OLDER PEOPLE PREVENTATIVE NEEDS ASSESSMENT: LITERATURE REVIEW

This literature review was undertaken with the purpose of identifying the characteristics of older people that are at risk of requiring intensive social care support in order that a range of early intervention services can be better targeted to meet their needs in future.

An initial search for articles and studies undertaken by staff at Bolton NHS library was taken as the starting point for the literature review. Where gaps in information were identified, further articles and studies were sought using references from the original articles and through searches on Google Scholar and relevant websites such as the Department of Health and Age UK.

Findings from all the articles and studies obtained have been collated into this literature review to address 5 objectives:

1. What are the key risk factors (and combinations of risk factors) that pre-determine the need for intensive social care support?
2. What is good practice in assessing relevant risk factors among older people?
3. Who benefits most from targeted prevention/early intervention services for older people?
4. Which targeted prevention/early intervention services/interventions are most effective/value for money/good practice?
5. What is the potential for communities to respond to the need to ensure older people can remain as independent as possible for as long as possible? What assets can be developed to meet this need?

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1. What are the key risk factors that pre-determine the need for intensive social care support

The risk factors that pre-determine the need for intensive social care support do not sit in isolation. The interaction between risk factors is very important as certain risks increase the likelihood of other risks and combinations of risks can further increase levels of risk. Some risks can trigger ongoing spirals and feedback loops which lead to increasing levels of risk, such as an old person who fears falling may be reluctant to leave their home and so may experience reduced levels of social participation. In turn this may increase the risk of depression which may further decrease the levels of social participation and therefore increase the risk of further depression.

The complex interaction between all risks makes it very difficult to establish which risks are more significant and which risks are more likely to occur. What is common throughout the literature is that **age, particularly older ages within the broad category of older people, is a significant risk** and can have a cumulative effect on other risks. As older people age risk increases and therefore increases the likelihood of triggering other risks and chains of risks.

Non-Modifiable Risks

Demographic

- Risk increases with age
  - Those over the age of 85 are most likely to receive any sort of care. Women constitute a greater proportion of this age group
  - Age increases other risks:

Cognitive impairment	Risk of falls	Co-morbidity
Level of physical activity	Depression	Age-related diseases
Living alone		

Gender

- Women are more at risk than men
  - Women live longer than men
  - Women are more likely to live alone as they live longer
  - Although women outlive men by an average of 6 years, the extra years often represent years of disability (often without the support of a partner)

Modifiable Risks

Social

- Living alone increases risk
  - Likelihood of living alone increases with age
  - Women are more likely to live alone (in 2006, 60% of women aged over 75 lived alone compared to 29% of men)
- Low social participation & frequency of social contacts increases risk
- Poor strategies to cope with other risks increases risk
- Having a caring role increases risk
  - Women are more likely to have a role as a carer
  - Nationally 49% of carers are aged 65 or over

Socioeconomic status

- Low socioeconomic status increases risk
  - Poverty increases risk of depression
  - Low socioeconomic status increases risk of living in poor quality housing
  - Low socioeconomic status increases the risk of social isolation – **exclusion and deprivation are strongly correlated with higher health and care needs**
- Socioeconomic status is a potent predictor of disability in older people
- Older people are more at risk of living in poverty
  - Widowed women are at the greatest level of risk
  - Older people from black and minority ethnic (BME) groups are more likely to live in poverty than white older people (49% of Pakistani and Bangladeshi pensioners live in poverty, compared to the national average of 16% of all pensioners)
  - Over 3.5million people aged 65 and over are in fuel poverty

Lifestyle and behavioural

- Tobacco use increases risk
  - Many old people become ex-smokers
  - Most smoking related deaths occur after age 65
  - Tobacco use increases the risk of complications in surgery
  - Tobacco use increases the risk of health problems (e.g. healing of ulcers, osteoporosis, fractures and vulnerability to infections)
- No or low/infrequent physical activity increases risk

- Age limits the ability of older people to partake in physical activity
- Regular physical activity reduces risk of falls
- Regular physical activity reduces the risk of mobility limitations
- Physical exercise can reduce the risk of depression
- People aged 75+ are much less likely to take the minimum levels of physical activity necessary to achieve health benefits

