PSSRU

National Evaluation of Partnerships for Older People Projects

Final Report

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Table of contents

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Executive Summary

The Partnership for Older People Projects (POPP) were funded by the Department of Health to develop services for older people, aimed at promoting their health, well-being and independence and preventing or delaying their need for higher intensity or institutional care. The evaluation found that a wide range of projects resulted in improved quality of life for participants and considerable savings, as well as better local working relationships.

- Twenty-nine local authorities were involved as pilot sites, working with health and voluntary sector partners to develop services, with funding of £60m
- Those projects developed ranged from low level services, such as lunch-clubs, to more formal preventive initiatives, such as hospital discharge and rapid response services
- Over a quarter of a million people (264,637) used one or more of these services
- The reduction in hospital emergency bed days resulted in considerable savings, to the extent that for every extra £1 spent on the POPP services, there has been approximately a £1.20 additional benefit in savings on emergency bed days. This is the headline estimate drawn from a statistically valid range of £0.80 to £1.60 saving on emergency bed days for every extra £1 spent on the projects.
- Overnight hospital stays were seemingly reduced by 47% and use of Accident & Emergency departments by 29%. Reductions were also seen in physiotherapy/occupational therapy and clinic or outpatient appointments with a total cost reduction of £2,166 per person
- A practical example of what works is pro-active case coordination services, where visits to A&E departments fell by 60%, hospital overnight stays were reduced by 48%, phone calls to GPs fell by 28%, visits to practice nurses reduced by 25% and GP appointments reduced by 10%
- Efficiency gains in health service use appear to have been achieved without any adverse impact on the use of social care resources
- The overwhelming majority of the POPP projects have been sustained, with only 3% being closed – either because they did not deliver the intended outcomes or because local strategic priorities had changed
- PCTs have contributed to the sustainability of the POPP projects within all 29 pilot sites. Moreover, within almost half of the sites, one or more of the projects are being entirely sustained through PCT funding – a total of 20% of POPP projects. There are a further 14% of projects for which PCTs are providing at least half of the necessary ongoing funding
- POPP services appear to have improved users' quality of life, varying with the nature of individual projects; those providing services to individuals with complex needs were particularly successful, but low-level preventive projects also had an impact
- All local projects involved older people in their design and management, although to varying degrees, including as members of steering or programme boards, in staff recruitment panels, as volunteers or in the evaluation
- Improved relationships with health agencies and the voluntary sector in the locality were generally reported as a result of partnership working, although there were some difficulties securing the involvement of GPs

Background

The POPP initiative was set up to provide improved health and well-being for older people via a series of individual projects providing local services. These services were to be person-centred and integrated, to promote health, well-being and independence, and to prevent or delay the need for higher intensity or institutional care. There was an expectation that strong partnerships would be forged with local providers of health care, as well as with many other local organisations, particularly local voluntary and community organisations (VCOs). A greater involvement of older people themselves was also an objective of the initiative.

The Department of Health designated 29 pilot sites (19 in a first round and 10 in a second round), running from May 2006 through March 2009. Each pilot site was a local authority in England. The Department also commissioned a national evaluation of the programme as a whole.

This summary is drawn from the full report submitted by the National Evaluation Team in October 2009.

Findings

The projects

In total, the 29 sites set up 146 core local projects, comprising many more individual services, aimed to improve health and well-being among older people and reduce social exclusion and isolation. The individual projects were determined according to local priorities. Of the 146 projects, two-thirds were primarily directed to reducing social isolation and exclusion or promoting healthy living among older people ('community facing'). The remaining one-third focused primarily on avoiding hospital admission or facilitating early discharge from acute or institutional care ('hospital facing'). Some addressed the full spectrum of needs. In addition to these 'core' projects, a further 530 small 'upstream' projects were commissioned from the third sector.

Altogether, 522 organisations were involved with projects across the POPP programme, including health bodies, such as PCTs, secondary care trusts and ambulance trusts; other bodies, such as the fire service, police, and housing associations; national and local voluntary organisations; and private sector organisations. Volunteers, comprising many older people themselves, also made an important contribution, becoming increasingly significant over the period of the project.

The services used by those engaged with POPP services were not limited to those within the programme. Just over a quarter of service users were referred on to other services, with a higher referral rate in the second round of ten pilot sites. Of the individuals referred, one fifth (21%) were referred on to voluntary organisations and over a quarter (27%) to some form of health care, including hospital (6%), GP (6%), other health professional (9%) or mental health provision (6%). Over one in ten (13%) of the referrals were to social care and the same proportion (13%) were to other POPP projects. The latter was particularly strong (17%) in the second year of operation, suggesting that the individual local projects had formed a sense of an overall programme of work.

Service users

Well over one quarter of a million people (264,000) used the services of POPP projects over the three years, with particularly heavy use in the third year.

The clearest information on the demographic characteristics of users comes from the standardised questionnaire. The average (mean) age of these service users was 75, with a range of 40 to 101. Two-thirds were women. Roughly one-third were married, with the remainder widowed, divorced or single. The great majority (81%) lived in their own homes (or that of a relative), but some lived in sheltered housing, residential or nursing care homes. Roughly two-thirds lived in areas designated as deprived. There was some variation in all these characteristics according to the nature of the projects.

Of those users receiving a service, almost one-third (30%) were aged 85 and over, with almost two-thirds (63%) aged 75 and over, with some variation with the focus of the service. A high proportion (60%) of those aged 85 and over accessed projects providing tertiary care, but one-third (34%) also accessed services offering primary prevention. This suggests that services focused toward early intervention are being used by the total older person population, not simply those in younger age groups.

Outcomes

Impact on older people

The POPP projects were widely thought by staff to have delivered better services for older people in terms of their quality of life and well-being. A greater range of services were said to be offered and there was a greater awareness among older people of the services available, coupled with easier access to them. In addition to obtaining new services, many individuals were also referred onto other services via the projects, for instance to social services, health care professionals or other POPP services. Some difficulties were experienced however, in providing access to 'hard to reach' (HtR) people and some services were felt to be insufficiently responsive to the needs of black and minority ethnic (BME) groups, despite considerable efforts on the part of staff to ensure that services were relevant and culturally sensitive. Where services were dedicated expressly to BME groups, engagement was much more successful.

Assessing the impact of these projects on users' health-related quality of life, as well as overall quality of life, is difficult, because many users were very old and frail and likely to experience deteriorating well-being in any case. Indeed, those in the POPP sample initially reported between one fifth and one quarter lower levels of quality of life, compared to the 'normal population'. Moreover, a number of services, although providing valuable help to people, were unlikely to have a striking impact on their overall quality of life, as other factors, such as poverty, illness or bereavement, were more likely to be critical here.

The evaluation addressed the issue of the Programme's impact in two ways. A standardised questionnaire, administered both before and after the POPP intervention, measured the health-related quality of life (HRQoL) of a sample of 1,529 older people, and recorded their perception of any changes in their overall quality of life. A sample drawn from the British Household Panel Survey was used as a comparison. First, attention was given to changes in HRQoL. These varied with the type of project, but improvements were seemingly found in 9 of the 11 types, compared to the comparison group. Those receiving practical help appeared to report a notable improvement (12% increase), as simple aids or services could affect well-being, such as a grab-rail making washing easier or minor repairs reducing anxiety. An equivalent improvement (12% increase) was also reported

following interventions providing exercise, presumably due to increased strength and flexibility and a positive effect on mood. Smaller improvements were found in those involved with projects offering community support, proactive case coordination and specialist falls programmes (3%–4%). A very slight deterioration was found in those people in projects offering hospital discharge and complex care (lower than 2% decline), but these individuals still fared better than the comparative sample. Moreover, when these latter categories were further analysed, it was found that some types of intervention 'bucked the trend'; if an intervention was multi-disciplinary, better outcomes were recorded.

The projects were further divided into the wider groupings of needs levels and 'community-facing' and 'hospital-facing'. People using community-facing services similarly appeared to experience improved HRQoL compared to the comparison group drawn from the BHPS. Those using tertiary services had an improved HRQoL of 25% and even those involved with low-level preventative projects reported a 2% improvement.

All these findings must be treated with caution, as the variance in the data made it impossible to attribute statistical significance across the wider groupings. Nevertheless, when individual services were examined as representatives of the whole, changes in HRQoL were found to be significant.

Second, a single question asked individuals to rate their quality of life as a whole, ranging from 'my life is so bad, it could not be worse', through to 'my life is so good, it could not be better'. Such a question is by necessity multi-factorial, with each participant interpreting it according to their own circumstances, preferences and beliefs. It may not be appropriate to expect low-level and short-term services to have an impact on such a wide measure, especially within a short time span (median administration time was six months). Overall, individuals reported a small deterioration in their quality of life, using these questions, following the POPP intervention, with some variation according to the nature of the area in which people lived and with age. Fewer individuals in the most deprived areas reported that their quality of life had remained the same, whilst younger individuals reported the greatest deterioration (but it should be noted that their level of disability was likely to be high, given their involvement with services).

Older people further benefited from the POPP programme through a reported increase in the receipt of state benefits. More people were receiving attendance allowance following the programme than before, with information and advice services increasing benefits by £23,000 per annum. The overall increase was £53,768 per year.

Impact on joint working

The projects were reasonably successful in developing good working relations with the wide range of partner organisations, with some variation across areas and organisations. In most areas, service delivery teams comprised staff employed by more than one agency; several had multi-agency multi-disciplinary teams. Such teams facilitated easy discussion, mutual respect and, on a practical level, advice and referrals across agencies; this was particularly notable where staff worked together in the same location, in contrast to 'virtual' teams. In some areas, new posts developed expressly to overcome organisational barriers were introduced and found to enhance good working relations. Link roles were also helpful in this respect.

Many local VCOs provided and received benefit from participation in the POPP programme. Local authority and health partners were able to benefit from their local knowledge of communities and voluntary services. Where commissioned to provide services, VCOs were able to strengthen their

skills and abilities, for instance in their capacity to obtain funding. Good networking and support between such organisations was also noted.

The direct involvement of older people in the design and implementation of the POPP projects, an underlying principle of the programme, was said to strengthen over time, with increasing commitment amongst project staff.

In most sites, there was an effort to go beyond tokenism to involve older people fully. The nature of this involvement varied across sites, however, and was generally stronger in the design (77% of the projects) and governance (93% had older people on a steering committee) of projects, compared to service delivery. Fewer than one-third (29%) involved older people as volunteers. The older people involved tended to be newly retired (the 'young old'), healthy and well-educated.

A number represented local voluntary organisations for older people. Some of the professionals employed by the sites noted that they found it difficult to fully involve older people, in part because of reluctance to hand over power, but also because of tight timetables and administrative constraints.

Expenditure and savings

The 29 pilot sites spent £50.7m on the projects developed over the period of the initiative. Of this, two-thirds (64%) was spent on 'community-facing' projects and one-third (36%) on 'hospital-facing' projects. Breaking down the spend across the types of prevention, one-third (35%) was spent on projects addressing tertiary prevention, one-third (31%) on primary prevention projects, one quarter (24%) on secondary prevention projects and the remainder on underpinning projects.

The costs of the POPP programme were examined by four different means. The first assessed the cost of the individual projects per user. These varied considerably with the focus of projects: those aimed at primary prevention cost £4 per user per week, compared to £7 for projects aimed at secondary prevention. These costs are low compared with other social and health care interventions. Such findings must be treated with caution, due to some probable inaccuracies in reporting and a high level of missing data.

The second analysis focused on the impact of the POPP projects on the use of hospital emergency beds, using areas without the POPP programme as a comparison. It was found that POPP projects appeared to have a significant effect on emergency bed days, and this has stabalised over time. The effect was such that an additional investment of £1 in POPP services would produce greater than £1 savings on emergency bed days. The projected figure varies with assumptions about management costs; under an assumption of 10% management costs, a £1 additional spend on POPP projects would lead to approximately a £1.20 reduction in required spending on emergency bed occupants at the mean. This is the headline estimate drawn from a statistically valid range of an £0.80 to £1.60 saving on emergency bed days for every extra £1 spent on the projects.

Differences were found here according to the nature of the projects, with 'hospital-facing' projects showing signs of diminishing effect, not economies of scale. That is, larger projects seemingly produced lower potential savings on emergency bed days. This may be partially due to the limit in the number of people who can be easily diverted from hospital by such projects. In contrast, 'community-facing' projects showed increasing returns against economies of scale, such that the larger the project, the greater the saving. These may require a 'critical mass', but once they are large enough, can seemingly reduce the need for emergency secondary care. Moreover, funding these services to a sufficient degree would be cost-effective in saving £1 for every £1 spent.

