process.

1. Introduction

Age UK welcomes this inquiry as a means to highlight the importance of investing upstream in interventions that help people to stay well and healthy. As the Richmond Group of Charities set out in *What is preventing progress?*, "effective prevention strategies can deliver short as well as longer term benefits to individuals, communities, health services and the economy"[i]. But they are also essential to a good later life. Increases in healthy life expectancy are not keeping pace with increases in life expectancy, meaning that more of us spend more years living with long-term health conditions and disability in later life.

Poor health is not, however, an inevitable part of ageing and there are a number of steps that can be taken throughout the life course, including in older age, to ensure we stay well and healthy for longer. Equally, with the right support, those of us who do live with long-term conditions in older age can maintain wellbeing and independence, and avoid further health complications. Age UK is working to challenge ongoing perceptions that older age automatically means poor health and higher needs, and welcomes this consultation as an opportunity to share evidence of what works in affecting behaviour change and improving the public's health, including in later life.

2. How can we accelerate positive behavioural change towards prevention and self care in the population and who should be responsible for this?

APPG comments – Behavioural change

"NHS England's Five Year Forward View recognises the need for change.The NHS has largely been a sickness service and whilst there is now an appetite for the NHS to move towards a wellness model which supports people to better look after their health and wellbeing and prevent ill health, intervention to affect behavioural change in this way is patchy and slow."

The recent focus on prevention, including through the *NHS Five Year Forward View*, is welcome. The challenge is now to translate this ambition into achievable steps that empower people to stay well and healthy for longer. Despite promising developments with the creation of a Behavioural Insights Team at the heart of Government, it seems that as NICE noted a few years ago, "there is no strategic approach to behaviour change across government, the NHS or other sectors, and many different models, methods and theories are being used in an uncoordinated way."[ii]

We believe there are a number of key conditions that are essential to accelerating behaviour change towards prevention and self-care on the ground.

First of all, effective prevention and behaviour change policies require **comprehensive, cross-sectorial and lifelong approaches**. As the Richmond Group of Charities recently highlighted prevention should occur in every part of people's lives, across the lifecourse and the disease pathways, to achieve a meaningful impact[iii]. We know that healthy lifestyle choices provide the best basis for good health in later life. Yet it is also never too late for prevention, and efforts to improve the public's health must be seen as just as important to older age groups as to other age groups. It is precisely by changing people's perceptions of poor health as an inevitable part of ageing that we can encourage and accelerate behaviour change towards healthy lifestyles and active ageing.

Public health policies also require combining a mix of policy instruments that focus on **all levels, from the individual to the community to wider society.** Older people's ability to live well and in good health is shaped by a variety of factors, including the home they live

in, the inclusiveness of their communities as well as many other social, psychological, cultural and economic circumstances. As such, when developing prevention and behaviour change interventions, policy-makers should consider how people's own capacity for change may be complemented by community assets as well as national regulation.

Furthermore, we believe individual-level behaviour change interventions should be **personalised and targeted**, including through risk-stratification mechanisms, to have a maximum impact. This should involve tailoring responses to different levels of need as well as spotting key events or transitions in people's lives that are likely to affect their lifestyle choices, such as retirement and bereavement, or the diagnosis of a long-term health condition. For instance, we know that many older people initially see the current target of 150 minutes of exercise as unattainable, which can put them off becoming more physically active. We would recommend ensuring that messages on physical activity in later life are as targeted as possible, e.g. with an emphasis on working towards 150 minutes in more manageable steps rather than just promoting 150 minutes as the recommended amount straight away.

Age UK's *fit for the future* programme demonstrated that person-centred, targeted, non-clinical activities can have a highly positive impact on healthy eating, physical activity and mental wellbeing among people living with long-term conditions. The evaluation concluded that cost savings to local services were likely, including from reduced need for NHS services. Successful segmentation tools, such as the Department of Health's *Health Foundations Life-stage Segmentation Model* (2010)[iv], should be promoted to assist in targeting and tailoring interventions to the different levels of needs.

To help spread such approaches, **local authorities and health and wellbeing boards should work in partnerships with stakeholders on the ground, such as voluntary sector organisations** and fire and rescue services to identify those at risk and target interventions. The Department of Health and Public Health England also have a key role to play in providing guidance on evidence-based behaviour change strategies, with input from organisations such as the National Social Marketing Centre or the Behavioural Insights Team, and other organisations working in specialist areas, the voluntary sector and the wider public. While improving prevention should be everyone's responsibility, we believe there should be national plan for ill-health prevention and behaviour change coordinated across Government to make this a priority.

Finally, accelerating behaviour change towards self-care/self-management and prevention requires a health and care system that **puts people in control of their own health and wellbeing.** This approach underpins work we are undertaking through our Integrated Care Programme, which brings together voluntary sector organisations and health and social care services in local areas to provide an innovative combination of medical and non-medical support for older people.

The model has been underway in Penwith, Cornwall since 2012 through the Living Well programme, and is now being rolled out in other parts of the country. It is based on **shared care management plans** which involve a local Age UK working closely with the local health and care multi-disciplinary team; **guided conversations** with an older person to co-produce a care plan that brings together the primary goals regarding their health, home and life and to address their social needs; and a **package of on-going 'wrap-around' support services** provided by the voluntary sector complementing the work of health and care agencies.

The first results of the pilot in Cornwall have been very promising, with a 31 per cent reduction in all hospital admissions. It has also contributed to improve older people's quality of life, with a 20 per cent average increase in wellbeing among participants. Specifically, the project has helped to demonstrate how older people are more likely to respond positively to preventative/self-care strategies when they are actively engaged in their health. It also acknowledges once again the fact that older people may have additional challenges, whether due to the environment they live in, their health condition(s) or mental wellbeing, and that addressing these in parallel is crucial.

