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A spotlight on preventative health care services for older people

No. 17
2025

Featured articles

Prevention and social care for older people in Wales: reflections from a research study

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Prevention has increasingly become a central principle for health and care services across the UK. Legislatively this is evident in The Care Act 2014 in England or the Social Services and Well-being (Wales) Act 2014; each making prevention a statutory obligation for governments to enact. Yet, recent research has highlighted how this legislative drive incorporates a 'definitional slipperiness'[1] that sees prevention linked to multiple agendas all at once: individual well-being; system partnership working; community development and resilience; statutory cost-saving, and financial imperatives, to name a few. Not all these agendas sit easily alongside one another, though, meaning that there is scope for multiple parallel interpretations of prevention[2] particularly in the social care context, and for older people.

Determining Best Preventative Social Care Practice for older people

This article reflects on a Health and Care Research Wales funded study exploring how prevention was being enacted for older people in Wales. The 'Determining Best Preventative Social Care Practice' (DBPSCP) study sampled four of the seven Welsh regions, adopting a case study approach[3] to examine how each region was interpreting legislation around prevention. Over several research phases, senior regional figures, local authority and NHS representatives, and community or third sector organisation professionals were interviewed or observed, as well as older people using preventative services.*

The purpose of this was twofold: i) to understand how different Welsh regions were perceiving and implementing best preventative social care for older people, and, ii) to explore how this preventative practice was experienced by individuals engaged with it. Initial interviews with professionals gathered data on how they were interpreting the legislative call for prevention, what they deemed to be best practice in their areas, and any barriers they thought were inhibiting this work.

*The DBPSCP study was given ethical approval by London – Camberwell St. Giles NHS Research Ethics Committee in February 2022 (REF: 22/LO/0004).

Once collected, these data were presented to the study Steering Group, comprised of older individuals based in each of the sampled Welsh regions. This process helped to make sense of data, generating key themes associated with prevention for older people, as well as ultimately defining the regional case studies to be explored in depth. Within these case studies, the views of older people and, where appropriate, their carers were further incorporated, giving voice to how preventative services had made a difference to them.

How is prevention for older people being interpreted?

The idea above of prevention being a slippery concept was noted in how professionals perceived the legislative agenda in DBPSCP study data. For instance, enhancing the well-being of older people was sometimes highlighted both as a moral incentive, but also a financial necessity.

"I would say that the priority has been on the system rather than populations groups. So, when we talk about prevention, we've had much, much more involvement in trying to prevent system collapse."
Regional Professional

Similarly, there were many discussions of how to move individuals away from state services, towards supports in their communities, both because it's the right thing to do, and because growing demand requires it.

For the most part, each of the Welsh regions were interpreting the call for prevention in similar ways, with variability predominantly a matter of emphasis. Generally, local efforts towards prevention hinged on partnership working to reduce the number of older people using state services, in ways incorporating statutory structures such as local authorities and NHS health boards, as well as community and third sector organisations. Discussions of community resilience were common in professional interviews, with this predicated on strong relationships between the state and 'communities'. These relationships were often mediated via community voluntary councils in each local authority, though it was noted that some areas adopted more of a 'top-down' than 'bottom-up approach, and vice versa.

Ideas of well-being were also often discussed, particularly in terms of social isolation and loneliness in older age. There was a notable commitment towards enhancing older people's well-being, and an awareness that life events such as bereavements and relocation upon retirement could detrimentally affect them. Again, though, this was often predicated on the idea that by helping individuals experiencing such life events to improve their well-being, state services would encounter less demand.

"We don't seem to be that willing to engage in the conversation about managing demand and prevention is an inherent part of that."
Regional Professional

What does preventative social care for older people look like?

The slipperiness of prevention as a concept also meant that a range of interventions and initiatives were described under its name. In total, professional interviews provided a long list of 60 potential options for consideration. These covered a breadth of areas including 'supported employment and volunteering initiatives', 'active ageing' and 'exercise schemes', 'community transport', 'digital inclusion', 'reminiscence therapy for those living with dementia', 'extra care housing', 'housing repairs and maintenance', 'community equipment services', 'technology enabled care', and instances of enhanced partnership working between multiple state and non-state partners. These were also accompanied by ideas of good practice around measuring or evaluating prevention, either as independent initiatives, or by their contribution to other parts of the 'whole system' – though, the latter tended to be predominantly health-focussed, e.g., hospital admissions and discharges, GP appointments, waiting times, etc.

The confines of the project meant that only 11 case studies from these many examples were taken forward for the final phase of the research, these being determined in conjunction with the lived experience Steering Group (Figure 1).