As with any analysis of this type, there are inherent limitations to the certainty which can be placed on such analysis, but within the context of this research, POPP projects can be recommended as a cost-effective policy option.

The third analysis explored whether the quality of life benefits delivered by the projects were cost-effective or more expensive than 'usual care'. Projects were analysed using the cost-effectiveness acceptability curve (CEAC), compared to outcomes in areas with no POPP projects, using the 'willingness to pay' cut-off figure of £30K for a point increase in QALY employed by the National Institute for Health and Clinical Excellence (NICE). It was found that, considering the POPP projects as a whole, there was a very high probability (86%) that the overarching POPP programme was cost-effective, compared with usual care. Decisions will need to be made as to whether the cost-effectiveness probability levels are high enough to support commissioning decisions. For example, commissioners would need to ask themselves if a 14% area of risk in setting up projects (that 1.4 projects in 10 may not be cost-effective as compared with usual care) is too great.

In exploring the different types of project (e.g., practical help, social/ emotional support, pro-active case finding) variations as to the probability of cost-effectiveness were found. Nevertheless, there was high probability in all cases and, within three categories, there was greater than a 98% probability that at £10,000 or less per point increase in QALY, such projects were cost-effective if compared with 'usual care'.

One operational example concerns those projects focused on improving well-being through the provision of practical help, small housing repairs, gardening, limited assistive technology or shopping. For an extra spend of £5,000 per person - £96.15 per week – there is a 98% probability that such projects are cost-effective compared with 'usual care'. Commissioners putting in place such projects could be reasonably confident that only around 0.2 projects in 10 would not be cost-effective.

Finally, individuals' use of health and social care services was analysed to address whether there was a change in costs arising from changes in the type and extent of services used before and after the POPP project. This information was based on 1,529 service users who completed the standardised questionnaire before and after their involvement in the POPP programme. Overall, hospital overnight stays appeared to be reduced by almost half (47%) and use of Accident & Emergency departments by almost a third (29%). Reductions were seen in physiotherapy/occupational therapy and clinic or outpatient appointments by almost one in ten. Such change had a notable impact on costs with a cost reduction of £2,166 per person seemingly reported. There was, of course, considerable variation depending on the type of projects in which the older people were involved; the highest reductions were for projects focusing on hospital discharge and the lowest was for specialist falls services.

This evidence of the POPP projects leading to cost-reductions in secondary, primary and social care was similarly demonstrated by many of the local evaluations. The main difficulty for sites was translating the evidenced cost-reduction into a cost saving. Moving monies around the health and social care system was seemingly a huge challenge, and proved an insurmountable one where budgets were the responsibility of more than one organisation. For instance, monies could be moved from residential care budgets to home care budgets within a local authority, but a claim for monies by a local authority from either primary or secondary health care budgets did not prove possible.

Key learning points

As with any new programme, the POPP pilot projects experienced a number of challenges in their implementation. Problems arose around the short duration of the POPP projects, as this inevitably meant hasty initial decision-making and staff concerns about their own future employment toward the end of the project. Recruitment of staff, particularly project managers, proved difficult, and it took time for them to clarify exactly what they should be doing. Similar problems were found with volunteers, who could be difficult to retain. The amount of administration time required for projects was often under-estimated. Second round projects were able to benefit, however, from the experience of the first round projects.

The involvement of older people could prove difficult, due to their own ill health or that of people for whom they were caring, as well as transport difficulties; people from BME communities were found to be difficult to recruit.

Difficulties in organisational partnerships are notorious and the POPP projects reported some problems, including the sheer time and commitment needed across agencies and considerable cultural boundaries between professions. Inter-organisational referrals were found to be complex. An inherent tension was noted in policies which promoted partnership across agencies on the one hand and competition on the other. There were also both practical and ethical problems in data-sharing. Those managing multi-agency teams experienced particular problems in coping with differing organisational arrangements, for instance with respect to pay, holiday and pension systems. It was found that GPs were difficult to engage, although playing a central role with service users. In addition, problems arose from specific developments at the time, such as the major reconfiguration of PCTs, which meant that PCT staff were preoccupied with the demands of their own jobs, together with considerable turnover of personnel.

Sustainability

The ability of projects like POPP to endure beyond their initial funding period is clearly important to their long term impact. The overwhelming majority (85%) of POPP projects secured funding to continue in one form or another, in many cases through their local PCT. In addition, the 'transformation agenda' for social care, incorporated in *Our Health, Our care, Our say* (2006), closely mirrored the focus of POPP and was influential on decisions to sustain projects via the Social Care Reform Grant. Only 3% of the projects 'closed', either because they did not deliver the intended outcomes or because local strategic priorities had changed.

Sustainability was often achieved through early attention to the issue. Local Area Agreements, for instance, proved an important mechanism for embedding and sustaining programmes. In many sites, final decisions concerning funding were not made until late in the final year; in contrast, where early agreements were made with agencies regarding their respective responsibilities for sustaining projects – and written into initial bids – the process of ensuring sustainability appeared to be timelier.

PCTs contributed to the sustainability of the POPP projects within all 29 sites. Moreover, within almost half of the sites one or more projects were entirely sustained through PCT funding – giving a total of 20% of POPP projects entirely sustained through PCT funding. In a number of other projects (14%), PCTs provided at least half the necessary ongoing funding.

Key factors in bringing about continued enthusiasm and funding were the involvement of local councillors and older people as representatives, raising the profile of POPP programmes both among

strategic managers and the wider public. Local evaluations were also important, with early findings shaping the development of projects. But recognition was necessary of the inherently long-term impact of some of the services, where short-term changes could not be demonstrated. It was particularly difficult to provide robust evidence of service cost-effectiveness within the two year funding period.

Implications for Policy and Practice

Achieving desired outcomes

The POPP programme, set up to test preventive approaches, demonstrated that prevention and early intervention can 'work' for older people. Local authority-led partnerships, working within the context of Local Strategic Partnership and Local Area Agreements, can help to reduce demand on secondary services, providing they are appropriately funded and performance managed. Moreover, it has shown that small services providing practical help and emotional support to older people can significantly affect their health and well-being, alongside more sizeable services expressly directed to avoiding their need for hospital. Most of the older people using POPP services had relatively high levels of need, but they nonetheless experienced improved outcomes and reported greater satisfaction than the comparison group, as a result of using these services.

Indeed, it is possible that the evaluation results understate the benefits which can potentially be derived from such a programme. The POPP projects were, by definition, largely untested and some were necessarily more effective than others. If those seeking to introduce similar programmes were to focus on those projects that were found to be most effective and those older people found most likely to benefit from them, the returns from similar levels of investment is likely to be greater. Moreover, the POPP projects took time both to bed in and to become embedded within local health and social care systems. It is possible that even greater value could be secured over the longer term, as new projects learn from their experience, and general expertise and confidence grow.

These gains were secured by pump-priming prevention and early intervention projects. Their cost-effectiveness gains cannot be fully realised unless cashable savings can be released and re-invested in such projects. Initially, only marginal savings may be identified. Some degree of financial systems reform is likely to be necessary to support the decommissioning of services in one part of the health and local government system alongside the re-investment of resources elsewhere.

From the results of this evaluation, it can be argued that the approach piloted by the POPP programme should be sustained, using the programme's learning to target investment to maximise individual and systems benefits. The realisation of the cost-effectiveness gains will be dependent, however, on the introduction of systems to support decommissioning and reinvestment.

Improving processes and management arrangements

Complex new programmes are inherently challenging to get off the ground, especially where they involve a range of agencies. Because it can be difficult to anticipate the particular problems likely to arise, time and resources for the implementation period should be built in from the start. It needs to be recognised – by both commissioners and programme managers – that recruitment, training and staff preparation is likely to take at least six months and local project managers should be in place to ensure appropriate implementation.

It should be expected that both project structures and processes will, quite rightly, evolve over time. Such changes will need to be mirrored by changes in project targets and monitoring tools. Good staff supervision should be ensured to support staff through such changes.

Multi-disciplinary projects benefit from the co-location of staff from different agencies and professions in one place, rather than seeking to develop a 'virtual' team, as well as from single line management. Co-located teams enable people to work more effectively together and achieve better outcomes, although they do not function without difficulties.

Where large programmes involve tendering for projects, attention should be given to the development of flexible commissioning processes appropriate to the scale of the exercise. Tendering must be arranged to assure an equitable process, particularly where small voluntary organisations are involved. Support and assistance with capacity-building should be available early on, together with clear information concerning requirements for monitoring and targets.

Where there is to be a programme evaluation, project leads should work with all stakeholders (providers, commissioners, programme clients) to think through their desired outcomes from the programme, rather than simple outputs. These outcomes should be used to develop a framework for evaluation, prior to commissioning external evaluators. Monitoring and measurement should then be embedded in any project recording systems prior to the start of any project. Base-line measurements must be established early on.

Involving consumers effectively in the design and direction of programmes is well known to be difficult and may be particularly problematic in the case of older people. Time and resources to assist this process must be built into the implementation programme, including for the provision of appropriate training and the establishment of systems for such practical issues as payment arrangements and transport. There also needs to be a balance of understanding between the necessary 'safe-guarding' procedures (through Criminal Records Bureau checks) and the level of support older people are providing. Management of risk may need to be undertaken and underwritten across the authority if the contribution of volunteers and representatives is to be optimised.

Methods

The National Evaluation of the POPP Programme involved 15 different methods of data collection and analysis. These were concerned to address questions focused both on *outcomes*, such as the extent to which projects improved the quality of life of older people or were cost effective, as well as *process*, such as the nature of the opportunities and challenges experienced in the course of implementing the programme. A first phase involved the collection of baseline information, including documentary analysis and a key informant questionnaire across the 29 pilot sites; a second phase involved substantial data collection via interviews and focus groups with both local staff and older people across five case study sites; and the third involved further interviews across the 29 sites.

Older people – and to some extent their carers – were involved throughout the evaluation. They helped with the design of key study tools, sat on a steering group and commented on the early findings. It is hoped that they will also be involved in dissemination activities.

1 Introduction

The "Partnership for Older People Projects" (POPP) programme was funded by the Department of Health to create a sustainable shift in the care of older people, moving away from a focus on institutional and hospital-based crisis care toward earlier and better targeted interventions within community settings. The programme began in May 2006 and was completed in April 2009, with a total of £60 million available to 29 pilot sites. The individual sites were selected by a process of competitive bidding to the Department of Health by individual local authorities, together with local health and third sector partners (voluntary and private organisations), for the establishment of innovative projects focused on improving the health, well being and independence of older people. In all, 19 pilot sites were funded in the first year to cover two years (2006-08) and a further 10 were funded in the second year, also for two years (2007-09). It was an underpinning principle that older people should be involved at all levels of the pilot projects, from planning through to dissemination.

The pilots covered a diverse spectrum of activity to meet varying levels of need, from low to high. The individual POPP projects aimed to:

- provide a person-centred and integrated response for older people;
- encourage investment in approaches that promote health, well-being and independence for older people; and
- prevent or delay the need for higher intensity or institutional care.

An evaluation of the POPP programme was built in from the beginning, with two arms. First, each site had a local evaluation team, who responded to specific agreed locality needs and was funded from the site's own budget. Second, to ensure that core data were collated and adequately analysed, an overarching National Evaluation of the pilot sites was established to explore the success of the programme with respect to the three key projected outcomes.

This final report of the national evaluation brings together findings from across the 29 sites, the 146 core projects set up within them and data gathered from numerous clinical, statutory, strategic and operational staff, as well as the participating older people themselves. Building on interim and annual reports and specific outputs from the different parts of the overall evaluation, it presents the evidence on the extent to which the programme succeeded in achieving its aims.

Section 2 outlines the methods employed by this National Evaluation and explores the challenges of such an evaluation – in particular the 'perpetual revolution' necessary to ensure that programme outcomes could be adequately and appropriately measured. The limitations of the methods are also explored; including a discussion, with the luxury of hindsight, of what steps might have been taken to ensure a more robust approach within some areas of the multi-method case study.

