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**thirdage**

Responding to the Opportunities  
and Challenges of Ageing in Ireland

# **The AgeWell programme as a public health intervention**

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## Introduction

The twenty-first century is experiencing a demographic shift in populations globally. The World Health Organisation (WHO) (2021) indicates that between 2015-2022, the world's population over the age of 60 years will have grown from 12 per cent to 22 per cent. By 2050, the number of older people is estimated to amount to two billion, up from one billion in 2020 (WHO, 2022). Irish statistics reflect a growing number of people over 65 years as a proportion of the population. In August 2022, there were 768,900 people aged 65 years and older in Ireland demonstrating a rise from 13.3 per cent of the population to 15.07 per cent since the previous census (CSO, 2022). Similarly, the Central Statistics Office (2018) *Population and Labour Force Projections 2017–2051* suggest that people 65 years and older in Ireland will rise from 629,800 to approximately 1.6 million by 2051<sup>1</sup>. In concordance with a rising life expectancy, increased numbers in those over 80 years of age are notable, with 147,800 recorded in 2016 to a projected 549,000 by 2050<sup>2</sup>. In the 2016 census, approximately 26 per cent of older people lived alone (CSO, 2016).

While increasing human longevity is a success of the twentieth and twenty-first centuries, it is imperative that the quantity of years also translates to optimisation of the quality of life for older people. Quality of life is defined as:

‘...an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.’ (WHO, 2012: 11)

As age is a risk factor for various chronic illnesses, many older people experience multi-morbidity which can impact their independence and limit mobility (Yarnall et al., 2017). For example, TILDA reports indicate that 13 per cent of adults over 50 years of age experience frailty with a further 32 per cent being in the pre-frailty category. Moreover, the decline in some cognitive domains is also associated with ageing, particularly in those aged 75 years and older (Turner et al., 2018). Equally, limited mobility, changing neighbourhood populations and reduced networks of family and friends (i.e. due to family geographic mobility, poor health in peers and bereavement) can increase the risk of loneliness and social isolation. Loneliness impacts older people living alone and those living with others; figures related to those living

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<sup>1</sup> Under M1 and M2 population projections

<sup>2</sup> Under M1F1 population projections

alone demonstrate 32 per cent being moderately lonely and 37 per cent being mostly lonely while figures of those living with others suggest 31 per cent being moderately lonely and a further 21 per cent being mostly lonely (Ward et al., 2020). This experience has been exacerbated by COVID -19 (Phelan et al., 2021) as public health measures recommended shielding and restricted movement. Phelan et al. (2021) also suggest that COVID-19 has had a deconditioning impact on the functional ability of older people living in the community, while other studies point to its impact related to diminished cognitive ability (da Silva Castanheira et al., 2021) and mental health stress (Amanzio et al., 2021).

Recent health policy in Ireland has increasingly supported the development of primary care which enables people to potentialise their health through prevention, early intervention and disease management (Committee on the Future of Healthcare, 2017). Acknowledging frameworks of the social determinants of health and a socio-ecological approach to health and social care, the wider view of health assumes principles of care integration, rights-based approaches and potentializing health outcomes, addressing health inequalities, service sustainability and quality-based service user care experience. In 1988, Ireland published its first policy for older people, *The Years Ahead Policy* (Robbins, 1988) with a second policy published in 2013- *The National Positive Ageing Policy* (DoH, 2013). Both policies focus on the optimisation of health for older people in Ireland. In addition, the National Integrated Care framework for older people (Integrated Care Programme for Older People and National Clinical Programme for Older People, 2017) recognises that older people need enabling community supports, which are person-centred, to maximise their quality of life.

