THE NHS SYSTEM FOR LIVING LONGER BETTER
and reducing the need for health and social care

Population ageing is a complex challenge which cannot be met by either reorganising bureaucracies or shifting activity to the private sector. To increase healthy life expectancy, and reduce the gap between the most and the least deprived sub-groups in the population, and therefore reducing the need for health and social care requires an integrated care system

"Certain nonlinear systems … are commonly described as being Complex, because their behaviour is defined to a large extent by local interactions between their components. When such systems are capable of evolution they are also known as Complex Adaptive Systems."
***Source*:** Rihani, S (2002) Complex Systems Theory and Development Practice. Understanding non-linear realities. Zed Books Ltd. (p.7).

Each system needs to have a specification setting out the objectives and the criteria that can be used to measure progress and standards that can be used to assess performance.

THE INTEGRATED CARE SYSTEM SPECIFICATION

The most appropriate response to the challenge of population ageing is a system with a set of objectives agreed once, nationally, delivered by local population based networks. The Live Longer Better System developed by the Optimal Ageing Programme at Oxford can realise the three principles of the Darzi Report also reinforced in the Neighbourhood Health Service guidance

- *Shifting from hospital to community care*
- *Changing from analogue to digital*
- *Moving from treating sickness to preventing it*

Set out below are the system objectives, developed initially in 2021 during Covid by the Living Longer Better programme which was a national programme sponsored by Sport England

- *To prevent and mitigate isolation*
- *To increase physical ability, resilience and healthspan and prevent frailty and falls*
- *To reduce the risk of, and delay or prevent dementia*
- *To prevent and minimise the effects of disease and multimorbidity*
- *To promote knowledge and understanding about living longer better among older people and the wider population to counteract the detrimental effects of ageism*
- *To create an environment in which people can fulfil their potential*
- *To enable strengthening of purpose*
- *To support carers better*
- *To minimise and mitigate the effects of deprivation*
- *To enable dying well as well as living well*

It also requires a significant change in culture to counter the adverse effects of ageism and it is essential to focus on the whole population. Good work for people identified as having frailty or being at high risk is already being done by Geriatric medicine through the PROACTIVE programme and by the NHS England Ageing Well programme, and this is reinforced by the inclusion of a population health management one of 6 core components in the 2025/26 Neighbour Health Guidelines but based on the epidemiological principle developed by Geoffrey Rose, we also need to shift the whole population curve because to prevent frailty, falls and dementia we need to address the high volume of acute problems which occur in low risk people to have impact at population level.

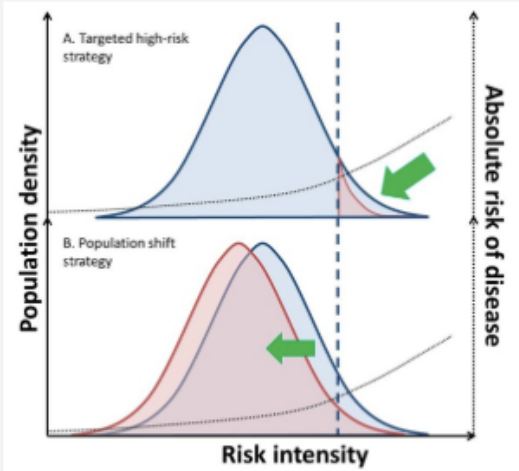


Figure 1. Illustration of disease prevention strategies. Inspired by Rose 1985 *IJE*.

Living Longer Better includes work aimed at the highest risk groups as recommended in the Neighbourhood Health Services model, for example the digital group learning programme for people with multimorbidity delivered in BNSSG ICB by Learning with experts but is also strongly committed to shifting the whole population curve.

RESOURCES

Living Longer Better fully supports the principle set out in the 2025/2026 priorities and operational planning guidance in particular this principle

- ***live within the budget allocated, reducing waste and improving productivity***. *ICBs, trusts and primary care providers must work together to plan and deliver a balanced net system financial position in collaboration with other integrated care system (ICS) partners. This will require prioritisation of resources and stopping lower-value activity*

Currently too much is being spent on often ineffective and harmful drug therapy for older people rather than non-drug therapy, as explained in the DHSC report *Good for You, Good for Us, Good for Everybody* which states that 10% of drugs prescribed for people over 65 are pointless, and 20% of acute admissions have drug side effects as a factor. This is waste. The DHSC report emphasises that one reason for overprescribing is the lack of non-drug therapy options. The development of social prescribing and