- Difficulties with activities of daily living (ADLs, e.g. bathing, dressing, housework) increases risk
  - More women than men need help for ADLs
- Nutritional deficiencies / low energy intake increase risk
  - Low energy intake reduces the ability of older people to partake in physical activity
  - Low energy intake reduces disease resistance
- No alcohol intake increases risk (compared with moderate intake)
  - Reduces risk of cardiovascular problems, such as heart disease
  - Alcohol abuse is less frequent among older age groups

<u>Psychological</u>

- Depression is a prevalent and strong risk factor for disability
  - Likelihood of depression increases with age (and therefore affects more greatly: women; people with disability; people with cognitive impairment)
  - 1 in 4 people aged over 75 has a depression that impacts on their quality of life
- There appears to be a strong correlation between depression and circulatory problems
  - After a stroke or heart attack the risk of depression rises dramatically
  - Being depressed can increase the risks associated with circulatory problems
- Cognitive decline/dementia - the most significant risk factor for disability and need of expensive care
  - Cognitive impairment increases risk of falls
- Fear increases risk (e.g. fear of falling, fear of crime, fear of abuse)
- Poor-perceived self-health increases risk

<u>Health</u>

- Long-standing illness increases risk
  - Likelihood of having a long-standing illness increases with age
  - In 2005 64% of people aged over 75 reported a long standing illness
  - In 2005 47% of people aged over 75 reported a limiting long standing illness
- Risk of a long stay in hospital increases with age
  - In 2006 the risk of a long stay in hospital, by age, was: 0.85% (65-74 years); 4.1% (75-84 years); 17.1% (85 years and over)
- The older the age a person attains without becoming disabled, the shorter the period of dependency to be expected before death
- Co-morbidity (the prevalence of one or more diseases/disorders in addition to a primary disease/disorder) increases risk
- Increased or decreased body mass index increases risk
- Age-related diseases (especially chronic diseases) increase risk
  - People aged 70 and on average have 2 or 3 chronic conditions and this age group accounts for around two-thirds of total health care expenditure
  - Chronic conditions increase the risk of depression
- Functional limitations increase risk
- Muscle weakness increases risk of falls
- Medications can increase risk (e.g. of falls)
  - Multiple medications can increase risk of falls

Mobility

- Gait and balance problems increase risk of falls
- Mobility problems increase risk
  - Mobility problems reduce ability to partake in physical exercise
- History of falls increases risk of falls
- Lower extremity functional limitation increases risk

Social and environmental obstacles

- Poor or Inadequate housing, particularly heating, increases risk
  - In 2011, 35% of the homes occupied by people aged 60 or over failed the decent homes standard
  - Older people in private rented accommodation tend to live in the worst conditions
  - Poor living conditions can increase risk of depression
- External environments can increase risk (e.g. of falling, slipping)
- Lack or breakdown of informal care / stress on carers increases risk
- Crises, such as bereavement, can increase risk
  - Negative life events can increase risk of depression

Key information sources

Heikkinen E (2003) What are the main risk factors for disability in old age and how can disability be prevented?, *Copenhagen, WHO Regional Office for Europe* (Health evidence Network report)

Age UK (2011) Later Life in the United Kingdom: factsheet

Age UK (2010) Health and Wellbeing: topic briefing

2. Good practice in assessing relevant risk factors among older people

There are a variety of screening tools and methodologies for assessing relevant risk factors among older people. In Denmark, all people aged 75 and over receive twice yearly home visits. In Nottinghamshire, the First Contact initiative has been developed as an assessment tool and source of information and advice for older people.