### **Third Age**

Third Age is a community and voluntary organisation that works for, with and on behalf of older people and is underpinned by an ethos of connectedness, creativity and social inclusion. It provides a range of services both within the Meath geographical area and nationally and is immersed in community development, aligning with the vision of the Department of Rural and Community Development (2019, revised 2021) and the WHO for people-centred care (2015). Third Age has two national programmes SeniorLine and Fáilte Isteach. SeniorLine is a national confidential listening and support telephone service for older people provided by older volunteers. Calls are free to a dedicated phone number (1800 80 45 91). The service is available from 10am to 10pm, 365 days a year. Fáilte Isteach is a network of over 190 classes

nationwide in all 26 counties in the Republic of Ireland, where predominantly older volunteers support migrants and refugees through the facilitation of language classes to enable the acquisition of conversational English.

## **AgeWell**

AgeWell is a community-based (County Meath) support programme facilitated by Third Age. Its aim is to combine sustained peer-based social engagement and mobile technology to improve health outcomes and well-being among older people. There are 6,878 people over the age of 75 years living in private households in County Meath with 2,168 living alone in their own homes (CSO, 2016). Between 2011 and 2016, there was a percentage increase of people aged 65 years and older of 27.4 per cent, demonstrating the potential rising demand for innovation in health and social care services delivery for older people (CSO, 2016). The recent 2022 Census is anticipated to represent additional rises in numbers.

The preparation stages of the AgeWell programme began in October 2017. A pilot programme was launched in February 2018 and ran until October 2018. A phased expansion to other locations outside the pilot areas began in early 2019 and was subject to the acquisition of additional funding. The final expansion into the remaining parts of County Meath, where the project had not yet reached, i.e. Navan and East Meath, began in February 2020.

The programme has several levels of support- the Care Co-ordination team and the AgeWell companions. Baseline assessments are carried out by the Care Co-ordination team before a trained AgeWell companion (volunteer) is introduced to the older person. The same member of the Care Co-ordination team conducts subsequent midline assessments (repeating the baseline assessments) which contributes to the continuity of care, identification of any deterioration/improvement from baseline as well as enhancing trust and positive relationships with the older person. The midline assessments applied by the Care Co-ordination teams are the WHO 5 (well-being) questionnaire (WHO, 1098), MOSS 8 scale (informational and Emotional Supports) (Clough-Gorr et al., 2007), and the UCLA loneliness scale (Russell et al., 1978) (appendix 1).

AgeWell companions are aged 50 years and older and are matched with clients to increase the potential for optimisation of health outcomes. AgeWell companions complete fortnightly questions embedded in a bespoke App (20/20 app) to identify any deterioration in areas such

as physical health, emotional health and/or well-being. The 20/20 app uses a standardised algorithm hosted by Third Age and is monitored by a data analyst with a healthcare background. Deviations are flagged to the Care Co-ordination team whose responsibility is to review concerns and take appropriate actions (i.e. locally or in the context of a referral). This enables real-time benchmarking and ongoing monitoring of physical, emotional and psychological health status and identifies symptomatic deterioration in the client's health and well-being domains. In addition, data collection includes any utilisation of health services (General Practitioner attendance, hospitalisations, falls, service contacts) and social contacts.

Actions can be proposed for discussion with the older person and are focused on addressing emerging health and well-being decline. As such, AgeWell is in a key position to influence the prevention of further deterioration and stimulate appropriate triggers for referral to intervention services. Given the context of care reorientation to the community in terms of a system of people-centred health care (WHO, 2015:10-11), AgeWell is underpinned by collaborations with statutory and voluntary agencies and community-based organisations in the provision of supportive care within both a community development and primary care framework. The aim of this study was to evaluate the AgeWell programme.

## **Methodology**

There have been calls, particularly within the pandemic period, to expand the spectrum of long-term care to include community-based care to enable older people to live at home as long as possible and to support families in caregiving (Citizens' Assembly, 2017; Sage Advocacy 2020). In this regard, Moore et al.'s (2015) framework for evaluating complex interventions has the potential to demonstrate the utility and application of programmes such as AgeWell using several key assessment points. These are:

- To assess programme fidelity, i.e. to assess whether the Age Well programme was implemented as planned.
- To assess the quantity of the programme, i.e. to assess whether the Age Well programme was sufficient to attain the intended outcomes.
- To investigate the modality of the Age well programme, i.e. to investigate how the programme was operationalized.
- To assess the reach of the, i.e. to assess who participated in the programme.
- To identify any challenges in programme.
- To examine contextual issues (local and external), which acted as facilitators or barriers to the programme's successful implementation.