3. How can we ensure there is consistency of message across the NHS with people clear about where and when to seek health advice?

APPG comments – Signposting

"People are confused about how to access the right part of the NHS for their health needs. NHS Choices states that A&E is for genuine life threatening emergencies such as loss of consciousness and yet 2014 data shows there were 3.7m visits to A&E for self treatable conditions such as flu and muscle sprains. GP consultations for self treatable conditions are also high with 53m calculated each year and only 1 per cent of calls to NHS 111 resulted in pharmacy referral. All of this indicates an inconsistency across the NHS which confuses people and puts unnecessary pressure on the system."

Evidence from our engagement with older people suggests that many of us already self-care and self-manage our health to some extent or call on family for advice in the first instance[v]. From older people's perspective, the decision to consult a GP about a health concern will be a rational one, so it would be unhelpful to think, as the current broader narrative on this issue often suggests, that all appointments for self-treatable conditions may be a waste of GP resources. In fact, because older people are already in frequent contact with the NHS, there is a real opportunity to communicate these messages about where and when to seek advice, and to empower them to self-manage their health. At the moment, this doesn't happen because older people can have their needs ignored (on admission to hospital for example) and because the expectations for what's possible with older people can often be low.

Supported self-management still remains an untapped resource in achieving person-centred outcomes. We know that older people often do not feel supported to look after their own health, particularly those with multiple long-term conditions, including frailty. Our research has found cases where, for example, older people are being asked to do their own blood tests but are not feeling confident/physically able to do so. For people over 75, 80 per cent with diabetes are not trained to manage their condition; 73 per cent with osteoarthritis are not supported to prevent it getting worse; and access to talking therapies is significantly lower compared to other age groups[vi].

We want to see self-management given a high priority, and this will require behaviour change among healthcare professionals too. To begin addressing this, NHS services will need to:

- fully embed the principles of shared decision-making and personalised care and support planning, including setting proactive care goals in partnership with patients;
- challenge attitudes that can "write-off" older people;
- implement fully holistic assessments, e.g. using the principles of comprehensive geriatric assessment for older people living with frailty;
- seek to enforce routine medication reviews for older people living with multimorbidity and/or frailty and ensure high quality medication management; and
- seek out and link in with local voluntary sector services, e.g. information and advice; exercise classes. Performance in achieving better integrated services, in line with the NHS Mandate, should be incumbent on this aspect of joint working.

Advice and support can be essential to good health and self-management in later life, including for those with complex needs. Age UK and NHS England's *Practical guide to healthy ageing* offers useful, practical advice for older people who may feel like they have started "slowing down" to stay physically and mentally well in their own home[vii]. The guide includes hints and tips on how to keep fit and can be helpful to slow down or reverse some of the health challenges that we may face in later life.

For those with more complex needs, support to self-manage doesn't have to come from a clinician, and may often involve voluntary sector-led practical or wellbeing services that are delivered in the community. Solutions like social prescribing (sometimes called "community referrals") or the availability of a care coordinator from the voluntary sector can be particularly helpful in signposting people to the support they need to live well and independently for longer. In times of financial constraint, there may be a reticence in investing in approaches that are not clinically-focussed. Our work in Cornwall suggests this is a false economy.

4. How can we raise levels of health literacy in the population to enable people to make positive choices for their physical health and wellbeing?

APPG comments – Information

"According to the Royal College of General Practitioners, health information is too complex for more than 60 per cent of work age adults in England. Without good health literacy people are unable to process and understand basic health information and make appropriate health decisions, and as a consequence are disempowered when it comes to looking after their health and accessing health services properly."

Low heath literacy in older people is associated with poor self-management of long-term conditions, increased use of emergency care services, low use of preventative health solutions and increased overall mortality[viii]. About one in three older adults finds it difficult to read and understand basic written health information[ix]. While many older people struggle to access, understand and use health advice, printed health materials are too often inaccessible and healthcare professionals regularly use complex words without realising it. Such low health literacy levels may be further compounded by longstanding practice in the NHS whereby people have not been engaged in decisions about their care or have not been adequately supported to manage their own health.

Given the negative impact of low levels of health literacy on people's health outcomes, it is particularly important to ensure that the content of health materials reflects the public's views and understanding of the issues at stake. As such, public health materials should be targeted and insight-driven, using qualitative research and message-testing with the target audience, i.e. the public, at key stages of the development process.

For example, the Malnutrition Prevention Programme, led by Age UK, developed materials such as the *Are you eating enough? Advice for older people* leaflet which was based on qualitative research (undertaken by a social research agency) that covered language, tone and messages[x]. The content was then further tested with older people through co-production. The leaflet was part of a wider pilot to reduce malnutrition in the community which included posters and info-graphics to raise awareness. The evaluation showed that these insight-driven materials had led to greater awareness of key messages, and in one area the proportion of those who had "enough information" had risen to 45 per cent.

Similarly, our joint *Practical guide to healthy ageing* with NHS England was developed and tested using focus groups and in depth interviews with older people[xi]. While the content aims to be simple and accessible, its evidence is based on a systematic review of 78 longitudinal observational studies. Since the first iteration of the guide was published in January 2015, over 160,000 copies have been ordered by individuals, charities, GPs, pharmacies, social care and many more to support older people to live well and independently. More recently the guide has been ordered by local Fire and Rescue Services to support "safe and well" visits with older people in their homes.

References

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