When assessing older people, they should be viewed as individuals rather than as average members of their age group. It is recommended that risk assessments are integrated with standardised assessment systems in primary care. The complex interconnections between risk factors indicate approaches should be holistic and address needs before they trigger a crisis or rapid deterioration. Case finding methodologies include using predictive tools, screening tools, activity data (information already in the system) and professional judgement

Predictive Tools

- These are routinely collected data, such as
  - Dr Foster's High-impact User Manager (HUM)
  - Kings Fund Patients at risk of rehospitalisation (PARR – PARR+)

Screening Tools

- Sherbrooke Postal Questionnaire - strongly recommended & the most commonly used
  - Questionnaire comprises of 5 items: living situation, medications, mobility, sensory deficits and memory problems
  - High response rate when used in the UK
  - Perceived by patients and practitioners as easy and straightforward to use
  - Good balance of sensitivity and specificity
  - Risk identified by a positive answer to two or more items or no response
- Castlefields Criteria
  - Identify people with complex needs who are also high resource users
  - Criteria include social care as well as health indicators
- Emergency Admission Risk Likelihood Index (EARLI) – *See Appendix A*
  - A simple-to-apply tool for identifying older people in the UK who are at risk of having an emergency admission within the following 12 months
  - Can be used as a simple triage-screening tool to identify the most vulnerable older people, either to target interventions & support to reduce demand on hospital services, or for inclusion in testing the effectiveness of different preventative interventions
- Mini Nutritional Assessment (MNA)
  - assess risk of health-related under-nutrition in older people
  - 6 item initial screen of BMI, recent weight loss, mobility, cognitive/mood state, appetite and eating **–** a full 18-item screen then used for those identified as "at risk",
  - Nursing Times article provides more information about nutritional screening tools

- Considerations when choosing a screening tool:
  - The desired size of the high risk subgroup: there is no point in identifying over half the population as at risk, or a very small minority at risk would be of limited value
  - Sensitivity & specificity
  - Shorter screening tools can be more convenient, but may lack detail
  - Computer scored screening tools do not necessarily mean greater accuracy

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Key information source

Philp I et al (2007) Screening tools for older people at risk of adverse outcomes

3. Who benefits most from targeted prevention/early intervention?

Due to the limited amount of published research on targeted prevention and early intervention strategies it is very difficult to assess who benefits most. Most literature focuses on one or two strategies, highlighting who those strategies particularly benefitted. As there is no research which systematically compares all types of prevention/intervention strategies, it is not possible to draw conclusions on who benefits most.

The following initiatives have been identified by some studies as having particular benefits for certain groups:

- Support for people following hospital discharge generates cost savings to health
- Targeting to address specific medical conditions (stroke care pathways, podiatry care, dental care, monitoring dehydration & continence care) can reduce demand for hospital admissions and subsequent demand on services
- Early intervention in cases of dementia can improve quality of life and reduce need for residential and nursing care by 22%

Whilst there is a scarcity of research to allow comparisons between the benefits of prevention/intervention strategies, particularly those aimed at preventing or delaying disease in people aged 75-80, there does appear to be a general consensus in much of the literature that interventions are required across the whole spectrum of need.

General benefits of targeted prevention/early intervention for older people

- Improved health and wellbeing
- Independent living
- Easier access to appropriate services
- Reduced need for long term institutionalisation
- Reduced need for full time care from carers

4. Which targeted prevention / early intervention services are most effective/value for money?

The scarcity of detailed research on targeted prevention and early intervention initiatives makes it difficult to assess which services are the most effective or value for money.

The following types of intervention have been identified as cost-effective:

- Low level interventions (e.g. information services, help around the house, falls prevention, physical activities)
- Hospital avoidance interventions (deliver a pronounced saving effect)
- Improving quality of life interventions, e.g. befriending, peer support, practical assistance (deliver discernable saving effect)

Prevention service	Average Saving
Postponing entry to residential care	£28,080 per person per year
Hospital discharge services (speed up patient release)	At least £120 a day
Housing adaptations	£1,200 - £29,000 a year (reduced cost of homecare)
Falls prevention (avoiding hip fracture)	£28,665

What research there is on the effectiveness of initiatives is very limited as much of the benefits of prevention accrue over a long-time, making them more difficult to measure. Research on prevention / intervention initiatives tends to be piecemeal, focussing on specific types of activity. There is currently a lack of research in many areas, particularly the risk factors and interventions for people aged 80 and over and environmental risk factors.