Section 3 then describes and illustrates the overall POPP programme and projects. We set out the national context of the programme and the rationale behind the 29 pilot sites bidding for the monies, the design of their projects and how they began to develop necessary partnerships with diverse organisations. The analytic categories developed to group the varied and diverse interventions are also set out and explained. Moving from structure to process, the barriers and facilitators to early implementation of the pilot projects are then discussed, together with the projects' underpinning aims. In addition, the levels and types of involvement of older people within the different structures and

processes are highlighted. Finally, some outcomes achieved within the POPP pilot sites are explored, including greater equality of access, culture change within and between voluntary organisations and new relationships developed by organisations with older people.

Section 4 sets out the overarching data on activity across the POPP programme, mapping the numbers and demographic characteristics of users, and their pathway to other organisations.

Following such descriptive analysis, we focus on some key outcome measures. In Section 5, the base-line findings from a standardised questionnaire are presented. In Section 6, the impact of the POPP programme on individuals' quality of life and access to state benefits are then explored. By presenting this information across a range of specific categories, we begin to build a picture of which types of projects seem to have a greater impact on participants' quality of life.

The cost-effectiveness of the programme as a whole is clearly important and this is analysed in Section 7 at three levels. First, the cost effectiveness of the whole programme is considered, with an assessment of the number of emergency bed-days saved by the POPP pilot sites, in comparison with non-POPP sites, and the potential cost-savings if all local authorities were to put in place such preventive programmes. Second, moving down a level, the cost-effectiveness of the individual projects themselves is addressed. Through Cost Effectiveness Acceptability Curves, we put forward the probability that the projects are cost-effective at different levels of 'willingness to pay'. Finally, changes in users' service use prior to and following the POPP intervention is explored, together with any concomitant increase or reduction in costs.

Section 8 addresses the important question of the sustainability of projects of this kind. This includes some attention to the mechanisms used by POPP sites to seek the continuation of their local projects and their success in this endeavour.

Finally, Section 9 brings all these data together into a broad discussion, including implications for policy.

The evaluation of such a diverse and varied programme has been challenging. It is hoped that the analysis goes some way to demonstrating the nature and type of preventive projects that are most effective in achieving the key outcomes.

2 The Evaluation Design

Key points

The National Evaluation involved 15 different methods of data collection and analysis.

- The evaluation addressed questions both on *outcomes*, such as the extent to which projects improved the quality of life of older people or were cost effective, and on *process*, such as the nature of the opportunities and challenges experienced in the course of implementing the programme.

- A first phase involved the collection of baseline information, including documentary analysis, key informant questionnaire and user focused standardised questionnaire across the 29 pilot sites; a second phase involved substantial data collection via interviews and focus groups with both local staff and older people across five case study sites; and the third involved further interviews across the 29 sites.

- Older people – and to some extent their carers – were involved throughout the evaluation. They helped with the design of key study tools, sat on a steering group and commented on the early findings. It is hoped that they will also be involved in dissemination activities.

2.1 Introduction

The National Evaluation of the Partnerships for Older People Programme involved a total of 15 different substantial data collection and analysis methods over the lifetime of the project (three and a half years). The initial design submitted and approved by the Department of Health changed throughout the process: specific methods and data collection were added, other methods altered and refocused, whilst some suggested approaches were dropped completely.

This section sets out the research design, including the selected framework, and summarises the methods used. The research aims and objectives are explored and the involvement of users and carers in the design and process of the evaluation is highlighted. Each of the different methods is then discussed in some detail. Where these necessarily changed, the underpinning rationale is provided. The challenges to the research are drawn out in each section

2.2 The research design

2.2.1 Introduction

The tender put forward by the Policy Research Programme (PRP) within the Department of Health (DH) identified the need for a formative and summative evaluation covering both 'waves' of the POPP programme pilot sites (see Appendix Q). Outlining the specific activities that any National Evaluation should undertake, it indicated five specific areas to be built into any research: the effectiveness of partnership and financial arrangements; the effectiveness of the preventive model of care; the effectiveness of the Project Leads Network (PLN) and shared learning; the integration of POPP with other policy directives; mainstreaming and generalisability and the cost-effectiveness of POPP. It stressed that the role of the National Evaluation team was not necessarily to carry out all the data collection, analysis and reporting themselves, but to review and comment on the activities of the local evaluation. For example, one activity the PRP perceived as a national evaluation task was *'a review of the different ways in which pilots have measured improved well-being for older people and the effectiveness of these approaches to inform cross-government work on the development of credible well-being indicators'* (PRP Tender 2005: 9). The detailed bid presented by the National Evaluation team (see Appendix P) responded to these different areas and built up a robust research plan in so far as this was possible at the time. At that stage, however, it was not known which sites (19) had been selected to form the first round pilots, the specific local interventions they would be developing or the types of local evaluation they would be setting up. The bid was written to take account of any necessary evolution, but it must be added that the extent of change that would be necessary throughout the process was unanticipated.

2.2.2 Research aims and objectives

The initial bid put forward a single research aim and six objectives. The overarching aim was to critically analyse the innovative partnership and financial approaches of the POPP pilots, whilst the six objectives specified the activities necessary to achieve this aim. This approach was awarded the contract by the PRP. Following an early meeting with the wider stakeholder group, commissioners, DH policy team and change agent team, the evaluation model evolved from an exploration of the process (e.g. partnership models) and differing pilot site approaches to an assessment of the Programme's cost-effectiveness. This requirement dramatically changed the nature of the evaluation from an overarching 'synergistic' role to one necessarily involving the collection of high-level standardised data. The final full set of core research questions are detailed in Figure 1, but there was a stress on those focused toward outcomes.

Figure 1: Core research questions

Research questions: Process

- What were the opportunities and challenges to the implementation of the POPP programme?
- Did the POPP programme change partnership working and practices across the pilot sites?
- What was the level of older people's involvement across the POPP programme?

Research questions: Outcome

- Did the interventions across the POPP programme improve quality of life for older people as compared to normal care?
- Did the POPP programme reduce use of high-intensity services?
- Were the projects/interventions cost-effective?
- To what level were the projects sustained beyond the POPP funding?

2.2.3 Overarching research design

To take forward these research questions, a multi-method approach was adopted, grounded within a case study approach (Yin, 1993, 1994). This was selected for four specific reasons. First, it ensured that appropriate analytical parameters could be placed around the multiple and paradigmatically diverse methods, seen as essential if the depth and breadth of the POPP programme were to be adequately encompassed. Secondly, it allowed for the inclusion of the strong policy context driving and shaping the POPP programme: '*case analysis affords a broad range of sources and multiple research designs. It is thus seen as an effective research method for understanding the complex influences that impinge on government and the often context bound, event driven nature of policy decisions*' (Marinetto, 1999:64). Thirdly, it enabled the evaluation to meet the understandable demand from the PRP and DH policy team that the outcome should be clear statements as to what interventions worked. Nuanced answers were considered with some suspicion and this grew as the POPP programme developed. As stated in the original bid *'The focus of this research will demand more than a simple descriptive presentation. There is a need to build explanations as to why one partnership/financial model and subsequent intervention may be more effective than another in achieving progress toward the external (e.g. PSA outcomes) and the internal (intervention objective) outcomes* (Original Bid: 8). Finally, a case study approach was used for the pragmatic reason that not all the proposed pilot sites (at that stage expected to be 36) could be explored at the micro level, given the level of proposed funding and thus staffing of the research project. There was a recognition that a balance would need to be struck between collecting data across all pilot sites and explaining some of the findings through in-depth examination of a specific pilot site sample.

The evaluation was planned to entail three phases. The first phase was 'exploratory' involving all 29 sites. The second was an explanatory case study, with five sites selected following the early analysis, based on demonstrable differences in demographics, service delivery models, operational structures and progress toward targets. Selection also became pragmatic, involving a process of negotiation with the DH policy and change agent teams responsible for the POPP programme. The final phase again encompassed all 29 sites and involved local pilot site programme managers and senior managers within the local authority. Figure 2 and Figure 3 summarise the three phases and the different methods within these; the latter explained below in sections 2.4 and 2.5.

Figure 2: Summary of the case study phases and research methods

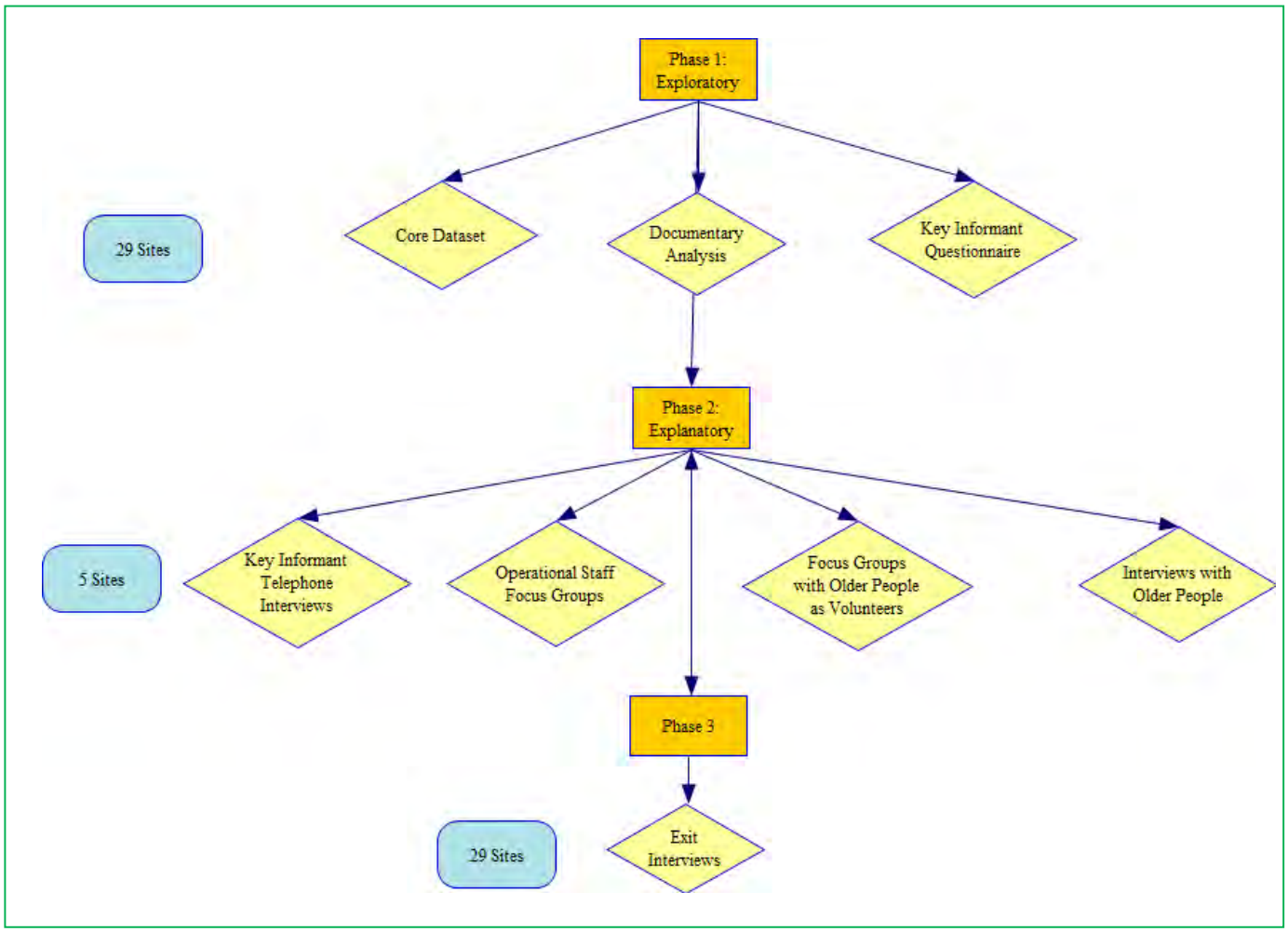
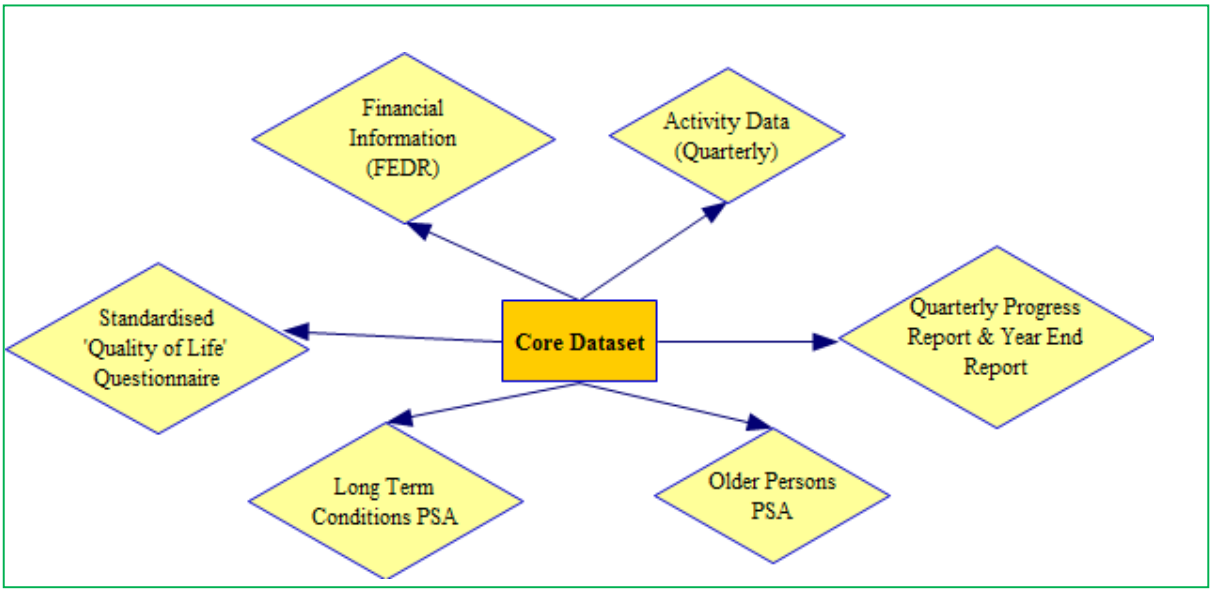