- To examine the relative efficiencies of programme

Findings were generated via a review of Third Age documentation and the AgeWell metrics.

## **Findings**

*Programme fidelity:* The aim of the AgeWell programme is to respond to the challenges and opportunities of ageing by enabling people to maximise health potential and community living for as long as possible. Ageing is a natural process which impacts individuals differently. However, there is a likelihood that various factors such as the higher risk of multi-morbidity, loneliness and social isolation can render increased risk to older people living at home (Hansen et al., 2021). The AgeWell programme uses traditional communication methods (face-to-face and phone calls) to support a companionship model of service as well as the integration of evidence-based screening tools by the Care Co-ordination team. Data is embedded in a technological platform to assess key social determinants of health, identify risk and trigger appropriate referral pathways' conversations in the context of prevention and early intervention. In this way, the older people participating in the programme remain key stakeholders in their health decisions and are supported to access help from agencies such as the public health nurse, the general practitioner, socialisation opportunities etc. This enables the programme to achieve its key aim to identify and address current and emerging health, social and environmental challenges in the lives of individual older people accessing the service.

*Quantity of the programme:* The quantity of the Age Well programme has been older people's assessment for several health and social care variables. Due to new funding streams, a phased expansion started after the initial pilot in early 2019, but the project did not reach Navan and East Meath until February 2020. Information gathered on the programme enabled the review of comparative data between those receiving the service pre-COVID-19 and those who commenced the service during the pandemic. Thus, data are presented under both cohorts. Changes in the mean well-being scores are compared from enrolment in the programme (from its start in February 2018) and tracked as the older person progresses in the programme. Not all older people enter the programme at the same time and not all clients remain in the programme for various reasons. The first participants entered the programme in February 2018. All clients' scores were examined through midline analysis. The results and



charts are from December 2021 which looked at stats in pre-Covid clients from February 2018 to November 2021.

#### Wellbeing: Existing clients (pre-COVID 19)

- Clients demonstrated a 22.3 per cent relative improvement in well-being scores after 4 months from programme enrolment.
- Despite the impact of the pandemic, existing clients demonstrated an increase of 26 per cent relative improvement within a 36-month period since enrolment.
- Client scores indicated an improvement in their emotional and informational support of 21 per cent after 18 months.
- After 40 months of support from AgeWell, clients' relative improvement in emotional and informational support was found to be 20.4 per cent.
- Existing clients demonstrated a 40 per cent relative reduction in loneliness in four months. After 3 years, the relative reduction was 23 per cent but figures are likely to be impacted by the COVID-19 pandemic. Moreover, the aggregate score on the UCLA loneliness scale was identified as 4.32 (most lonely index of 6) at enrolment, reducing to 2.88 after 40 months.
- 91 per cent of clients had either improved or maintained their self-rated health scores at 25 months.
- Self-rated health scores remained steady over a 40-month period (particularly given the mean age of clients) with this being 2.67 at enrolment and 2.63 after forty months (Max score for self-rated health scale= 4).
- After 16 months in the programme, 90 per cent of clients (as opposed to 82 per cent at enrolment) were moderately or very physically active, and 90 per cent self-reported as being more active than their peers (as opposed to 73 percent at commencement).
- 99 per cent reported being satisfied or very satisfied with the AgeWell programme with 97 per cent stating that it met their needs and 88 per cent indicating they would recommend it to a friend.