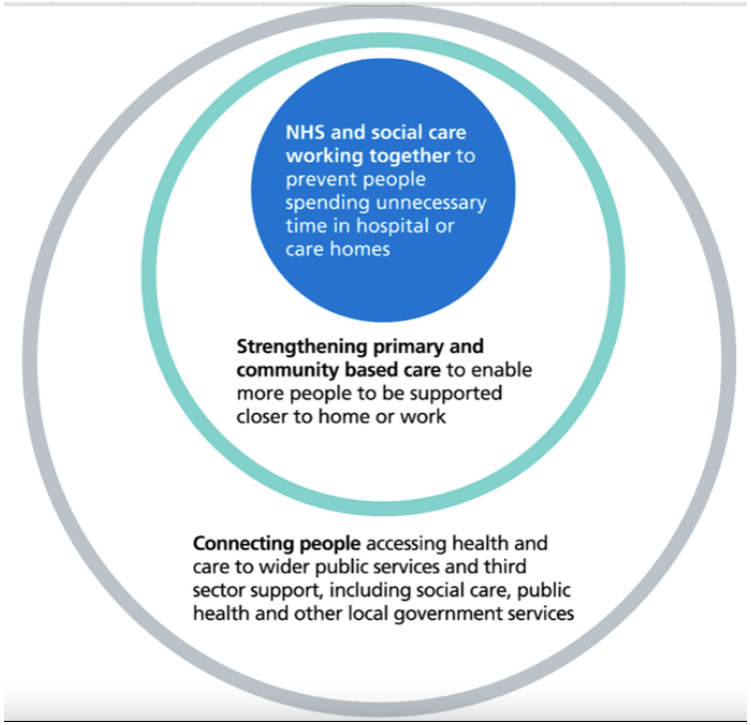
the digital moves described below will tackle some of this problem but PCNs needs to be given the power to shift resources from drug to non-drug interventions through social prescribing.

LIVE LONGER BETTER IN THE 2025/26 NHS ENGLAND CONTEXT

Set out below are a number of NHS initiatives which have the aim of increasing healthy life expectancy and reducing the gap between the most and the least deprived. Obviously, they will be reflecting on the implications of the NHS policy documents published on the 30th of January, namely

- The Priorities and Planning Guidance
- The **2025/26 priorities and operational planning guidance**
- in particular the focus on Neighbourhood Health Service models which reiterated the three Darzi priorities
- The recognition that culture change is key

The Living Longer Better system includes action on all three levels of the Neighbourhood Health guidelines shown below



The Living Longer Better system is

- Primarily focused on prevention; primary, secondary and tertiary to increase healthy life expectancy, lessen the impact of deprivation and reduce need for health and social care
- Strengthening communities and supports them with digital networks involving all the agencies including NHS, local authority and VCFSE (voluntary, community, faith and social enterprises)

- Connecting people both locally and digitally with other people with a common interest encouraging participation and contribution. This will reduce the inappropriate and unhelpful "*1 in 5 GP appointments …taken up for non-medical reasons"*

THE NEED FOR A CULTURAL REVOLUTION

The Planning Guidelines and Operating Framework emphasise that culture change is key and there are two cultural changes that the Living Longer Better system will lead are:

- Work, in line with the excellent Centre for Ageing Better campaign, to combat and reduce ageism
- The promotion and creation of a culture in which older people are seen as a resource and not a burden, enabling older people to make an even bigger contribution to the wellbeing of other people of all ages

Strategic priority as defined in the Darzi Report, the 2025/26 Operating Model and the Neighbourhood Health guidelines	Objective	Action	Key Contact
	Learning and empowering with wellbeing planning linked to pension planning	The NHS Business Service Authority is capable of offering online learning about Living Longer Better digitally linked to its pension planning and delivery. Starting with NHS staff as the largest employer in the country could have significant impact	Michael Brodie
			Tony Jamieson

Moving from treating sickness to preventing it *Changing from analogue to digital*		There is an important opportunity to promote deprescribing and represcribing activity as with the focus on reducing opiod prescribing and using biopsychosocial interventions to manage or live with pain.	Patient Safety NHSE
Changing from analogue to digital *Moving from treating sickness to preventing it*	Complementing, supplementing and relieving Primary care professionals and other clinicians in every neighbourhood by issuing activity prescriptions digitally and automatically linked to diagnosis and postcode	This is being launched in South and West Herts based on the population of 4 PCNs representing each Neighbourhood within South and West Herts, with close involvement of Active Hertfordshire, the support of NHS Digital and the NHS App Director for the W:ISH technology Walking prescriptions and arts prescriptions will be introduced with Let's Dance and Let's Walk More movements. Repeat drug prescriptions will also be accompanied by Booster messages and NHS Birthday Boosters can also be produced This is a whole population approach which will link with the Dacorum Proactive Care Pilot , based on the principle of population health management and risk assessment	Alan Naismith Polyatrics Dr Pani Sissou GP, Alpha PCN Director and Dacorum Clinical Lead The East of England Health innovation Network is also closely involved
Moving from treating sickness to preventing it	Recreating local neighbourhoods and	Goldster is being developed by a group of people in their 60s, 70s and 80s using the principles of social pedagogy,	Andrew Lane Andrew.lane@npa.org.uk