As there are few examples of research comparing the effectiveness of initiatives, establishing which initiatives are the most effective is difficult. However, what does emerge from the literature is a wide range of intervention / prevention strategies that have been evaluated as effective:

Information, advice & advocacy

- Older people need more choice, support and information to make informed decisions
- Access to information and support to help older people reverse the ill effects of smoking
- Health education - ineffective unless combined with initiatives to encourage behaviour change
- Older people prefer information in either face-to-face or written formats
- Older people particularly need information at times of crises and key life transitions and also on daily hassles.
- For more information on the information and advice needs of groups of people, please *see Appendix B*

Navigators & Outreach Workers

- Assist individuals in accessing services
- Coordinate provision of support & services
- Limited research on benefits and effectiveness

Support for Carers

- Can decrease demand for more expensive social care services
- Vital to promoting independence of older people

Housing

- Housing related support to help secure financial benefits

- Housing adaptations can enable a person to remain in their own home & also benefits future residents too. Spending between £2,000 - £20,000 on once off-housing adaptations can have a payback period of between 3 months to 3 years
- Housing adaptations reduce costs of home care (saving £1,200-£29,000 a year)
- Supporting People programme - strategically planned housing-related services to support vulnerable people – to improve quality of life, independence, health and well-being
  - Provision of high-quality cost-effective, reliable housing related services to complement existing health and care services
  - Highly preventative programme
  - Very cost effective
- Extra care housing

Community safety partnerships
- Can tackle older people's fear of crime
- Can help prevent crime against older people

Exercise
Potential benefits of physical activity (benefits are backed up by strong medical evidence)
- Reduced depressive symptoms; significant increase in satisfaction
- May ameliorate diseases
- Prevent / delay of functional limitations and disabilities
- Postponed / prevent disability
- Sustained independence
- Reduced health & social care demands among older people with circulatory diseases (which are also the largest single cause of long-term health & disability – including 50% of dementia cases)

Requirements for realisation of potential benefits of physical activity
- Must be long-term
- Appropriate facilities and good supervision are important

Specific recommendations
- Tai Chi – can positively affect mental health, but other less specific exercise programmes have similar effects too
- Telephone-based efforts to encourage participation in ongoing physical activity programmes
- Moderate centre-based exercise
- Group activities
- Targeting specific at-risk populations
- Active ageing (55/60 to 75/80)

Age proof mainstream services
- Design and deliver mainstream services with older people in mind
- Particular focus should be given to addressing the barriers to inclusion for older disabled people

Telecare & Telehealth
- Empower people to take control of their needs, under the guidance & support of a case manager

Rehabilitation
- Older people with the following needs should be considered for referral to geriatric rehabilitation

i. Any new disorder or disease in a patient with multiple underlying physiology
ii. Disability or new impairment of an uncertain cause
iii. Rapid or unexpected deterioration of impairment or disability
iv. Strain on care giver resources
v. Barely coping, permanent institutional care being considered
vi. New referrals to home care services

- Older people often have multiple needs - rehabilitation must fully evaluate the patient and deal with all treatable / modifiable issues simultaneously

Re-ablement

- Prevents unnecessary acute hospital admission
- Prevents premature admission to long-term residential care
- Connection with intermediate care services is very important
- Can deliver significant financial and quality of life gains

Crisis response – out of hours service

- Single integrated point of access
- Support service delivered within locally agreed minimum time
- Generically trained community support staff
- Links to intermediate care services and medicines management

Care managers as key workers

- Work proactively with very high intensity users and those with complex needs
- Develop shared care plans with realistic goal setting

Key information sources

Schroll M (2005) Health and Social Care Management for Older People, *European Forum on Population Ageing Research / European Group on Quality of Life – Extending Quality of Life in Old Age*

Turning Point (2010) Benefits realisation: assessing the evidence for the cost benefits and cost effectiveness of integrated health and social care

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CASE STUDIES / EXAMPLES

Self Care

Overview

- Allows individuals to be treated as partners and to do more for themselves – which improves outcomes

Findings

- Reduced visits to GPs by 69%
- Reduced hospital admissions by up to 50%
- Decreased feelings of helplessness
- For every £100 spend on self care, around £150 benefits can be delivered in return
- Self care in older people's conditions (e.g. chronic arthritis, Parkinsons disease) will lead to savings
  - Reduced visits to GPs and hospitals
  - Reduced need for social services such as meals on wheels, home help & day care centres