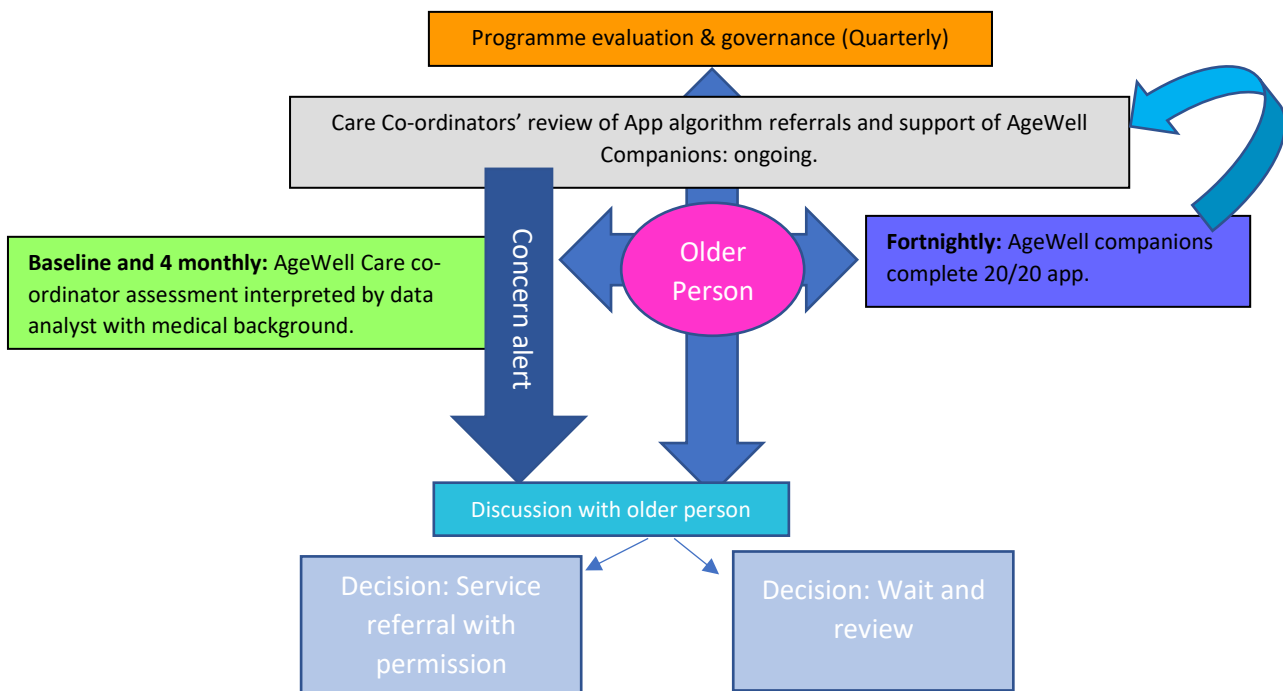
#### Sláintecare clients (Commenced in COVID 19)

- Clients demonstrated a relative increase over a 24-month period with a 23.7 per cent improvement from the baseline score.
- Clients reported a 66 per cent decrease in poor well-being since scores on enrolment.
- Clients experienced a 31 per cent increase in social and emotional support in the first 18 months since enrolment. As the pandemic continued, this dropped to 14 per cent at 22 months but rose again at 24 months to 27 per cent improvement in social and emotional support.
- Clients reported a 25 per cent reduction in loneliness at 9 months since enrolment with this rising to 42.5 per cent by 12 months. However, the impact of COVID-19 restrictions translated to a 16 per cent reduction from baseline after 12 months.
- 84 per cent of clients maintained or improved their self-rated health.

- *On enrolment, 75 per cent of clients reported being as active as their peers with 88 per cent indicating being as active as their peers at 9 months. After 24 months in the programme, 64 per cent of clients reported that they were as physically active as their peers.*
- *At nine months post enrolment, 90 per cent reported being moderately or very active. This dropped to 76 per cent at 24 months. Both this observation and the previous finding are likely to reflect a modest statistical reduction of activity over two years due to increasing age but also the impact of COVID-19 cocooning statistics.*
- *99 percent of clients reported satisfaction with the programme, with 94 per cent identifying the programme met their needs and 88 per cent would recommend this to a family member or friend.*

*Modality of the programme:* Referrals to the programme are initiated via several points. The highest referral source is from the older person themselves (39 per cent). This is not unsurprising as Third Age, as an organisation supporting older people, has been in Meath since 1988 and has established a strong reputation. Other referral sources are the health service (30 per cent), family and friends (16 per cent), community groups (6 per cent), the senior alert scheme, gardai and politicians. Of note, 49 per cent of referrals are older people on service waiting lists for various healthcare services, indicating a demand for such alternative support.