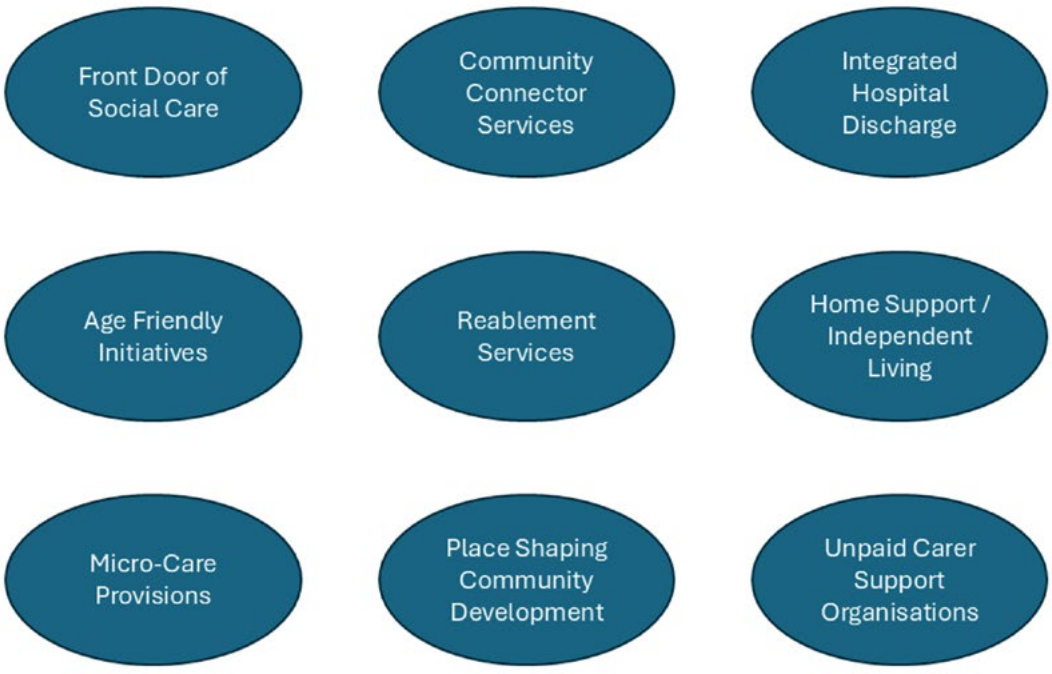

Figure 1: DBPSCP case study coverage

These ultimately covered the 'front door' of social care, community connectors / social prescribing, integrated hospital discharge services, reablement services, age friendly initiatives, place-shaping community development, micro-care provision, carer-focussed organisations, and home support for individuals to remain independent. The latter of these also incorporated attempts to avoid hospital admissions by helping should an older person fall in their own home, but not necessarily require medical assistance.

Notably, most case studies tended to emphasise certain aspects of the prevention puzzle, with some exploring the contributions of communities and social networks to prevention, proffering questions around how state services can help communities do this. Likewise, other cases depicted how the support provided by unpaid carers delayed an individual's approach towards statutory services, or how the front door of social care could allocate individuals to the most appropriate part of a 'whole system' once that approach was made. Some cases were further down the chain, and looked at examples of good practice to intervene to prevent hospital admissions, safely accelerate discharges, and ensure individuals that are discharged do not immediately re-enter the system.

Key themes

The detailed specifics of each of the case studies are outside the scope of this article. Instead, the key themes emerging from the analysis will now be outlined; elements which transcended the sample of preventative initiatives being explored. These will be detailed under three headings: complexity and the life course; acknowledging different preventions; and prevention measurement.

Complexity and the life course

For professionals, complexity was mainly mentioned in relation to health and social care systems themselves. As mentioned above, they tended to speak about prevention in terms of a 'whole system' with this incorporating both statutory services such as local authorities and NHS health boards, but also community organisations and the third sector. Each of these organisations are complex systems, with some of these complexities magnified by the need for enhanced partnership working between them. The management of these partnerships was pivotal. Most localities had closely entwined networks between health, social care, third sector, and private organisations, though this obviously did vary from case to case. Even in areas where links were generally well-established, there could still be crinkles and boundaries within particular teams or departments.

"We have this 111 Option 2 system so there is that emergency mental health support. And that's where the referral came from and then you're just like... that's going to be the thing I was going to suggest, you've got problems and you're at that point, phone these people. But if that's where they're coming from it's like, there's a gap somewhere isn't there?"

Community Professional

Complexity also emerged in relation to the life course, and the lived experiences of older people. Many interviews with older individuals talked through significant life events, such as bereavements, decreased mobility, and health comorbidities, that can often accelerate in older age. With these also comes the threat of diminished social networks, and thereby a risk of social isolation and loneliness. Many of the prevention initiatives offered narratives on how they made a difference to individuals navigating such circumstances, be those carers of those living with dementia, or people who have recently lost their long-term partners.