Shifting from hospital to community care *Changing from analogue to digital*	creating digital therapeutic communities	and the potential of digital, to strengthen the therapeutic power of relationships in local communities and create digital therapeutic communities to complement and supplement the local face to face communities Elgin, Morayshire is the development population	www.goldster.co.uk
Shifting from hospital to community care	Developing a new generation of leaders in social care to work, skilled in employing systems, networks and culture, not only a culture that challenges ageism but also a culture of social pedagogy in which things are not done to older people but with them	This is a graduate programme at Kingston University with the aim being to have at least five people trained in every local authority, not only from social services but from other departments such as housing	Yvalia Febrer Kingston University Department of Social Work
Moving from treating sickness to preventing it *Shifting from hospital to community care*	Developing population based networks with Public Health professionals and librarians playing a key role. Knowledge will be made available through learning programmes and Let's Walk More will be launched	The Northamptonshire programme for Living Longer Better Living Longer Better in Hertfordshire	Frank Earley | Public Health Principal West Northamptonshire Council Carl Dorney

			Head of Library Services
Changing from analogue to digital *Moving from treating sickness to preventing it*	Online group learning for older people, including older people with multi morbidity, frontline professionals and volunteers about the determinants of living longer better and the actions that individuals can take	This is an online learning system based on the principle of the Fourth Education Revolution, namely that people learn more from one another than from the lecturer. This is being used in Torbay and Bristol with the latter being a learning programme for people with multimorbidity. There is a complementary programme for front line staff and volunteers	Elspeth Briscoe and Mark Fishleigh Learning with Experts Oxford www.learningwithexperts.com
Changing from analogue to digital *Moving from treating sickness to preventing it*	VR walking for people who cannot stand or who may become immobile through lack of activity. Primarily directed at preventing Hospital Acquired Deconditioning (HAD) and reversing HAD where this occurs	This is a VR system combining physical, social and cognitive therapy to improve patient outcomes and reduce healthcare costs. This VR system provides seated social immersive (VR) walks that patients want to engage with and has demonstrated high levels of exercise compliance. This plug-and-play system requires no wifi, internet or mobile reception and delivers physical mobility data useful to healthcare professionals. Primarily directed at preventing HAD in acute hospitals and the spiral down such inactivity leads to, this safe, social (2 patients) exercise can be self-	Charles King Motus VR Charles.king@motusvr.com info@motusvr.com

		administered freeing up healthcare professionals. This VR technology was developed for people in care homes and hospitals, some with dementia, and has been co-developed with Oxford and Cornwall hospitals and care homes and input from Stoke Mandeville where its ease of use and ability to motivate unwitting exercise has great value. Application in hospitals in Oxfordshire is anticipated in 2025. Motus VR technologies are designed for digital, ethnic and wide ability inclusion and is in use in UK and Hong Kong	
Changing from analogue to digital	Enabling digital inclusion Link to: Digital Inclusion Framework	*A Digital Inclusion Framework for Health and Care - Interactive tool* The digital inclusion framework for health and care has been co-produced with members of the public across Sussex and developed in collaboration with NHS Sussex, University of Sussex and Health Innovation KSS. The framework takes into account the different requirements needed for a service user to be able and motivated to engage with digital health and care. It is a resource for commissioners of health and care services and	Katherine Sykes Lucie Hooper Kent ,Surrey Sussex Innovation Network Katherine.Sykes@nhs.net Lucie.hooper@nhs.net 07778 448612

		technology, it considers inequalities introduced due to being digitally excluded or disadvantaged. It is being adapted for use by industry partners to enable them to design for inclusion in health and care. The framework is referenced by NHS England in the national digital inclusion framework and is a practical tool to embed the recommendations.	www.ksshealthinnovation.com
Moving from treating sickness to preventing it	Reconditioning Programme https://doi.org/10.1093/ageing/afab227 Link to evaluation: https://mcas-proxyweb.mcas.ms/certificate-checker?login=false&originalUrl=https%3A%2F%2Fgbr01.safelinks.protection.outlook.com.mcas.ms%2F%3Furl%3Dhttps%253A%252F%252Ffuture.nhs.uk%252FECIST network%252Fview%253FobjectID%253D215499781%26data%3D05%257C02%257Camit.arora%2540uhnm.nhs.uk%257C048d283be60	This is led by the geriatric medicine services which have a key role to play in changing culture and making the acute sector population bases and making a contribution to neighbourhood health. Following the inaugural 'National Deconditioning Awareness and Prevention Campaign' in 2016, a national program against deconditioning 'ReconditionTheNation' was launched in 2022. The aim was to improve patients' outcomes and improving staff morale by reducing deconditioning in hospitals and care homes. Over 100 organizations spread across 34 ICSs took part voluntarily, over 1500 medals and certificates were provided to participant teams. A network of 500 volunteering	Amit Arora President Elect British Geriatrics Society and Clinical Director, Emergency care improvement Support Team, NHS England Evaluation attached as a slide set which can be developed a s a link or vi NHS Futures website