Figure 3: Methods used within the core dataset



In presenting the overarching evaluation, we have removed those methods that were within the original proposal, but were requested to be omitted by the POPP DH policy and change agent representatives. For example, it was initially argued that time was necessary in the early stages to develop a strong theoretical framework to guide the analysis and explain the findings, i.e, theories of change. Given the change in focus of the evaluation from exploring processes to a formative and summative cost-effective, 'real-world' evaluation, this was no longer deemed essential.

2.3 User/carer involvement within the research design and process

Users and carers were involved within the National Evaluation at three levels and in three specific ways (see Figure 4).

Figure 4: Summary of user/carer involvement

The project Steering Group set up by the PRP (the commissioners) and the POPP DH project team (including DH policy and change agent team) involved representation from service users. The Steering Group had bi-annual meetings, at which future plans were presented and findings discussed. To support such discussions, papers were circulated between meetings and feedback received from users. The second level of representation was the 'Older Persons Advisory Group (OPAG) drawn from the

organisation, 'Better Government for Older People' (BGOP). OPAG (consisting of at least 20 older service users and carers) had been involved in the initial setting up of the POPP programme by the DH policy team and they continued to feed into its ongoing development. Their responsibilities were extended to include the National Evaluation (NE) of POPP and the NE team members were invited to their quarterly meetings, giving presentations on progress and being robustly questioned on actions and outcomes. The third level of involvement of users was the 'Public Involvement Research Group' (PIRG), based at the University of Hertfordshire. PIRG is a collaborative forum comprising service users and carers involved in research studies across the University. To ensure a 'level playing field' between researchers and users, a series of research training days had been undertaken. The PIRG met once every two months and the National Evaluation was a regular feature of their meetings.

Using representation at these levels, users were asked to assist the NE team in three key ways: the design of the research tools, the analysis of data collection carried out with users of the POPP programme, and the dissemination of the findings. To give some examples: with respect to involvement in design, six representatives from PIRG attended a full-day meeting to discuss the standardised questionnaire and make recommendations on structure and wording, noting which questions could prove sensitive. They also made suggestions concerning the recruitment of the research participants. Users and carers assisted in developing thematic coding through the use of an anonymised excerpt from a service user interview (see Appendix U). Finally, users and carers assisted in developing publicity material through developing lay summaries explaining the research process.

Although the NE team gave considerable thought to the involvement of service users in primary research, it was decided that this would not be appropriate in this case. This was due to the practical constraints of geography (interviews being undertaken in five different sites across England) and extremely tight timescales.

2.4 Phase 1: Methods and analysis

2.4.1 Documentary analysis

Site documentation plays an *'integral part in policy case analysis'* (Marinetto 1999, p69). It ensures that factual information can be assessed, provides corroborating evidence of objectives, and demonstrates the development of strategic policy (Yanow 2000, Baker 2000, Owen & Rogers 1999, Shaw 1999, Yin 1994, Yin 1993, Scott 1990, Plummer 1983).

Documents were requested from each local pilot site on a six monthly basis. These included the second stage applications for POPP funding; Project Initiation Documents (PIDs), minutes from POPP steering groups, advisory groups and project teams; documents relating to older people's involvement within the POPP programme; Local Area Agreements and local older people strategy documents, including mental health. A content analysis (Scott 1990) of these documents was then undertaken and key areas coded. For example, the involvement of older people was coded into five areas (see Section 3.6). Similarly, the structures of the projects were unpicked, recording the cost, proposed numbers of users, line-management responsibility, numbers of staff, balance of funding and so forth. Summarised outcomes were returned to the sites for verification. The documentary analysis facilitated the development of a picture of each local POPP programme and was fed into subsequent stages of the evaluation process, ensuring the formulation of *'important questions [pursued] through more direct observations and interviewing'* (Patton 1990, p233).

2.4.2 Core dataset

The core, or minimum, dataset involved six specific data collection and analyses (see Figure 3). Five of these six 'activities' are discussed in this section. The sixth – the standardised, 'quality of life', questionnaire – is discussed separately in section 2.4.3 (below).

Older Persons Public Service Agreement

One target that each pilot site was contracted to measure was the extent to which the Older Persons Public Service Agreement (OP PSA) was met. The PSA included two components. All Councils with Social Services Responsibilities (CSSRs) were required to

- Increase the proportion of older people being supported to live at home by 1% annually (non-intensive indicator) and
- Increase the proportion of older people being supported to live at home intensively to 34% of the total of those being supported to live at home or in residential care. (Intensive indicator)[1].

All returns from the PSAs are collected centrally. However, the time-frame of collection and publication of these data did not correspond to the NE reporting requirements; e.g. a report was required in December 2006 to feed into HM Treasury Comprehensive Spending Review. A proforma collection tool was therefore designed and pilot sites were required to complete three returns across eighteen months. Analysis of the progress toward the targets was undertaken and fed back to the sites and the DH. However, the indicator did not provide any robust findings that could be fed into the National Evaluation. All that could be said was which sites had achieved which indicator. Following discussions with the DH, no further collection was made after December 2007.

LTC Public Service Agreement

The second target that the pilot sites were contracted to meet was the LTC PSA, a reduction of 5% in emergency bed-days by 2008 (from the expected 2003/04 baseline). The National Evaluation did not explore the extent to which the sites had achieved the necessary target, as this would not have provided information on the impact of the POPP programme on changes in the overall health and social care economy. Rather, the impact of POPP on the use of emergency bed days was explored, estimating what usage of emergency beds POPP sites would have made if they had not implemented POPP projects.

Emergency bed-day use in any PCT at any given time varies for many reasons, including both local factors (local need) and wider effects, such as national policy. Because the POPP sites were not selected randomly for any given time period, attributing any changes in bed-day use to the POPP programme would require the removal, as far as possible, of any confounding effects. Simply comparing average bed-day use before and after the implementation of the programme in POPP PCT sites would not have been sufficient.

Instead, the NE team used a statistical model, exploiting the high number and spread of data points. This entailed an analysis of bed-days for both POPP and non-POPP sites from April 2004 - March 2009, with 18,180 PCT months of data (303 PCTs by 60 months). A 'difference-in-difference' estimation was

[1] Within this indicator, 'intensively' is defined as households receiving more than 10 hours of home care and six or more visits during the week.

used, exploring whether hospital use for POPP sites reduced after the implementation of the POPP programme compared with their hospital use before implementation. The 'before' and 'after' differences of hospital use in non-POPP sites were used as a base-line. This analysis isolated differences between PCTs in the changes in their bed-days over the three years as well as differences between time periods (months) for the average PCT. With this information, it was possible to predict what bed-day change would have occurred in POPP sites in the absence of the POPP programme and to compare this figure to the change that actually took place in these sites once the programme was in operation. Furthermore, to improve precision and to estimate cost reductions, the differing amounts of spending on the POPP programme reported by each site were included within the model.

Local 'performance' indicators

Many of the projects developed by the POPP pilot sites were low-level, 'upstream' projects. Concern was expressed by project managers that such projects would not show an impact on the PSAs against which the sites were being measured. Following discussion between the DH policy team and the pilot sites, it was suggested that local indicators should be developed to encompass those outcomes that each pilot locality wished to achieve. A proforma was developed by the NE team and a discussion document circulated to support the identification of outcome data and the agreed six monthly collection. However, pilot sites found it extremely difficult to conceptualise outcomes and instead tended to highlight output data, such as numbers of individuals using services or numbers of referrals to particular services. Although on-going advice was provided by the NE team, the pilot sites either did not submit local indicators or, having submitted them, did not continue to provide these over time. Reminders were sent out and the lack of data was highlighted at the Project Leads and Evaluators Network meetings, but after two years with very patchy returns, the local performance indicators were removed from the evaluation.

Financial Evaluation Data Requirement (FEDR)

The cost data necessary to support the 'difference-in-difference' analysis around emergency bed-days was collected through a developed proforma (see Appendix I). The pilot sites were required to complete and return the FEDR every six months. The data requested was divided between expected and actual spend and included the following categories: management costs, project costs, evaluation costs, dissemination and any other costs. Sites were also asked to detail the level of the POPP grant, whether they were in receipt of any other grants and the total income received and spend made. The data were taken into excel across the three years and basic analyses undertaken (descriptive, bi-variate). These data also supported the exploration of the 'weight' of spend on projects within the different developed categorisations (see Section 3.4).

Quarterly progress report and activity data

As part of their contract with the DH as POPP pilot sites, each locality was required to complete a 'Quarterly Progress Report', indicating an overall 'traffic light' for their pilot, the summary position, the risk to project progress, and milestones over the next quarter – in short, a performance monitoring return. These were analysed by the NE team, using content analysis (Scott 1990), and fed into the documentary analysis to provide further understanding of the structure, process and outcomes of the POPP pilot sites.

However, following receipt of the first two quarter submissions, it was recognised that the DH policy and NE teams did not know how many projects in each site had been put in place, their staffing or the number of users offered a service. Working with the DH, the NE team developed a data capture form to

collect this information. As with all data collection, this was done in negotiation with the pilot sites at the Project Leads & Evaluators Network meetings (PLEN). The agreed proforma included a breakdown of type and level of staffing (social services, health and voluntary organisation staff as well as volunteers); demographics (sex, age and ethnicity) and the 'pathway' of users, for example, from which organisations users were referred and, following any contact, those organisations to which they were referred (see Appendix K).

Pilot sites were required to complete this activity data on a quarterly basis. The data was entered into Statistical Package for Social Scientists (SPSS 15) and analysed using non-parametric statistics (descriptive, bi-variate analysis). This data was fed back to the sites at each PLEN to provide an indication of progress as to actual and forecast activity. Discussions were also held at that time around on-going reporting inaccuracies and missing data. The latter became a particular problem for this data. Over the three years, there was always at least one third of the data missing on specific variables (e.g. age range, ethnicity). This was reported to each pilot site verbally and in writing, but little improvement was made, limiting the accuracy of the analysis. Nevertheless, such data collection did support much of the evaluation. For example, the activity data allowed an assessment of cost per user, an understanding of when full implementation had been achieved and likely user pathways following contact with the POPP projects.

2.4.3 The standardised quality of life questionnaire

Introduction

The standardised questionnaire was central to the core or minimum dataset. Administered at two time points – prior to the POPP project and at either three or six months after the POPP project – it was designed to identify changes in user quality of life and service use. Thus, for the analyses, both Time 1 and Time 2 matched data was needed from respondents. Each section fed into different parts of the analysis and proved fundamental to the assessment of the POPP programme outcomes. Nevertheless, this was the most challenging part of the evaluation in its design, coverage across the POPP programme, administration and analysis.