"Where we used to go, some of the things we used to do... I get emotional about things like that. It was very, very difficult. Coming to these sessions in the hubs changed things for me a lot, because, all of a sudden, I get up in the mornings and I think, 'Right, this is what I'm going to do'."
Older person

In some instances, the trajectory of an individual's well-being could be seen to shift significantly based on their interactions with community groups. Where this appeared to be working well, positive relationships between professionals and individuals using a service were negotiated over time, with an awareness of, and sensitivity towards, the complex life stories and events that often led to people attending.

Acknowledging different preventions

There are numerous models and strategies of prevention. Predominantly, these invoke three levels, and broadly cover the public health depiction of 'upstream', 'midstream' and 'downstream'[4] activities. Within this the idea is that by ameliorating issues of people falling into the river 'upstream', there will be less people presenting 'downstream' where problems are already ingrained and difficult to solve. In other models, these three levels are named differently (e.g., universal, selective and indicated prevention, or primary, secondary and tertiary prevention) but they still largely follow a similar pattern of looking to address issues early, and the logic that doing so will ultimately mean fewer presenting issues in the future.

Elsewhere, we have argued that these models of prevention, largely stemming from the sphere of public health, may not fit the social care landscape so readily[5]. Certainly, in the DBPSCP Study professionals rarely cited these models when applying them in the context of social care for older people. It was more common for other associated strategies, such as Age Friendly Wales[6], to be guiding activities. Nevertheless, across the case studies, it was possible to see initiatives that broadly fitted the 'upstream' or 'universal' level (age friendly initiatives, community resilience and development), as well as the 'downstream' level (integrated hospital discharge and admissions prevention).

Beyond this, there were different types of prevention operating depending on where one looked. For instance, the front door of social care was largely seen as being preventative in that it allocated those approaching the service into the appropriate, specific part of the system. However, one of the case studies around the front door also incorporated a pro-active call team who would telephone older individuals subscribed to the service for regular check-ins, assessing them for any interventions that could be put in place before they approach the system. These were felt to be quite different activities – one a responsive form of prevention, and the other a pro-active one.

Aside from this, professionals often cited prevention in terms of systemic 'hotspots' where there were specific strains or issues. During our research, this was often associated with the flow of older individuals into and out of healthcare systems, particularly hospitals. While modifications to service provision in this context are undoubtedly important, it was felt that this form of crisis prevention was fundamentally separate to that of pro-active outreach work. This was because at another time, and in other places, these 'hotspots' and the work required to mitigate them could be quite different based on which parts of the system were under strain.

Prevention measurement and justification

Prevention is notoriously difficult to measure[7] and evaluate. This is partially down to the challenges of evidencing that undesirable things have been avoided because of preventative activity. But the breadth of how prevention is conceived, its 'definitional slipperiness', also contributes towards this, as do the long-term nature and complexity of social care outcomes.

Within the study data, there was a sense that prevention had the buy-in of key professionals, but that the effect of preventative interventions needed to be more fully understood. In a context of reduced budgets and financial austerity, the use of scarce resources on hard-to-prove initiatives was perceived as high-risk. Professional focus on prevention was partially driven by the desire to reduce the number of older people entering statutory systems (i.e., hospitals or local authority social services). Where systems were experiencing specific 'hotspots', generally in hospitals, there was a hope that prevention might alleviate these, and a determination to demonstrate its impact in doing so.

Based on the 'whole system' approach, this meant that a lot of social care or community-focussed initiatives were being measured through health care system metrics, e.g., GP appointments, hospital admissions. For integrated discharge teams, this would be a more appropriate a set of metrics than, for instance, a community connectors service. The latter might well influence an individual's path towards statutory services, but this will likely be tangential and long-term in its nature. Certainly, aiming for older people to avoid healthcare settings such as GPs and hospitals altogether does not necessarily align with the preventative agenda, which would ideally see people have their needs met in whatever way is best.

Pragmatically, the measurement and justification of prevention work requires a multidimensional approach. Community connector or social prescribing services intend to enhance an individual's social network and resilience which, in the longer term, may link them to help and support outside of the state, or provided by the state. In most instances, though, outcomes associated with the growth of an individual's network of supports were largely unmonitored in favour of outcomes related to the healthcare system. Long-term throughput metrics to the front door of social care or into and out of hospitals are obviously important. These, though, need to be considered alongside alternative top-level metrics that link to the preventative agenda – one such being the Healthy Days at Home[8] suite – as well as initiative-specific measures that more meaningfully evaluate the work that preventative services do.

Conclusion

This article has reflected on how preventative social care for older people has been characterised and enacted in Wales, drawing on data from the DBPSCP study. The study's aim to explore best practice in this area brought with it many stories of life-changing interactions between individuals and preventative services. Within this, finely tuned, inter-system partnership working was often in lockstep with the caring and nurturing dispositions of professionals working face-to-face with older people. That said, the study also naturally highlighted some of the contextual, systemic issues that threatened the preventative agenda. Constrained budgets and demographic pressures were limiting the resources available to system actors; this backdrop repeatedly being discussed during professional interviews. Consequently, the perceived role of prevention in alleviating systemic pressures was paramount, as was the need to evidence this and thereby justify the long-term future of preventative services.