	64787ed9c08dd4f300030%257Cc52f36dcd35a4a8d9291804eb4965bd5%257C0%257C0%257C638753789936793630%257CUnknown%257CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%253D%253D%257C0%257C%257C%257C%26sdata%3DCsbFj48fxLolaDXqDF7LlrIPsxOvuavRWtJfMaHKt5g%253D%26reserved%3D0%26McasTsid%3D20893&McasCSRF=f6ddfaee7a762acc0f5e55b508a3ea7a685710ba73f764bc59160149f6df6917	Reconditioning Ambassadors was developed which continue to meet monthly and spread good practice. Next phase will include younger ages and community-dwelling adults too in line with the neighbourhood health plans. Awareness and education of populations across the country is key. For example, the benefits of exercise and the CMOs recommendations on physical activity can be displayed in public areas, shopping malls, GP surgeries etc for maximum impact.	
Moving from treatment to prevention *Moving from Hospital to Community* *Moving from analogue to digital*	NHS Position Statement on Physical Activity Four Ways Forward	Ensuring that everyone working in the NHS understands the importance of physical activity i) Empowering Healthcare Professionals ii) Integrating physical activity into clinical pathways iii) Supporting the NHS workforce to increase their physical activity iv) Supporting innovation and evaluation with partners	Sarah Price Director of Public Health NHS England

Obviously there is work by other organisations such as the Centre for Ageing Better, AgeUK and Sport England which needs to be connected but the first step is to relate these NHS and social care projects to one central aim of increasing healthy life expectancy and reducing the gap between the most and the least deprived described in the CMO's Annual Report on *Ageing in a Healthy Society.*

This will also significantly reduce the need for health and social care.

Muir Gray and Sarah Price

I am not sure if this will be of help re the prevention side of things but feel free to add if you feel appropriate. These are not related to physical activity as such but in light of the move from treatment to prevention these may be relevant.
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1. The Staying Well service is a specialist team providing preventative services to individuals over 55 years of age in the community across South Staffordshire.

The service supports adults within their own home who have been identified as having mild to moderate frailty. The aim of intervention is to proactively manage the deterioration of frailty by taking a preventative approach and help individuals to stay well, live well, and age well.
People who are referred to the service have been identified as those with mild to moderate frailty. One of our Staying Well Facilitators will then visit the person at home and carryout a holistic assessment looking at General health, medications, social support, cognition / memory, mood, mobility, functional performance and functional independence.
The service supports individuals to understand and manage their own health and wellbeing, promote healthy living and behaviours, signpost and onward referrals are also made. Links into local communities are also made to reduce isolation.
The team is made up of nurses, registered mental health nurses, occupational therapists and occupational therapy assistants. We also work alongside consultants and pharmacists.
They work closely with Community Connectors and Social Prescribers to link people to their local communities.
Following the assessment, personalised plans are provided and monitored, and followed up by the Staying Well Facilitator at six weeks and six months following the initial assessment.

2. Staffordshire and Stoke-on-Trent's Weight-related Interventions Tailored in Care for Health (SWITCH) is a specialised service to support people with managing the many contributing factors that can make reaching lifestyle and/or weight goals difficult.

It is designed to listen to a participants' strengths and concerns, and understand the challenges they face, in reaching their personalised lifestyle goals. The SWITCH multidisciplinary team then aims to offer appropriate assistance in reaching these personalised goals.

- Dietitians and Dietetic practitioners (Nutrition specialists)
- Community connectors (specialists in linking with local support and activities)
- Specialist Nurses (providing specialist medical screening)
- Physiotherapists (Musculoskeletal specialists)
- Endocrinologists (Hormone specialists)
- Bariatric Surgeons (Weight loss surgery surgeons)
- Psychologists (Mental health specialists)
- GP's with interest (General Practitioner specialising in weight management)
- While also having direct links to Mental health and Wellbeing coaches

SWITCH has partnered with Patients Know Best, a free online patient portal that links with the NHS App, allowing you to contact the SWITCH team at any time when you are actively participating in the program.