Design of the standardised questionnaire

It was agreed with the DH project team that if appropriate outcome information was to be collected on the impact of the POPP programme, the NE team had to move from reviewing the measures of quality of life used within the pilot sites to collecting and analysing changes through a standardised questionnaire. It was agreed that the standardised questionnaire should be designed in association with the sites and administered by their local evaluation teams. The initial ideas on the questionnaire structure and content were presented to the programme pilot leads and those evaluators that had been appointed in April 2006 at one of the earlier Project Leads & Evaluator Network Meetings (PLENs). It would be an understatement to suggest that there was huge initial resistance. Negotiation and compromise around its structure and administration took nine months and included the circulation of three discussion documents, (see Appendices M, N & O), a day event further discussing the structure and time set aside at two PLEN meetings. The final structure was a compromise to ensure that pilot sites would use the tool, omitting some of the wished for instruments (e.g, GHQ12) and partial omission of key questions (on weekly income and receipt of state benefit).

The standardised questionnaire (see Appendix H) as finally developed incorporated four sections. The first was a measure of health-related quality of life: the Euro-QoL or EQ-5D (see Appendix J) that

includes five health domains: mobility; self-care; usual activities; pain/discomfort; and anxiety and depression. The second section (developed by Professor Ann Bowling) asked users to rate their quality of life as a whole using a seven-point Likert-type scale, ranging from 'so good it could not be better' to 'so bad it could not be worse'. The third section was a client services receipt inventory (Beecham & Knapp 1992), wherein users were asked to indicate the type of services they used (within secondary, primary and social care) three months prior to the POPP project and three months following their contact with the project. The final section recorded the necessary demographics: age, sex, education, postcode, marital status, accommodation, current employment situation, receipt of state benefits, income and ethnicity.

Administration

Resistance to a standardised questionnaire continued throughout the first 18 months of the POPP programme. Of the 29 pilot sites, four sites initially opted out of use entirely, arguing that the standardised questionnaire was not suitable for their users: people with diagnosis of dementia. Following further discussions with these sites, a limited use of the DEMQoL (Smith 2005) was agreed. However, of these four sites, one returned information on only seven respondents with matched data for both Time 1 and Time 2, a second only 16, whilst the other sites did not return any questionnaires at all.

To ensure that the other 25 sites adopted the tool, it was agreed that specific projects would be selected, rather than the overall local programme, that local additions could be made to the core questions and those questions perceived as 'sensitive' could be removed if the local areas felt these were not appropriate. Only six sites agreed to incorporate the question on state benefits, whilst only seven agreed to the question on weekly income. Questionnaires were prepared for each site by the LE team, code books written and delivered. Despite the agreement that the local evaluators should be responsible for administration and data entry, this did not happen in the majority of sites owing to issues of capacity and funding; many local evaluators being contracted prior to the selection of the NE team. The NE team took on administration in 10 of the 25 sites and data entry in the majority of sites, neither of these tasks being written into the bid.

Where sites selected to administer the questionnaire themselves (15), the NE team provided guidance on population sampling (see Appendix O). Sites were followed up to obtain details of their chosen sample and response rates. Sites selected single or multiple projects across their programme. The majority then carried out a full population sample or, in the case of face-to-face interviews identified key informants through purposive sampling (Gobo 2004).

Within those sites (10) where administration was the responsibility of the NE, projects were identified in discussion with the local pilot sites and full population samples were used. Participants were only excluded if it was felt that administration of a questionnaire was inappropriate (e.g., severe dementia, end of life care, severe mental health difficulties). Following non-response, two further reminders were sent. Owing to the requirements of the research ethics committees (see 2.7 below), no further contact as to reasons behind non-response could be carried out. No information was available as to whether such non-response was solely based on poorer health, on-going deterioration, communication difficulties, perceived sensitivity to the questions or conversely, that participants achieved such improvement in their symptomology that completing the second questionnaire was felt superfluous. From exploring some of the comments written in the returned questionnaires, there is some indication that the minority of those who did not respond at time 2 felt the questions were inappropriate and

others that they did not understand that the questionnaire needed to be completed at two time points to measure change. For example, some individuals sent back their uncompleted time 2 questionnaire, with the comment that they had already filled in such a questionnaire only six months previously.

The type of administration, by necessity, varied across the sites. Where the local evaluators took on this task, some selected to carry out face-to-face administration, others used a postal survey, whilst still others carried out telephone administration. The specific tools had been selected to be suitable for all types of administration, but the type of administration can skew reported outcomes. As no monies had been put into the NE bid for the administration of such a large questionnaire, by necessity, postal questionnaires had to be employed. Consent forms were signed by users within each site and their names and addresses forwarded onto the NE team. The questionnaire was then sent out with the necessary information sheets and letters and two reminders where sent at three week intervals following any non-response.

The time-frame between the first and second administration also varied across the different sites; again, a compromise to ensure as wide as possible site 'buy-in' (see Table 1).

Table 1: Administration lengths and percentages of responses

Administration Length	Number of Responses	Percentage of Responses
6 months	858	56.1
4 months	41	2.7
3 months	372	24.3
2 months	203	13.3
7 weeks	10	.7
6 weeks	38	2.5
10 weeks	7	.5
Totals	**1529**	**100.0**

Numbers and analysis

Data for time 1 and time 2 were available for a total of 1,529 respondents across 62 projects (of the 146 core). Due to the nature of the POPP study, confidentiality arrangements (not all questionnaires were administered by the NE team) and differences in postal administration (i.e., no reminders being sent in some pilot sites), individuals either did not complete the questionnaire or only submitted the base-line data. Fewer older individuals and fewer frailer individuals (assessed by the EQ-5D score) completed questionnaires at both time points. As usual, any conclusions drawn from the analysis should be considered in the light of the potential effect of the drop-out group. Specifically any improvements found should not be solely due to the withdrawal from the study of those individuals who were older and frailer (regression to the mean). To ensure this was not the case, the reported outcomes (see Sections 6 and 7) are based only on those individuals who participated in data collection at time 1 and time 2. It is therefore impossible that any changes are due to the exclusion of the drop-out group as this group was excluded from the analysis at both time points.

This leaves use with one question; what do the data look like when all participants are analysed pre-intervention? To discuss these effects, the example of 'Health-Related Quality of Life' as measured by the EQ-5D is used.

The overall change in EQ-5D for those individuals who participated at both time points (aged 60 and over) was a small and non-significant decrease of 0.006 (see Section 6). If all individuals who only completed the base-line questionnaire are included, the EQ-5D increases by 0.03. In a regression analysis predicting the EQ-5D scores at time 1 from the demographic information that was available for each person in the survey (eg., age, gender, smoking, marital status, ethnicity), the effect of removing the drop out group was for the EQ-5D to increase by 0.011. In other words, removing the drop-out group accounts for approximately 30% of the EQ-5D increase observed. In this report, we opt instead to detail the very reliable but conservative reduction in EQ-5D that was found for those individuals who participated at both time points.

Overall, the analyses presented in this report (see Sections 6 and 7) are cautious and conservative. Instead of suffering from a drop-out effect, our data may be conservative by nature of the 'stay-in' effect. Participants who were unhappy with their situation, quality of life or health were motivated to participate in both data collections, causing this group to be potentially over-represented.

2.4.4 Quasi-control sample: British Household Panel Survey

The POPP Programme developed 146 core projects and 530 lower level 'upstream' initiatives. Each had a different focus with no one project randomising any user into either the POPP project or 'usual care'. As no control group had been planned for in the design of the National Programme and, given such a range of foci, it was impossible for the NE team to set up any control areas. Nonetheless, it was paramount that the reported changes in quality of life (whether improvement or deterioration) could be benchmarked against some form of 'usual care'. In particular, given the general frailty of the population in question, it would be expected that people's health and well-being would deteriorate over time as part of the natural aging process. If such a downward trend is evident in the respective population, then any impact of the POPP projects should be benchmarked against such a trend.

Without a specifically constructed control group (preferably with randomised allocation between intervention and control group) for all 146 projects, an attribution of effect is necessarily limited. Nonetheless, it is possible to compare how the POPP sample fared, relative to the general population in the same age group, by drawing on the British Household Panel Survey (BHPS). Crucially, the longitudinal nature of the BHPS allows an assessment of cohort effects i.e. how the same individuals progressed one year to the next. For this analysis, a common quality of life indicator is needed. The POPP evaluation uses the well-established EQ-5D (Euro Quality of Life-5 Dimensions) measure (Brazier et al. 1999). Unfortunately, EQ-5D is not measured in the BHPS. A further step therefore needed to be added to this analysis, which was to impute EQ-5D scores from covariates available in BHPS. This was achieved using weights estimated in another population survey (but not longitudinal) – the Health Survey for England. The final component of the analysis was to compare the yearly change in EQ5D from the POPP sample with the same change in imputed EQ5D in the BHPS for a comparable population.

Benchmark sample

The last two available waves (16th and 17th) of the British Household Panel Survey (BHPS) were used, corresponding to the years 2006 and 2007 respectively. Although the period does not overlap with the POPP Programme, this represents the best alternative, given that wave 18th was not (and is still not) available.

To act as the benchmarking sample, people were selected from the BHPS on the basis that they were aged 60 and over and reported at least one or more limitations in activities of daily living (ADLs). Furthermore, to achieve greater comparability of this benchmark group with the POPP sample, the BHPS sub-sample was re-weighted so that the age structure in age categories 60-74 years and 75 and over was the same as for the POPP sample. All the individuals included in the sample appear in both waves, allowing changes in their quality of life to be followed.

Table 2 gives descriptive statistics for age, sex and (first year) EQ5D score. The two samples are well matched in these dimensions.

Table 2. Descriptive statistics, BHPS benchmark sample & POPP sample

Variable	Number of Observations	Mean	Std. Dev.	Min	Max
BHPS					
age	494	76.22	6.94	65	98
male ratio	494	0.35	0.48	0	1
initial EQ5D (first wave)	494	0.555	0.20	-0.15	0.97
POPP					
age	1215	77.11	8.59	60	99
male ratio	1215	0.31	0.46	0	1
initial EQ5D	1215	0.553	0.33	-0.59	1.00

Imputed quality of life

In order to estimate EQ5D scores for the BHPS sub-sample, the Health Survey for England 2005 (HSE05) was used to derive parameters for an imputation. The 2005 wave focused on older people's health and measured a range of relevant factors.

Whilst EQ5D is not available in BHPS, its five attributes correspond closely with a set of variables that are available in the survey. A regression estimation of EQ5D score against the equivalent variables in HSE05 was used to produce parameter estimates that can be used to weight the BHPS proxy variables and so give an EQ5D score for the BHPS sub-sample. In particular, for each of the five EQ5D attributes, the BHPS proxy is as follows.

Mobility (I have no problems in walking about, I have some problems in walking about, I am confined to bed) is being proxied by the corresponding wHLLTD from BHPS
(Health hinders walking more than 10mins).

Self-care (I have no problems with self-care, I have some problems in washing and dressing myself, I am unable to wash or dress myself) is assimilated to 'Ability to manage a bath/shower' (wADLE)

Usual activities (I have no problems with performing my usual activities, I have some problems with performing my usual activities, I am unable to perform my usual activities) is found to be similar to 'Health hinders doing the housework' (wHLLTA).

Pain/discomfort (I have no pain or discomfort, I have moderate pain or discomfort, I have extreme pain or discomfort) is assimilated to 'Regularly troubled by pain' (wHLPAIN).

Anxiety/depression (I am not anxious or depressed, I am moderately anxious or depressed, I am extremely anxious or depressed) is proxied by 'Health problems: anxiety, depression or bad nerves, psychiatric problems' (wHLPRBI).

Unfortunately, the question related to pain/discomfort is only available in the 16th wave, so it had to be dropped from this analysis. Despite this, the explanatory power of the EQ5D estimation (using the HSE05 data) was good (R-squared of 0.59). The other covariates, apart from the EQ5D questions, include gender, age, number of limitations in ADLs and self-assessed health (SAH). In order to ensure a good match with the BHPS corresponding variables, some of the covariates have been expressed as single dummies (mobility, anxiety, usual activities) while self-care is divided into two dummies.

The results of the EQ-5D parameters, including all the available determinants, are given in Table 3.