The programme targets the modality by creating both horizontal and vertical axis networks (figure 1). The horizontal axis is mainly comprised of the relationship between the AgeWell companions and the older person, in terms of frequency. This is rooted in the establishment of trust-based relationships with AgeWell companions, articulated through regular phone and face-to-face communication. Further communication and assessment are demonstrated in the use of health assessment technology, (20/20 App) where data is generated, and interpreted by algorithms to trigger potential actions for early further assessment and intervention initiated by the Care Co-ordination team. The autonomy of the client is respected as proposed actions are discussed with the older person. The horizontal axis is further reinforced by baseline and quarterly assessments by the Care coordinator with the client using validated assessment tools for well-being, informational and emotional support and loneliness (appendix 1). The vertical axis is demonstrated in the support that the AgeWell Care coordinators provide for the AgeWell companions and the operationalisation of the programme itself as well as quarterly programme governance and service impact evaluations.



**Figure 1: Horizontal and vertical axial processes in AgeWell programme**

*Reach of the programme:* This programme commenced as a pilot in South-West Meath in February 2018 and with the help of *Sláintecare* extended to County Meath in December 2019. Currently, it is available in 66 locations in the county. By December 2021, the programme had supported 338 older people. Most of the clients are female, which somewhat reflects the higher female population demographic in the country. However, the proportionate greater uptake by females is most marked in the 75-79 and over 85 age groups. While the mean age of clients is 82 years, many of the programme clients are in the 85+ age group (41 per cent), followed by 80-84 years (27 per cent), 75-79 years (17 per cent), 70-74 years (10 per cent) and 60-69 years) (5 per cent). This demonstrates the relative demand within the older old age groups, where the risk of social exclusion and physical and/or cognitive decline is higher (Hansen et al., 2021). Thus, supporting those in the over 70 years age group presents the major value within the programme.

The demographic breakdown also indicates that almost 70 (69 per cent) per cent of clients are widowed, 11 per cent are single, 9 per cent are divorced and 11 per cent are married. Male clients are higher in the married (21 per cent vs 9 per cent), divorced (11 per cent vs 9

per cent) and single relationship (18 per cent vs 9 per cent) status groups while the number of females is higher in the widowed category (71 per cent vs 50 per cent). The uptake and findings of the programme also point to the need for support systems, particularly for loneliness and social isolation (which contribute to health decline) when previous social networks are disrupted by bereavement, relationship breakdown or when living alone (67 per cent) as the risk to functional and cognitive health is higher. The distribution of clients in rural and urban areas is the same (50 per cent per area). This points to the important distinction related to subjective and objective loneliness and that service demand is predicated on ageing rather than the location in the community.

It is noted that the impact of the programme was hampered by the COVID-19 pandemic. Public health guidance provided for additional protections, primarily for those over 70 years of age and those with at-risk health conditions, to cocoon. Emerging evidence (Phelan et al., 2021) points to the negative impact of this guidance on the well-being of older people. A total of 74 older people availed of the expanded service from December 2019-December 2021 on foot of *Sláintecare* funding. The demographic characteristics differed from pre-existing clients. For example, the mean age from the start of the programme (pre-existing clients) in 2018 was 82 years as opposed to almost 85 years (84.9 years) in new clients at the end of December 2021 with a higher percentage of these clients being female (80 per cent) and in the widowed category (80 per cent as opposed to pre-existing 64 per cent). Within the COVID client group, almost 50 per cent (48 per cent) of clients in September 2020 triggered a 20/20 app alert. The second highest trigger from the 20/20 app for this group was in March 2021 (30 per cent). Statistics on response to the triggers demonstrate that from September 2020 to December 2021, between 88 per cent to 97 per cent of these were responded to by the AgeWell services, with only 9-11 per cent requiring referral to external services. Existing clients from the period November 2018 to 2020 demonstrate a fluctuation in age profile, however, the main service consumers were consistently in the 85 years and older age groups which peaked in November 2018 (52 per cent) and 56 per cent in April 2021.