Partnerships for Older People's Projects (POPP) findings

Overview

- 29 pilots, 136 local projects
- 2/3 of projects were community facing, 1/3 hospital facing
- Centre of POPP programme – recognition that prevention & early intervention must be at the heart of the vision for future care & support
- High initial set up costs, but average costs lower than many health and social care interventions

Findings

- Integrated co-located health and social care teams improves outcomes for older people
- POPP interventions health-related quality of life
  - 29% reduction in A&E admissions
  - 47% reduction in hospital overnight stays
- Projects providing services to individuals with complex needs were particularly successful in improving quality of life
- Low level preventative programmes also had demonstrable impact
- Intervening early through proactive case co-ordination is effective
- Small services providing practical help & emotional support can significantly affect the health and well-being of older people, alongside more sizeable services designed to avoid the need for hospital admission
- 86% chance that POPP projects are cost-effective (varies by project, e.g. handyman & gardening schemes found to be 98% effective)
- Reduction in demand for physiotherapy, occupational therapy & outpatient appointments
- Focus on discharging outpatients - highest reduction in hospital facing projects
- Only 4% of POPP projects not continued after end of DH funding

Key information source

DH (2010) Improving Care and Saving Money: learning the lessons on prevention and early intervention for older people

LinkAge Plus

Overview

- Co-production model
- Widening access, opening doors and making connections
- Aims to bring together various forms of mutual help, services and support for older people at a local level in a way that adds value
- Older people involved throughout
- 8 pilots
- Services developed to promote independence and wellbeing (e.g. keepfit, help services, adaptations, activities, social groups)
- Upfront investment required for first 2 years – began delivering net-savings quite quickly, breaking even in year 1.

Findings

- £2.65 benefit for every £1 spent
- Balance classes – high effective way to reduce incidence and associated cost of falls, leading to fractures, hospitalisation and operations (for every £1 spend on tai chi a saving of £1.35 was made)
- Home adaptation services – benefits of £74 per adaptation, against average adaptation cost of £67
- Benefits to older people – for every £1 spent a benefit of £1.40
- Involvement of client group is very important as it fosters ownership and service utilisation. Also, projects can be led volunteers which reduces staffing costs
- Reduced duplication & built on and integrated existing projects & initiatives

Handypersons service

- Less research done on benefits and effectiveness
- Northampton care & repair service handyperson scheme: costs £1,900 per month and will typically help discharge 20 people from hospital (compared to one hospital day for 20 patients at a cost of approximately £5,500)
- Handy person service with funding of £394,000, used by 2,317 households in 1 year. Benefits include:
  - 224 falls prevented
  - 2 burglaries prevented
  - Reduction in fuel poverty
  - 39 people prevented from moving to sheltered accommodation/care homes
  - Reduction in hospital stays for 10 people
  - £51,000 saved for local householders (reduced crime & fuel poverty)
  - £455,000 saved for social services
  - £162,000 saved for health (reduced falls)
  - £3,000 saved for police
- Improve wellbeing, independent living &easier access to appropriate services
- Consistently highly rated & well supported by the community

Key information source

CLG (2011) Handypersons Evaluation

Falls Prevention

- Each year 35% of over 65s experience 1 or more falls
- Around 45% of over 80s who live in the community fall each year – between 10-25% of these will sustain serious injury
- Over ½ of all women and 1 in 6 men experience a painful and disabling fragility fracture later in life
- Osteoporosis underlies many risk factors. It affects 1 in 3 women and 1 in 12 men aged over 50

Prevention

- A major area where known health and economic benefits can be seen
- Preventing fall leading to hip fracture - average saving of £28,665
- Falls prevention - only effective with reform of health & social care siloed budgetary arrangements
- Initiatives:
  - Multi-factor & multidisciplinary approaches, which also address the complexities within older people's lives are the most successful
  - Physical activity & balance training (e.g. Tai Chi)
  - Targeted exercise for the over 80s
  - Review medication and diagnosis
  - Home assessment - recommended only for those identified as being at risk or having fallen
  - Hip-protectors to some nursing home residents
  - Encourage healthy lifestyles
  - Reduce unnecessary environmental hazards
  - Assessment and consequent modification of risk factors following attendance at A&E due to a fall