Table 3. Determinants of EQ-5D (source Health Survey of England 2005 data)

Variable	Parameter	S.E.	t	p-value	L.I.	U.I.
number of limitations in ADLs	-0.024	0.008	-2.86	0.004	-0.040	-0.008
age	0.025	0.015	1.74	0.081	-0.003	0.054
age squared	0.000	0.000	-1.59	0.112	0.000	0.000
female	-0.026	0.011	-2.44	0.015	-0.048	-0.005
self-assessed health	-0.065	0.008	-7.87	0.000	-0.082	-0.049
mobility	-0.151	0.015	-10.07	0.000	-0.180	-0.122
self-care (some problems in self-care)	-0.194	0.014	-13.42	0.000	-0.223	-0.166
self-care (unable to manage self-care)	-0.481	0.037	-12.91	0.000	-0.555	-0.408
anxiety	-0.129	0.013	-10.10	0.000	-0.154	-0.104
usual activities	-0.097	0.014	-6.96	0.000	-0.124	-0.070
constant	-0.017	0.562	-0.03	0.976	-1.119	1.086

n = 1361, R^2 = 0.5901

Using the BHPS variables and weights described above, EQ5D scores were estimated for the people in the BHPS sub-sample at time 1 (wave 16). An EQ5D score was then calculated for the same set of people (surviving in the survey) a year later i.e. time 2 (wave 17). The means of these two values are given in Table 4 (by sub-group in the BHPS benchmark sample).

Table 4. Imputed BHPS EQ-5D scores, 'benchmark' sample.

Age range	Time 1 EQ-5D	Time 2 EQ-5D	% variation	n.obs.
60-74	0.54985	0.54981	-0.007	223
75+	0.55880	0.53041	-5.081	271
All ages (non weighted)	0.55476	0.53917	-2.297	494
All ages (weighted for PoPP age classes)	0.55531	0.53798	-3.121	494

The last row of the table has the age-weighted result. The POPP sample has about 60% of individuals aged 75 and over and about 40% of individuals aged 60 to 74. Weighting the BHPS sub-sample to achieve these same proportions gives a closer match. For this weighted BHPS sub-sample, EQ5D score decreased from Time 1 to Time 2 by 3.12%. In other words, for the general older population (as represented by the BHPS sub-sample), an average reduction in EQ5D score of just over 3% year-on-year

could be expected. This estimate gives a benchmark change with which to compare the POPP sample change in EQ5D. It is *suggestive* of the underlying reduction in EQ5D that would have been seen for the POPP sample if they did not receive support through a POPP programme. Without a properly conducted trial for each POPP intervention, the effect cannot be directly attributed to the POPP programme, but it is possible with this analysis to understand how the experience of the POPP sample compared with the more general BHPS sample.

2.4.5 Key informant questionnaire

The key informant questionnaire (KIQ) (see Appendix A) was administered twice during the POPP initiative – to respondents in the 19 first-round pilot sites in June 2007, and to those in the ten second-round pilot sites in June 2008. Project managers within each site were asked to compile a list of at least 30 individuals from the statutory and non-statutory agencies involved with the design, implementation, project delivery and governance of the projects that comprised their POPP programmes. A one in two (1:2) sample was then identified through a random number table (www.random.org) to ensure appropriate anonymity and confidentiality for respondents, given their name had been provided by their local project manager. Those individuals selected were then sent an e-mail link to an online questionnaire (www.SurveyMonkey.com).

There has been some debate regarding the relative merits of on-line and postal surveys (Litaker 2003; Pettit 2002; Bliven, Kaufman & Spertus 2001). Given that most key informants had access to and were familiar with electronic mail, together with the obvious administrative advantages, we elected to use an on-line survey. Nevertheless, postal copies of the questionnaire were also sent out to those individuals for whom we did not have e-mail addresses, and to those who requested paper copies after having been sent the link by e-mail.

In the first administration, (Round 1 sites), the KIQ was sent to 639 people, with a 44% (n=280) completion rate, and the second administration, (Round 2 sites), was sent to 315 people, with a 60% (n=188) completion rate. The questionnaire comprised mainly tick boxes on Likert-type scales, with spaces available for respondents to add comments if they so wished. Examples of the topic areas include the degree to which respondents believed partnerships had existed within pilot sites prior to the initiation of the POPP programme, the degree to which POPP had strengthened those existing partnerships, what respondents perceived to be the key barriers to partnership working, the key challenges to the initiation of the POPP projects, and the main outcomes of the POPP partnerships thus far. The mean number of respondents from each pilot site was 19 (range 11-31). The findings were analysed through SPSS using non-parametric bivariate statistical tests (e.g. descriptives and chi-square).The findings of the survey were also used to inform the selection of the five Phase 2 sites, and to inform the design of the topic guides to be used in the qualitative research.

2.5 Phase 2: Methods and analysis

2.5.1 Selection of the case study sites

Given the inter and intra-variation across the pilot sites, selection of the five sites for Phase Two of the evaluation was not a simple procedure. Initially, a matrix was developed with key variables, but this provided little insight into which pilot site areas would be suitable for the explanatory analysis. As a result, a broader 'cluster' analysis was undertaken, using the key 'clusters' of:

- Mental Health Focused Programmes

- BME Focused Programmes
- Case Finding Projects
- Level and Focus of Older People's Involvement
- Low-Level (up-stream) Programme Focus

From this clustering, together with demographic variables of population (older people and BME), deprivation levels and the average 'needs-levels' or focus of the project, the pilot site areas were selected (see Table 5). The sites selected were representative of the different clusters and authority types across the POPP and of Round 1 and Round 2.

Table 5: Sites selected for Phase 2 of the Evaluation

Cluster	Site	Authority Type	% Pop from Average	BME % Pop from Average	IMD	IMD Quartile	Average Needs Focus
Mental health focus	10	City	-1.8	4.3	32.9	1st	2
BME focus	73	London Borough	-6	14.8	18.5	1st	3
Older people involvement	22	Metropolitan	-1.6	0.4	33.7	1st	2
Low-level focus	56	County	3.9	-3	15.8	4th	1
Case finding	06	County	6.9	-2.6	17.3	3rd	3

2.5.2 Qualitative data collection

The second phase of the evaluation sought to explain some of the outcomes generated across the 29 sites. Three qualitative methods were selected (see Appendices B, C, D, F and G for topic guides). Each form of data collection was tape-recorded, transcribed verbatim, and thematically analysed (Huberman & Miles 1998) using the qualitative analysis package, NUDIST. An example of the coding structure can be found in Appendix U.

First, a series of 24 semi-structured telephone interviews (Shuy 2002) were undertaken with a purposive sample of key informants across the five selected sites. The interviewees included the Project Manager, Project Lead, Older Person's Lead (Officer) and an older person (either champion or representative).

Focus groups were then carried out with those staff responsible for delivering the projects. Where the projects were jointly delivered with older people as volunteers, a second focus group was set up to ensure that the volunteers did not feel constrained by their operational colleagues. In total, 12 focus groups were carried out, exploring individuals' experiences, perspectives and perceptions of the effectiveness of their respective models of partnership working, barriers and facilitators to project implementation, impact on older people, their relationship to the wider health and social care economy, practice changes and sustainability.

Finally, semi-structured interviews were carried out with older users, with two samples: users of POPP projects and a matched sample of individuals presenting similar needs, but who had not yet experienced a specific POPP service. Across the five sites, the latter (non-POPP) samples were accessed in different ways. For example, in one site, participants were recruited from people who had been referred for a service, but who had not yet started to receive it. In another site, the non-POPP sample was drawn from

voluntary organisation lunch-clubs and day services not funded by the POPP programme. Using such different techniques, 30 interviews were carried out with POPP users and 30 with non-POPP users.

2.6 Phase 3: Methods and analysis

The final stage of the research was 'exit interviews' with project managers across all 29 sites (see Appendix E for the topic guide). Participation in this phase was widened to include senior members of the statutory or health authority (e.g. assistant directors, chief executives), to provide an assessment of the impact of the POPP programme on the wider locality. A total of 39 interviews were carried out. All were transcribed verbatim and thematically analysed using NUDIST.

2.7 Ethics

The NE protocol received ethical approval from:

- Charing Cross Research Ethics Committee (REC Ref: 06/Q0411/61) on 24 April 2006; a substantial amendment to incorporate the standardised questionnaire was received in September 2006.
- Research Committee of the (then) Association of Directors of Social Services
- Research Governance and management in each of the 29 pilot areas.

3 The POPP Programme and Projects

Key points

- The 29 pilot sites set up 146 core local projects, according to local priorities, comprising many individual services to improve health and well-being among older people and reduce social exclusion and isolation;

- Two-thirds of the projects were primarily directed to reducing social isolation or promoting healthy living (Community Facing) and one-third focused primarily on avoiding hospital admission or facilitating early discharge from acute or institutional care (Hospital Facing);

- The projects were widely thought to have delivered a greater range of services for older people, improving their quality of life and well-being, and there was easier access to them; projects found it difficult to access 'hard to reach' (HtR) people and services may have been insufficiently responsive to the needs of black and minority ethnic (BME) groups;

- The projects were reasonably successful in developing good working relations with a range of partner organisations, with some variation across areas and organisations; new posts developed expressly to overcome organisational barriers and new link roles were helpful in this respect;

- Service delivery teams tended to comprise staff employed by more than one agency; several had multi-agency multi-disciplinary teams; these teams facilitated easy discussion, mutual respect and, on a practical level, advice and referrals across agencies, particularly where staff worked together in the same location.

- Local VCOs benefited from the support provided by POPP projects, widening their perspectives on what they could provide and strengthening their skills; there was also good networking and support between such organisations;

- The direct involvement of older people in projects increased over time; such involvement was generally heaviest in the design and governance of projects, compared to service delivery; the older people involved tended to be newly retired (the 'young old'), healthy and well-educated;

- The involvement of older people could prove difficult, due to their own ill health or that of people for whom they were caring, as well as transport difficulties; people from BME communities were found to be difficult to recruit;

- The POPP pilot projects experienced some challenges in their implementation; their short duration meant hasty decision-making early on and staff concerns about their own future employment later on; staff and volunteer recruitment proved difficult and the amount of administration time required for projects was often under-estimated;

- There were some inevitable difficulties in organisational partnerships, including the complexities of inter-organisational referrals, the inherent tension in policies promoting competition and collaboration across agencies, practical and ethical problems in data-sharing and cultural boundaries between professions; those working in multi-agency teams experienced particular problems in coping with differing organisational arrangements.

3.1 The national context of POPP

In recent years, the government has placed increasing emphasis both on the improvement of services for older people and on greater partnership working. There is a concern to achieve more integrated services for older people, designed to prevent ill health and promote healthy living and well-being. To deliver these services, partnerships are now expected to extend beyond social and health care to include other statutory and non-statutory agencies, and voluntary organisations, as well as greater service user involvement. The section examines the way in which these strategic priorities have informed the POPP initiative, together with the selection process of pilot sites, and thus sets the context within which the POPP programmes were developed.

3.1.1 Where POPP sits within the national policy framework

As already noted, the POPP initiative had several objectives: to provide person-centred and integrated services for older people; to encourage investment in approaches that promote health, well-being and independence for older people; and to prevent or delay the need for higher intensity or institutional care. For these objectives to be achieved there was felt to be a need for strong and effective partnerships between key stakeholders. Indeed, if there was to be a real shift towards preventive community care, away from reactive secondary care, these partnerships needed to extend beyond hospitals, primary and social care agencies to incorporate other statutory organisations, such as police and fire services, housing associations and libraries, together with both national and local voluntary and community organisations (VCOs). Furthermore, there was also a related aim to develop sustainable communities and encourage a greater engagement of service users and their carers in the design, provision and governance of local services.

The evidence base supporting the effectiveness of prevention and well-being services has remained weak (Curry 2006), but there was nevertheless an underlying assumption that such a service shift would eventually bring cost savings. There was therefore seen to be a need to assess the impact of preventive services on long-term health and quality of life, which was built into the remit of the POPP initiatives. Indeed, the POPP programme was one of a number of recent government policy initiatives, including Individual Budgets and Link Age Plus, that sought to test new approaches in making the shift towards prevention and at the same time improve the quality of life of older people.

3.1.2 Partnership and collaboration

The boundaries between health and social care have long been regarded as problematic for older people who require community based support. Over the last decade, the government has sought to promote joint working practices between these two agencies, to the extent that collaboration is now at the heart of any new social and health care policy. Such foci emerged early in the lifetime of the Labour government. The White Paper *Saving Lives: Our Healthier Nation* (DH 1999a) advocated a 'joined-up' approach across central government and locally through partnerships between social and health care agencies. Health Action Zones were launched as the result of recognition that *'effective action to tackle ill-health and health inequalities was not the remit of one organisation or sector'* (Leach & Percy-Smith 2001: 202).