*Challenges of the programme:* The programme has particular importance as a community development service drawing on the principles of people-centred care. However, like the experience of other older person services, the impact of COVID-19 was apparent in outcomes. In an analysis of the impact of the service, it was demonstrated that pre-COVID-19 existing

client scores were higher in many health and well-being domains as opposed to post-pandemic commencement scores as detailed below in table 1.

**Table 1: Impact categories in baseline, existing and post-COVID-19 enrolments**

Category	Baseline per cent	Existing (Pre-COVID enrolment) group per cent (n=304)	Post-COVID enrolment per cent (n=104)
<i>Loneliness</i>	44	20	50
<i>Depressed</i>	25	3	9
<i>Client Physical Activity (less active)</i>	30	10	13
<i>Frequency of Physical Activity (seldom active)</i>	24	10	12
<i>Self-Rated Health (poor/fair)</i>	29	14	16
<i>WHO5 wellbeing score</i>	20	20	18

While the impact of COVID-19 is likely to have contributed to the score difference, in all but loneliness and the WHO 5 score, participation in the AgeWell programme has demonstrated significant health and well-being improvements in the lives of individual older people. Although the loneliness is higher and WHO 5 score is lower than baseline, the public health restrictions severely impacted both subjective and objective loneliness (and consequently the experience of well-being) of older people both nationally and internationally as limitations in the physical meeting with family and friends were adopted while shielding at home was advised, day-care and other health and social care services were suspended and leisure pursuits (meeting friends, travel, occasions) cancelled.

*Contextual issues in the programme:* While the AgeWell programme has demonstrated a tangible impact on the health and well-being of older people, its funding is precarious and is dependent on annual applications for financial support. While AgeWell receives some core funding from the Health Service Executive (HSE), the sustainability of funding is not guaranteed and is subject to annual review. Even with HSE funding, there is a shortfall as this accounts for less than 60 per cent of the total programme costs in County Meath. The remaining 40 per cent presents a challenge for Third Age and, despite various efforts to generate the remaining cost, has resulted in an annual funding deficit. The benefit of the programme has been tracked via empirical data based on valid and reliable health and well-being measures. There is scope for this programme to expand to provide benefits to older people within a regional and national context.

*Efficiencies of the programme:* The efficiencies of the programme can be evidenced in three domains. Firstly, it provides a community-based complementary programme of older person support services which interconnects with the formal health and social care system as well as networking with other community-based services to enable the human flourishing of older people within the agenda of person-centredness. Secondly, early intervention has a dual positive outcome. It enables the optimisation of health through case finding and reduces cognitive and functional loss through either primary intervention or early referral for expert assessment and subsequent care planning. Without such referral, symptoms may not be overtly recognised or acknowledged and may deteriorate further. Thus, engagement with therapeutic services may be delayed due to the insidious nature of symptoms. Such delays may confer irrevocable yet preventable loss to the cognitive and functional abilities of the older person. Moreover, while functional and cognitive decline may not be amenable to full rehabilitation, early recognition can translate to minimisation of impact as symptoms may be mediated through compensatory intervention (targeted care plans-home support, physiotherapy, continence support, medications, linking with social events, link with voluntary groups etc). In this context, the efficiencies are evident in both qualitative and quantitative experiences of older people and within the data. Maximising health status enables older people to enjoy life to the fullest and supports the person to live at home and reduce hospitalisation episodes. From a quantitative point of view, there is the potential to avoid preventable hospital admissions, minimise/postpone health service dependency and circumvent/delay residential care admissions. A secondary effect is to support carers through health interventions for the older person and instigate modes to avoid or delay functional and/or cognitive decline.