Early interventions

- Features of interventions in the community with the highest quality evidence base:
  - A falls care pathway
  - A falls service
  - A falls coordinator
  - Multi-factorial interventions
  - Community based therapeutic courses

Key information sources

DH (2009) Falls and Fractures: Exercise training to prevent falls

DH (2009) Falls and Fractures: Effective interventions in health and social care

5. What is the potential for communities to respond to the need to ensure older people can remain as independent as possible for as long as possible? What assets can be developed to meet this need?

So far, there is very limited information in relation to this question. What emerges from the literature so far is some guidelines and suggestion for developing effective prevention and early intervention initiatives. Some of this seems to loosely link with question 5.

Requirements for developing effective prevention and early intervention initiatives

Build community capacity

- Involve older people
- Develop local approaches
- Outreach
- Join-up services
- Big Society agenda offers opportunity to widen the scope of preventative services
  - Community and volunteer led initiatives should not be seen as a substitute for existing publicly funded provision
  - Voluntary sector has many years experience of the type of community development work and mutuality which is key to the Big Society

Involve older people

- An essential starting point
- Enable and support older people to have a strong voice in local services
- Engage service users and carers as a means of offering choice and personalisation
  - Person-centred planning – develop personalised care plans using joint care planning
  - Develop initiatives that give older people greater choice
  - Support and enable people to take appropriate & effective self-directed care & greater responsibility for managing their own health
- Use client feedback to build cases for services with local commissioners & identify improvements
- Develop infrastructure to support older people as volunteers

Intergenerational activities

- Strongly recommended

Staff training

- Attitudes and skills of frontline staff are very important
- Training needed in key areas for staff (e.g. dementia care communications, emotional support, recognition & support for mental health support needs)
- Support to training of care home staff is important

Innovation

- Particularly community based options & solutions

Multi-agency working

- Staff from different agencies need to join up more
- Develop joint health & social care teams to address complex needs
  - Reengineering pathways out of hospital
  - Rapid response services
  - End of life care
- Develop joint commissioning plan
- Join up multidisciplinary working along the care pathway
- Ensure high levels of awareness by linking with other services & groups

Planning

- Understand the local population & their needs (JSNA & future needs)
- Understand how the system currently responds to need
- Prioritise the areas for change
- Invest rather than spend (sole focus in net-savings is too narrow)
- Rigorous medium to long-term business planning (3-5 years)
- Monitor performance & effectiveness

For more examples of community led early intervention and prevention initiatives, refer to the Joseph Rowntree Foundation Paper cited below.

Key information source

JRF (2011) How can local authorities with less money support better outcomes for older people?

Other useful information sources

Age UK (2010) Short-term protection, long-term vision

*DH (2008) Making a Strategic Shift to Prevention and Early Intervention: A guide

JRF (2009) Older people's vision for longer term care

Audit Commission (2010) Under Pressure: Tackling the financial challenge for councils of an ageing population

(* *Strongly recommended*)

APPENDIX A

EMERGENCY ADMISSION RISK LIKELIHOOD INDEX

Please answer the following questions by putting a cross in the relevant box as shown in the following example:

Example ☒ YES ☐ NO

Please complete all questions

Have you ever had any of the following illnesses (please put a cross in the appropriate box)

1. Heart problems ☐ Yes ☐ No
2. Leg Ulcers ☐ Yes ☐ No

Please answer Yes or No to the following questions by putting a cross in the appropriate box:

3. Can you get out of the house without help? ☐ Yes ☐ No
4. Do you have problems with your memory and get confused? ☐ Yes ☐ No
5. Have you been admitted to hospital as an emergency in the last 12 months? ☐ Yes ☐ No
6. Overall, would you say your state of health is good? ☐ Yes ☐ No

Thank you for taking time to complete this questionnaire

If you need help with filling in this questionnaire, please ring the practice for assistance

For office use only:

Practice ID ☐☐☐☐☐☐ Date Form Completed ☐☐ ☐☐ ☐☐

Patient's NHS Number ☐☐☐☐☐☐☐☐☐☐

Patient's Post Code ☐☐☐☐ ☐☐☐☐

Date of Birth ☐☐/☐☐/☐☐

Lyon D et al (2007) Predicting the likelihood of emergency admission to hospital for older people: development and validation of the Emergency Admission Risk Likelihood Index (EARLI), *Family Practice, 24, pp.158-167*

APPENDIX B: Summary of information and advice needs of different service user groups

Service User Group	Preferred info channels	When info is needed	Types of information needed (or gaps in provision)	Information should be…	Additional points
Older People	1. Face to face 2. Written • Information centre • Media • Telephone • GPs to signpost • Internet	• Key life transitions • Crises • Daily hassles	• Often same as general population • Work; Exercise; Learning; Transport; Financial; Sexual health. • Bereavement • Local services • Residential care & social care charges	• Topic based • Jargon free • Reinforced by guidance and support	• Involve older people • No unnecessary form filling
Disabled people	1. Face to face 2. Print 3. One stop shop • Internet • Telephone • DVD/CD-ROM	• Onset • Life changes and transitions		• Clear signposting	• Involve disabled people • Ownership of information • Free from bureaucratic & attitudinal barriers
People with sensory impairments	• Not just Braille • Verbally • More use of libraries • One stop shop • Audio • Large print	• Ongoing	• Visual equipment (gap) • Social care services (gap)	• In appropriate languages and formats (barrier for BME groups) • Clear signposting	• Involve specialist service and service users • Consider accessibility issues to info & advice from the start
People with long term conditions	1. Single point of contact • Trained staff	• Diagnosis/onset • Ongoing • Crises	• Symptoms, medicines, treatments • Understanding professional advice • Accessing services (e.g. transport, work, leisure, social care) • Dealing with psychological effects		

Service User Group	Preferred info channels	When info is needed	Types of information needed (or gaps in provision)	Information should be…	Additional points
People with learning disabilities	• Easy Read • Audio • DVD • Large Print	• Diagnosis • Transitions	• All information/mainstream services • Education & training; Housing; Employment; Leisure • Support • Financial • Disability specific information	• Simple • Straightforward • Jargon free • Bullet points • Use of pictures	• Easy Read is not just used by people with learning disabilities
People with mental health issues	1. Face to face • Trained staff • Internet (for younger people)	• Onset • Ongoing	• Respite services, residential care & day care (gap) • Planning ahead options (dementia)	• Provided directed to people • Straightforward • Real life experiences	• Info available where people can pick it up (e.g. GP surgeries) • Stigma can prevent people seeking information face to face
Carers	1. Face to face • Tapes • Telephone • Print • One stop shop • Information pack • Support networks	• Onset of caring role • Ongoing (needs change over time – incl. when caring role ends)	• Rights, benefits & support • Emotional side of caring • Making a complaint • Local services and support • Health	• Simple messages repeated • Reinforced by support	• Hidden carers
Young people in transition	• Written • Internet		• Rights and choices • Local services • Routes through the transition process	• Directed primarily at young people themselves • Interesting and relevant	• Looked after, homeless and socially disadvantaged young people are the greatest in need • Glossary

Service User Group	Preferred info channels	When info is needed	Types of information needed (or gaps in provision)	Information should be…	Additional points
Substance users	1. Leaflet • Internet can be problematic		• Easy to understand medical information (gap) • Local services and organisations	• Easy to understand • Available in languages other than English	• Substance users may have difficulties attending training courses
LGBT people	• Better staff training	• Critical life stages • Ongoing	• Mental health • Substance use • Social care • Local services/organisations • Issues of loneliness, isolation & financial hardship	• Free from discrimination	• Involve LGBT people
Self funders	• Written • Verbal	•	• Financial advice, funding & costs • Local services • Government information • Eligibility criteria • Assessment procedures • Types of care available • Needs are akin to those on personal budgets	• Provided directly to self funders	• Traditional image of social care can deter people form seeking information and advice • Monitor effectiveness of signposting
NOTES	*Numbered items indicate a clear priority*			*Many criteria are common to all groups – see document "key findings common across all or most service user groups"*	