Local Area Agreements (LAAs) were launched by the ODPM and piloted in 20 sites in April 2005, rolled out to all local authorities by April 2007. These LAAs required local authorities and their key partners to improve public sector services and the health and well-being of older people. Structural reconfigurations of both PCTs and Strategic Health Authorities (SHAs) were made in 2006, with the aim of reducing management and administration costs. This focus on collaboration and partnership between health and social care was further reinforced through the Green Paper on adult social care

Independence, Well-being and Choice (DH 2005b) and the White Paper *Our health, our care, our say* (DH 2006a).

The government's drive towards the development of more person-centred care and higher quality services for older people was reflected in the *NHS Plan* (DH 2000) and the *National Service Framework for Older People* (DH 2001). This was later followed with an overarching national strategy for older people, set out in '*Opportunity Age – Meeting the Challenges of Ageing in the 21st Century*' (DWP 2005). Together these documents were drivers for 'active ageing', where older people were to have the opportunity to play a full active role in society and where services were aimed at promoting independence, choice and control. To enable older people to live full, healthy and independent lives, social and health care services needed to focus on the prevention of ill health in older people, as well as of crisis situations, rather than merely reacting to them, and providing services that promote health and well-being.

3.1.3 Financial levers to facilitate partnership

The centrality of partnerships and the movement toward preventive services demanded appropriate flexibility in funding arrangements, and to this end a number of financial mechanisms were developed. The *Health Act* (1999) contained three particular sections to enable partnership working: Section 29 expanded funding transfers from the NHS to local authorities, Section 30 permitted local authorities to transfer funds to health authorities, and Section 31 introduced the new flexibilities of pooled budgets, lead commissioning and integrated provision. In short, the Health Act removed the legal obstacles to joint working between health and social care. The most popular of these was the use of pooled budgets (Glendinning et al. 2002).

As part of the *NHS Improvement Plan* (DH 2004) and *Creating a Patient-Led NHS* (DH 2005a), joint commissioning mechanisms were extended through social and health care partnership boards to enable a strategic approach to service development. From April 2005 each GP practice was able to ask for a delegated indicative budget from their PCT, covering that practice's share of the NHS budget. From 2006, all PCTs were developing arrangements to support and facilitate GP practices to become involved with practice based commissioning (PBC). By utilising their local knowledge, GP practices can now work with their social care partners to plan, develop and implement services around the needs of their population. By tracking care pathways across health and social care, it is possible to minimise duplication of services and to identify areas where health partners might effectively commission services from social care.

Payment by Results (PbR), announced in *Creating a Patient-Led NHS* (DH 2005a), was designed to allow commissioning decisions to be taken at local level and thus be responsive to the needs of local service users. PbR replaced existing block contracts with a transparent financing system whereby the payment of acute health service providers was linked to activity and case mix (e.g. the mix of type of patients and/or treatment episodes), and on the basis of a national price tariff. This mechanism was expected to result in a reduction in admission and readmission rates, to reduce lengths of hospital stay, and to allow flexibility on the part of primary care to commission a plurality of providers. The savings made from the reduction of acute service activity would then increase the resources available to community services.

Such budgetary 'levers' were intended to provide opportunities to shift the balance of expenditure from acute hospital care to preventive community based care. The purpose of the POPP initiative was not only to set up new and innovative services for older people, but also to develop appropriate partnership and financial models that could effectively utilise these levers to transfer monies between secondary and primary care. Indeed, these levers have to varying degrees been utilised by

pilot sites within their POPP programmes, both in their implementation and in the process of ensuring their long-term sustainability, and have to varying degrees proved effective.

3.1.4 User choice

The recent reforms did not simply involve promoting partnerships and collaboration. They also required that any collaboration or partnership should include service users/ consumers/citizens and respond to *'their needs and wishes'* (DH 2005a: 5). Moreover, those services were to be delivered in radically different ways. Direct Payments, for example, constituted *'a financial payment [that] gives the person flexibility to look beyond 'off-the-peg' service solutions for certain housing, employment, education and leisure activities as well as for personal assistance to meet their assessed needs*' (DH 2001: 1). For many people, social services would no longer be responsible for providing services, but rather for facilitating choice. The Green Paper (DH 2005b) and White Paper (DH 2006a) built on such 'innovations', stating that the 'vision' for social care should incorporate choice and control for the user, in addition to more integrated and preventive services. Setting these policy documents together, it can be seen that a myriad of social actors were to be involved in the provision of health and social care, extending far beyond the statutory social and health care agencies.

The new transformation agenda in social care, and the growing personalisation of services, represented a further step in the strategic shift towards early intervention and prevention. This new policy initiative was accompanied by a ring-fenced Social Care Reform Grant (SCRG), which was intended to assist councils to redesign and reshape their adult social care services in ways that would help people to maintain their independence, health and well-being. It was expected that by 2010/11, councils would have made significant steps in this direction. The aims of the transformation agenda, supported by the SCRG, strongly mirrored much of the work undertaken within the POPP programme and other initiatives, such as the *Innovation Forum* and *Link Age+.*

3.1.5 The concept of prevention

There remained a lack of clarity with respect to both the meaning of 'prevention' at the interface between primary health and social care, and to how to measure it effectively. As one writer noted: '*rather than being discrete and easily definable, preventive services present a continuum of support that range from relatively formal intermediate care services provided by health and social care professionals to so-called 'low-level' interventions … services not necessarily provided by a health or social care professional*' (Curry 2006: 7). Wistow and Lewis (1997) argued that prevention has three aims: to prevent or delay ill health or disability consequent upon ageing; to promote and/or improve quality of life, independence and inclusion in social and community life; and to create healthy and supportive environments. Thus, preventive services can encompass a broad spectrum of interventions. The categorisation of prevention services most often adopted, however, is that outlined by Canada (1995):

- Primary prevention – 'low level' services such as befriending, health promotion and exercise that are targeted at older people who are relatively healthy and active, with the aim of maintaining independence and well-being;
- Secondary prevention – screening and case-finding services to identify individuals 'at risk' of emergency attendance (although not imminent) and supporting them at home;
- Tertiary prevention – services that are aimed at minimising disability or deterioration from established diseases, and which are targeted at relatively ill and frail older people. Such services will seek to prevent imminent admission to acute health care settings, such as rapid response services and adult placement schemes.

The policy response

Within health and social care policy, a broader understanding of prevention has had increasing influence for more than a decade. An explicit policy focus on independence as a goal for service provision was evident in the policy paper *Modernising Health and Social Services* (DH 1998a) and the subsequent White Paper *Modernising Social Services* (DH 1998b).

The Kaiser Permanente triangular model of care, adopted by health and social care for the treatment of long-term conditions (DH 2005d), also has a three tiered scale of need. The model acknowledges that people affected by, or at risk of, long-term conditions (LTCs) have greatly differing needs, varying from preventing the development of an LTC in the first place to the complex needs of highly dependent patients. The levels of care provided in this model are termed 'stepped care' and are seen as providing a framework for using limited resources to the greatest effect (von Korff et al, 2002). A broad definition of prevention was also adopted by the Department of Health in the selection process of pilot sites for POPP funding, describing preventive interventions and approaches as those '*that maintain and enhance the physical and mental health, well-being and independence of older people and thereby prevent or delay the need for more costly, higher intensity or institutionalised care*' (DH 2006c, Pt A, para 4.2).

POPP pilot sites' response

All the separate projects within the POPP initiative were 'preventive' in the sense that they sought to prevent older people from requiring more intensive and expensive services by intervening at an early (or earlier) stage. The POPP programmes were also aimed at facilitating a shift in the focus of service provision from the acute to the social and primary care sectors. Nevertheless, whether 'prevention' was to be interpreted as involving primary, secondary or tertiary prevention, and whether the interventions comprising POPP programmes were to be aimed at more complex needs and hospital avoidance or to comprise solely lower level prevention services were questions left largely to the pilot sites themselves to decide. From the start the POPP programmes were to be very much led by local priorities.

Of the 29 pilot sites, a minority interpreted the concept of prevention as hospital avoidance and focused their programmes on the more complex, higher level needs (sites 3, 13, 48 and 73). A larger proportion of sites aimed their programmes at low level projects and community development (including sites 12, 22, 52, 56 and 67). These often incorporated a high degree of user involvement, and focused on building closer relationships with organisations within the independent and voluntary and community sector (VCS). But shifting the emphasis of prevention to the lower end of needs, and investing in healthy ageing activities designed to combat social isolation and inactivity, was often a difficult message to sell to senior managers and commissioners, especially when facing a constrained financial environment:

> '*For years, people in the PCT and LA were only interested with 'vulnerable' older people, so it was difficult with some managers to think it was a good idea to do things for people who were 50+, quite active, and still engage with them to prevent them getting more dependent*.' POPP Project Manager (Site 47)

In addition, a third group of POPP programmes developed interventions that covered the full spectrum of needs (sites 6, 10 and 25). These sites included such low level 'upstream' projects as navigator services, tele-club and teleshopping projects, to higher level 'downstream' projects such as unplanned night support, emergency care practitioners and specialist falls services.

Measuring prevention

The effectiveness of these different interpretations of preventive interventions can be assessed in different ways. The success of projects aimed directly at hospital avoidance, such as rapid response services, proactive case finding and intermediate care, may be effectively measured through reductions in emergency bed days (EBDs). In contrast, low level prevention services, often commissioned from voluntary and community sector organisations (VCOs), and often with a strong degree of community involvement, are more difficult to measure in the short term, as they are likely to take some years to translate into a reduction of EBDs. Their effectiveness can be assessed, however, by measuring possible changes in the quality of life of those affected.

3.1.6 The primary objectives of the DH in regards to POPP

The 2004 Comprehensive Spending Review (CSR) provided ring-fenced funding of £60m (£20m in 2006/07 and £40m in 2007/8) to Councils with Social Services Responsibilities (CSSRs) to establish innovative pilot projects aimed at providing integrated preventive approaches for local older people. Partnerships were to include a broad range of partners drawn from Primary Care Trusts (PCTs), other secondary health partners, voluntary and community organisations (VCOs), although '*the specific partners involved in proposals should, however, be determined locally depending on the nature of the proposal*.' (DH 2005b). There was also a clear requirement that the partnerships should include older people who '*must be involved from the outset in developing the idea for the pilot proposal and should be fully engaged in the application process*' (ibid). Indeed, pilot sites needed to secure the formal support and approval of a forum of local older people in order for their application to be considered, and all applications had to be co-signed by the chair or another designated lead of a forum of local older people that had been involved with the development of the proposal.

The key themes underpinning the POPP programme were the need for services and approaches which would:

- Support independence and interdependence;
- Put older people in personal control and provide integrated, holistic and flexible packages of care and support;
- Focus on prevention of ill-health and promotion of well-being to enable older people to live full, healthy and independent lives.

POPP programmes were expected to map the needs of their older populations, including identifying 'at risk' populations, and to present a clear rationale for the proposed interventions and approaches. As part of this process, potential pilot sites were encouraged to address issues that were raised via engagement processes with local older people. Potential sites were also encouraged to ensure that interventions be aimed at demonstrating improvements in three key areas:

- Providing more low level care and support in the community to improve the health, well-being and independence of older people, preventing or delaying the need for higher intensity and more costly care;
- Reducing avoidable, emergency admissions and/or bed days for older people;
- Supporting a greater proportion of older people to live in their own home.

Bids were selected on the basis that they provided: '*a real opportunity to test a range of different approaches for making a systemic and sustainable shift towards prevention*'; were potentially replicable to both other geographical areas and other care groups; and had the potential to deliver the outcomes set out in the social care Green Paper *Independence, Well-being and Choice* (DH 2005). These social care outcomes were:

- Improved health
- Improved quality of life
- Making a positive contribution
- Choice and control
- Freedom from discrimination
- Economic well-being
- Personal dignity

Pilot sites were also encouraged to seek ways to reach out to those older people who did not normally come to the attention of social care services. In addition, the programmes were also intended to provide:

- Evidence about the effectiveness of prevention which, as noted above, was currently lacking;
- Progress in delivering the service shifts and targets contained within the National Service Framework for Older People (NSF-OP);
- Progress towards delivering the service shifts and targets within the Public Service Agreements for Older People (PSA-OP), which involved supporting more older people to live independently at home, and for Long Term Conditions (LTCs), which aimed at reducing EBD use by 5%;
- Begin to demonstrate the practical mechanisms that can be used to shift resources within a 'whole system' to achieve a preventive focus.