There have been bold steps forward in thinking through how prevention can be evaluated. Maintaining this path will require systems to measure prevention not just in terms of throughput metrics from the front door of social care or emergency admissions, nor in terms of just potential cost-savings and financial efficiencies. These will need to operate alongside how preventative interventions can offer positive individual outcomes for older people – enhanced social networks where they will be beneficial, growth of informal support in communities, and an improved sense of well-being. There are many challenges ahead for prevention, particularly for older people, but understanding how it works across multiple domains is a key first step.

Further information

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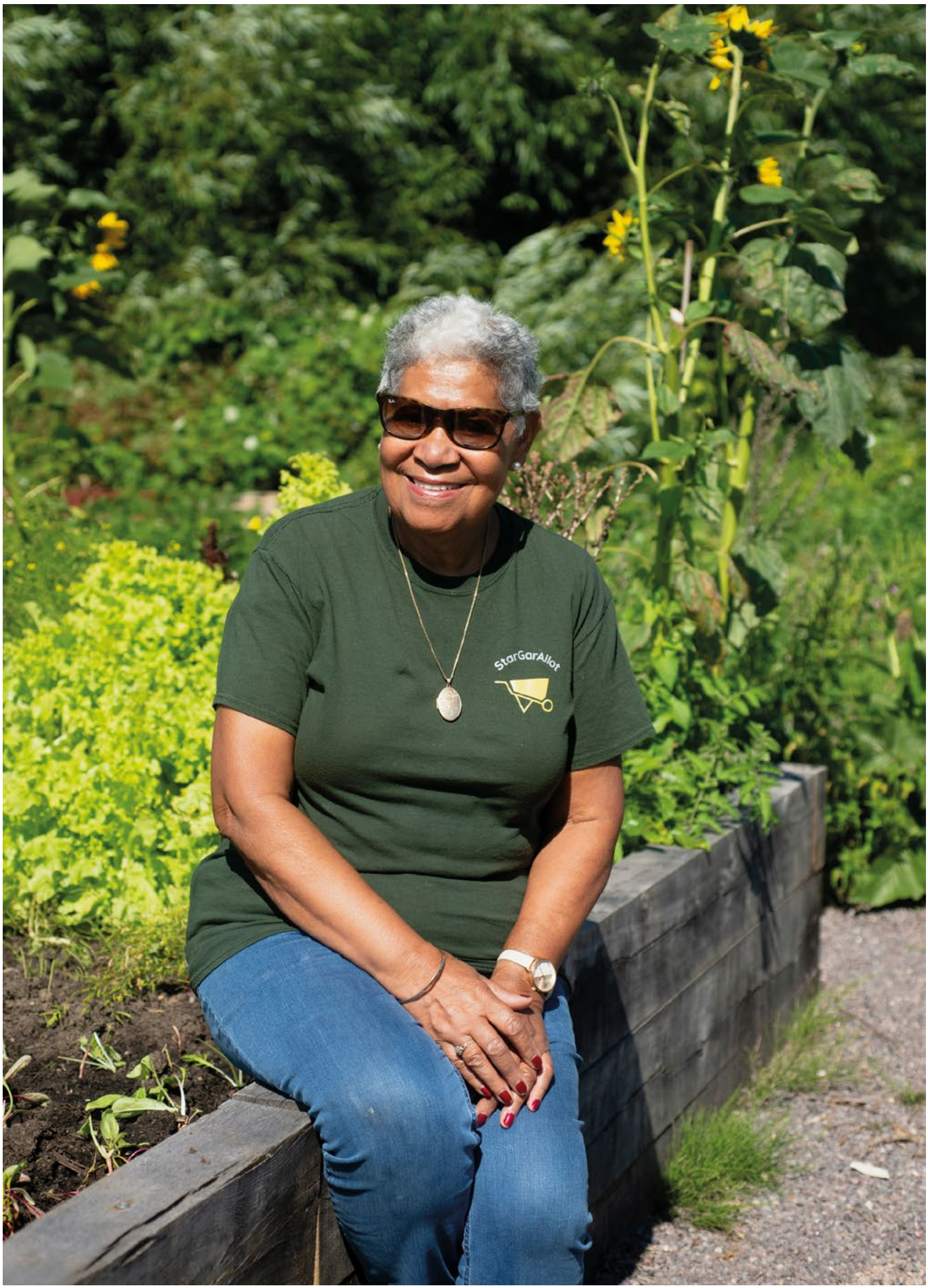
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