AgeWell activities also correlate to an impact on health economics in the context of health budgets. In 2021, the AgeWell team undertook a financial analysis on savings to the healthcare budget due to the intervention of the programme to avoid unscheduled hospital admissions. As discussed, the primary advantage of the programme is to initiate prevention and early intervention in the context of case finding related to health decline. Thus, rather than a progressive health deterioration leading to a crisis admission or attendance at emergency departments, emerging issues are addressed before their worsening to the crisis state.

From a total examined dataset of 40 clients in East Meath, 28 had a history of hospital admissions; 16 had more than one admission allowing some comparative potential. Six were deemed outliers giving a total of 10 clients for final analysis. Findings demonstrated that for the 10 older people, 40.44 projected admissions were anticipated given their previous admission trends and date. Based on calculations, 32.29 admissions did not occur impacting the cost of hospital admissions for these older people. Applying the average cost per patient is €7,374 per admission in Irish acute care (Brick et al., 2015), this represents a saving of €238,106. Taking the AgeWell funding from *Sláintecare* into account (€68,106), this provides a saving to the Exchequer of €170, 000. This figure does not include secondary costs, for example, additional medications, increased community visits (community nurses, general practitioner), costs related to adaptations, dressings, increased carer responsibilities or the qualitative experience of health. Prevention and early intervention also impact premature nursing home admission, which again may impact the exchequer through fiscal support of care within the Fair Deal scheme. In 2020, the Comptroller and Auditor General Special Report identified that the average cost for Irish public nursing homes was €1,564 a week while the average maximum chargeable price the State from private or voluntary homes was €968. Taking the public nursing home cost into account, the annual cost for an older resident's care is €81,328 as opposed to €1,230 per client receiving the AgeWell programme in their own home.

## **Discussion**

Since its inception and expansion in the county of Meath, the AgeWell programme has demonstrated both a qualitative and quantitative impact. The qualitative impact is demonstrated in the lives of older people, through a reduction in negative indicators of well-being, loneliness (with the caveat of COVID-19 experiences), and health and social care indicators. This has been supported quantitatively in the regular evaluations from baseline assessments, reduction in hospital admission, evaluation of the programme by older people and a review of the impact in the context of health economics of the programme. Comparative analysis was enabled by examining the impact on two client groups in receipt of AgeWell (existing and *Sláintecare* clients), which both indicated general positive improvements in the lives of older people (apart from COVID-19 exacerbation of loneliness and WHO 5 mean scores). AgeWell has also collected positive experience testimonies of

programme impact, which provide instances of the AgeWell team's assistance in terms of actions such as helping older people to navigate the care systems, linking with other services, enabling clients' understanding and health literacy, networking with community supports (other groups, gardai), providing information, advising on entitlements, helping build resilience and coping skills, organising transport and operationalising compensatory contingencies when needed (i.e. Food/grocery/medication delivery).

The strength of a programme is also inherent in its ability to transform in crisis situations, enable flexibility of service provision and the fostering of innovation. Within the context of the pandemic, many services were forced to suspend, reduce or transform delivery. AgeWell responded and enhanced care provision by:

- AgeWell Companions (older volunteers) were provided with Personal and Protective Equipment and training on conducting home visits safely. Companions remained in constant touch throughout the year whether on home visits, on phone or socially distanced door visits, as permissible. This enabled continuity of service provision.
- Phone calls increased from 2 to 5 per week during the height of restrictions to offer additional support and counteract public health restrictions.
- AgeWell organised essential supplies and repair services (medications, groceries, medical equipment, access to electricians, plumbers) and helped navigate the health system and services within the constrained provision.
- AgeWell companions also became a link for Primary Care Teams providing intermediary support for Public Health Nurses.
- AgeWell's 20/20 App picked up many signs of Covid-19 infections, supporting clients to seek medical help while also keeping an eye on any routine health issues.
- AgeWell provided updates and information for volunteers and clients including updates on the pandemic, the vaccination programme, and health promotion generally.

One of the innovations of the programme is that AgeWell has successfully integrated technology into its service provision. The expansion of the use of technology in AgeWell should be considered. What COVID-19 has enabled is the accelerated increasing potential of virtual platforms to enhance communication with older people (Kichloo et al., 2020; Goldberg et al., 2022). While face-to-face communication is the gold standard and its full return to AgeWell's routine is an important objective, the potential supplementary use of technology as an additional communication tool as well as a health assessment tool should be considered (ie ipads etc) in conjunction with equality in broadband accessibility.



The AgeWell programme findings also demonstrate the value of a complementary community-based programme mapping to primary health care and people-centred agendas (Integrated Care Programme for Older People and National Clinical Programme for Older People, 2017). Although the financial analysis was undertaken with a modest sample size (n=10), in an age of fiscal rectitude, the programme demonstrates important financial savings' potential on a wider geographical and volume scale as well as partnership working with the community and acute-based statutory services and other agencies. This can, in addition to financial savings, potentialise human flourishing, autonomy and choice in the lives of individual older people living anywhere in the community, thus epitomising social capital and social solidarity impact.

At the primary interface of the service, data from the AgeWell programmes demonstrate that most emerging health issues within the programme participants are managed locally with only over 10 per cent requiring escalation to formal health and social care services. Without this service and intervention, these issues would likely progress and continue a trajectory of exacerbation, leading to crisis situations and higher demand for formal services. In this context, the AgeWell programme forms an important response in addressing fragmented care and represents a key factor in person-centred integrated care of older people. Moreover, it has been shown that volunteering such as acting as a care companion, can engender the experience of a sense of purpose, a sense of fulfilment, a connection to community, a sense of physical well-being and provide opportunities for personal growth (training, skills acquisition) (Stathi et al., 2021). For family members of the older person, the AgeWell programme can provide reassurance of social connection and oversight in health and wellbeing within the community with processes for both prevention and intervention on multiple key health domains through primary local action (social prescription), interagency collaboration or service referral.

## **Conclusion**

As we experience a demographic shift with rising ageing populations, the challenge is to create innovative, person-centred systems of care that are efficient, effective and financially sustainable. AgeWell, one of the programmes delivered by Third Age, provides an example of re-imagining care in the community by creating support networks for older people to

potentialize health and springboard onward, timely referrals to formal health and social care services. Using Moore et al.'s (2015) framework as a lens to examine AgeWell enables policymakers and health and social care budget holders to tangibly review the impact in terms of fidelity and quality of the programme using a firm evidence base. As we enter the era of increased demographic ageing and Ireland focuses more on creating a comprehensive spectrum of community-based, long-term care for older people, the imperative for longevity in financial support and a vision for AgeWell programme expansion is clear.

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## **Appendix 1**

### **Validated Tools used to assess older people in the AgeWell Programme**

#### **WHO-5 (WHO 1998)**

The WHO-5 is used to assess wellbeing - is a short questionnaire consisting of 5 simple and non-invasive questions, which tap into the subjective well-being of the respondents. The scale has adequate validity both as a screening tool for depression and as an outcome measure in clinical trials and has been applied successfully across a wide range of study fields. Subjective quality of life based on positive mood (good spirits, relaxation), vitality (being active and waking up fresh and rested), and general interest (being interested in things). The scale scores between 1-20 with higher scores meaning better well-being.

#### **MOSS 8 (Clough-Gorr et al., 2007)**

It is an 8-point scale universally recognised as assessing social support for older people.

Social support has been shown to provide many benefits to the overall health and well-being of older adults. Social support drawn from a variety of sources (e.g., family, friends, community) has been associated with better outlook and better emotional health. Studies have also shown that older adults with adequate social support are less likely to have negative long-term effects (e.g., poor emotional health, pessimistic attitude, hospitalisation, poor survival) of life stressors.

#### **UCLA loneliness scale (Russell et al, 1978)**

This is a 3-point scale that is widely used across the world to measure loneliness.

Research has shown that feeling lonely is linked to risk of an earlier death, depression, dementia and poor self-rated health. Loneliness has a negative impact on our quality of life, and mental and physical health. Secondly, measuring loneliness will help you to demonstrate the positive impact of this work on the way people feel about their relationships and connections.