3.1.7 Pilot site selection process

The POPP initiative was ongoing for three years and consisted of two rounds of pilot sites: the first round receiving funding in May 2006 and the second round in May 2007. The application process for funding itself had two phases. At the first phase potential pilot sites were requested to provide an 'expression of interest', referred to as a 'stage one application'. These were received from applicants for Rounds 1 and 2 by the Department of Health (DH) in May 2005 and May 2006 respectively. An expert panel agreed criteria for selection, which were then published in the guidelines for applying for the POPP grants (see DH 2006, Annex B). The ten criteria comprised:

- Involvement of older people
- Targeting excluded groups
- Innovation
- Analysing local needs
- Links with national strategies
- Partnerships with health
- Wider partnerships with a diverse range of partners
- Value for money
- Capacity to deliver the project,
- Evaluation and effective performance management.

Applications were then short-listed and a more substantial second stage application (SSA) was submitted by sites at the end of October 2005 and October 2006 respectively. The final selections of successful proposals were announced in December 2005 for Round 1 sites and December 2006 for Round 2 sites. Each pilot site was required to submit an Implementation Plan (IP) which then formed the basis of an agreement between the pilot and the Department of Health. Within the first round of the POPP initiative, 19 partnership bids were awarded funding from an assessment of 144 bids received; within the second round ten sites were awarded funding. The duration of the funding

period for the second round pilot sites had initially been set for one year. However, this was extended to two years when it became apparent that such pilots would require more time.

As Round 1 sites had a good representation of interventions focused on older people with mental health needs and housing interventions, such as extra care housing initiatives, preference was given in the second round to applications that addressed the needs of carers and older people with long-term conditions (LTCs), that entailed greater involvement of the community, voluntary and independent sectors, and that sought to link the health and social care needs of older people with their wider needs in areas such as transport, benefits, housing, leisure, social participation, community safety and crime reduction (DH 2006).

Throughout the lifetime of the POPP initiative, ongoing support was available to pilot sites from the Care Services Improvement Partnership (CSIP), acting as a 'critical friend'. A named regional CSIP contact was available to provide peer support, and opportunities for shared learning and problem solving were provided through bi-monthly Project Leaders and Evaluators Network (PLEN).

3.2 POPP programme context

This section focuses on the contexts of the 29 individual POPP programmes, and examines the key objectives that sites sought to achieve in the design of their programmes. The types and numbers of organisations that became partners in the POPP partnerships are outlined, along with the numbers of projects that comprise the 29 programmes. The nature of the relationships between the various partners to the POPP programmes are discussed, as are the principal challenges faced by pilot sites and the main facilitators utilised to resolve them. The discussion of these issues draws on data collected by the National Evaluation team from several sources: the documentary analysis; the key informant questionnaire (KIQ); and interviews and focus groups undertaken with project managers, strategic and operational managers, staff and volunteers involved with the delivery of POPP services.

3.2.1 Key objectives of sites for entering POPP Bids

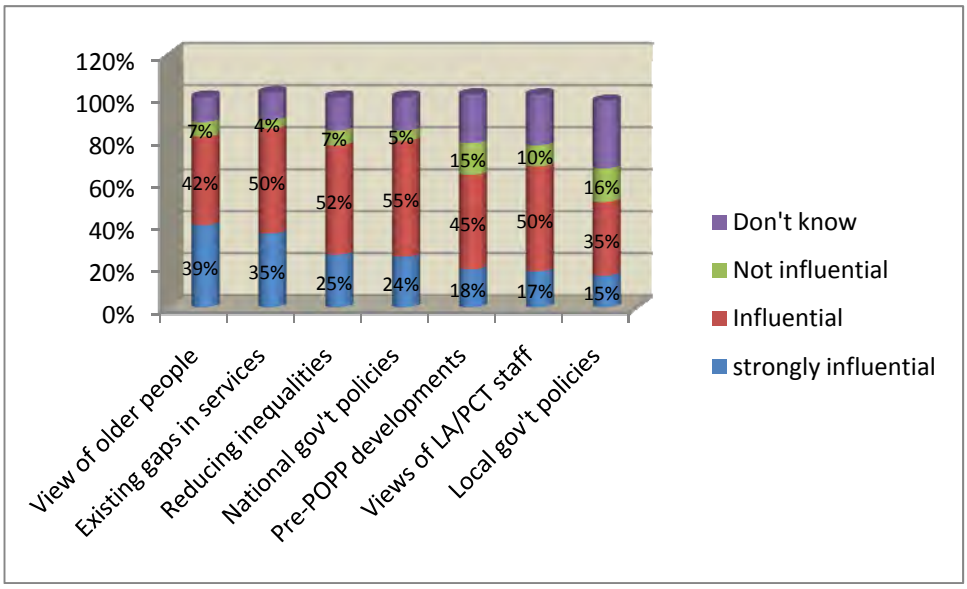
Two principal objectives were cited by pilot sites in their original bids for POPP funding. First, all pilot sites acknowledged that the projections of demand and increasing costs in the provision of both social and health care were unsustainable, and there was a widespread recognition of a need to implement preventive services aimed at reducing the growth of demand on services within the acute sector. Secondly, there was also recognition by pilot sites that gaps existed within the health and social care services currently available, and that a whole systems redesign was necessary to promote joint working and the provision of seamless care to patients. The POPP funding was widely identified as an opportunity to facilitate the comprehensive programme of change necessary to achieve these objectives.

Nevertheless, the programme design of each pilot site reflected a particular local context, including the existing service models and financial, working and governance arrangements, and each site had particular demographic, geographic and socio-economic characteristics that shaped local priorities. Therefore, in addition to the two principal objectives noted above, there were also several other factors that had a bearing on the actual design of the POPP programmes within each site.

In order to examine factors affecting programme design, research participants were asked in the KIQ to indicate which factors from a given list were most influential in the design of their POPP programme, i.e. the services that were to be developed and the target population selected. As Figure 5 indicates, the factor that respondents thought most strongly influenced programme design (39%, n=174) was the views of local older people. Altogether, those who believed this factor to have been strongly influential or influential comprised 81% (n=359) of respondents. There were several

forms in which older people's views were collected and used in service design within pilot sites, and further discussion of older people's involvement within the design and other areas of the POPP programmes is discussed in Section 3.6.

Figure 5: Level of influence of key variables on the design of POPP projects



Recognition that organisational separation exacerbates costs

There was a broad acceptance among pilot sites that organisational separation between social and primary health care might increase the overall cost of caring for their local populations. One reason for this could be the duplication of assessments and services which could be more efficient with greater co-ordination. A second, and related, reason might be that a lack of co-ordination or joint working between agencies led to late or inappropriate referrals between services. Greater co-ordination could therefore provide a more effective service to individuals.

One pilot site (Site 10) identified the organisational separation between specialist mental health and mainstream health and social care systems as a factor affecting the design of its POPP programme. The site noted that older people suffering from a co-morbidity of physical and mental health needs were particularly likely to accelerate through the care system into more dependent and institutional forms of care.

Financial recovery plans

The health and social care agencies within many of the pilot sites had been facing challenging local economic environments in the years leading up to the POPP initiative and it might have seemed that such conditions would weigh against the undertaking of structural redesign to care services. Such an economic environment is particularly challenging, because pressures to achieve financial balance make it very difficult to set aside funds to pump-prime the necessary service shifts. Nevertheless, sites such as Site 06 identified the constrained economic environment as a factor in the design of their programme; because the POPP funding provided the necessary funds to pump prime in the short term, it was expected that the long-term financial savings from reduced use of the acute care sector would then help underpin a financial recovery plan.

Achieving savings

A minority of pilot sites believed that in order to use the short-term nature of the POPP funding effectively, cost savings would be required within their local health and social care economies during that time. It was argued that such savings would most effectively be made, and be quantifiable, within a POPP programme aimed at the more 'downstream' preventive services, focused directly at higher levels of need and admission avoidance

> '*We were always very clearly of the view that with POPPs being a two year programme, if we were going to get any money for sustaining POPPs, then we had to address the NHS agenda. ... If we'd have gone promoting healthy eating classes or something like that, or doing more exercise, then if POPPs was a ten year programme, we might have been able to have the numbers which demonstrated that. But you don't get to do that in two years. ...It's only going to be useful if it's a two years actually translates into something sustainable. We didn't have any money. The money's in the NHS. How are we going to attract the money? We have to talk bed days*.' Project Manager (Site 13)

Identification of particular gaps in existing service provision

Gaps in existing service provision might take two forms: gaps in particular services (e.g. low level prevention services) or gaps in services for particular population groups (e.g. BME, HtR, or those 'at risk' of falls). For example, the partners to the Site 15 POPP viewed the funding grant as an opportunity '*to complete the whole jigsaw of older people's services*' (Site 15 SSA, p4). The missing piece of the jigsaw was perceived to be low level preventive services that might exist between specialist health and social care, appropriate for the '*few*', and universal services that often do not meet the specific needs of older people who require '*small but useful*' services. In response to this gap in services, the POPP programme within Site 15, along with nine other pilot sites, included a project aimed at commissioning local VCOs to provide low level services.

Another pilot site, Site 06, completed an Equalities Impact Assessment of their pre-POPP services and found that there was low take-up of existing services by members of BME groups. Consequently, it was an intention of its POPP programme to contract for services with organisations working with BME groups to help ensure that proactive contact was made with these older people.

Reducing health inequalities

There is some evidence to suggest that partnership working is an important prerequisite of strategies to reduce health inequalities (Gillies 1998), and government policy strongly supports joint working practices as a key mechanism for this purpose (DoH 1998, Evans & Killoran 2000). Several pilot sites (including Sites 11, 13 and 67) emphasised the need to reduce health inequalities within their areas, and between their areas as a whole and other areas, as a principal factor in the design of their POPP programmes. The programme within Site 11, for example, involved a multi-agency case-finding team identifying and visiting all older people residing in an area to assess their needs and signpost services. This multi-agency team was to '*target in the first instance the most deprived areas in the Borough*' (Site 11 SSA, p2). These areas usually experience both adverse socio-economic and health outcomes.

Issues relating to rurality

Sparsity of population has been identified as a cause of increased costs of local health and social care services which weigh against rural areas (Asthana et al. 2003). Some pilots, (such as Sites 06, 38, 47, 56 and 79) had more geographically sparse populations compared with others, and this condition presented problems that the POPP programme in those areas were specifically designed to address. For example, within one locality project (Site 47), the census defined the population as 'super-

sparse'. In response, their POPP programme developed a generic worker role, based on localities, as the most effective and cost-effective support for older people living there, rather than specialist roles over the whole geographical area. The problem of rurality has also been linked to the lack of access to transport experienced by many older people (ODPM 2003). To address this problem, the programme in Site 06 included budgetary provision to assist with transport, and one of the POPP services was reportedly costed to allow for higher rural transport costs.

Identifying 'prevention' as going beyond statutory health and social care agencies

There was wide acceptance among the pilot sites, as evidenced by the diverse types of partners to POPP programmes described, that 'prevention' involves the input of a broad spectrum of organisations, such as housing associations, the pension service, the fire and police services, and even retail companies. Moreover, the areas of life encompassed within POPP programmes include employment, culture, and transport and community safety. This idea was particularly strong in the design of the low level services and CVS capacity development projects that comprised the POPP programmes in a number of pilot sites (including Sites 12, 15, 22, 37, 52, 56 and 95).

As part of prior/ongoing service developments

In several sites, social service departments, primary health agencies and CVS organisations were already in the process of restructuring their services to achieve local priorities, and the POPP initiative allowed a pump-priming process to facilitate the short-term funding required to make the necessary changes. Site 73, for example, had started to implement radical changes in 2004 in the way that health and social care professionals were managed and worked together. These changes involved integrated locality teams based close to where people lived, supported by integrated specialist services. A key feature of these changes was that all services now had a single manager covering the health and social care remit based around GP practice populations, and with a single access point. The basis of the interventions selected by this pilot site (73) was to build on the success of this previous integrative work.

Learning from other projects

Several pilot sites referred to the learning they had gained from projects undertaken prior to POPP. In one London Borough site, for example, the London Older People's Service Development Programme (LOPSDP) started in 2002, and the site became one of nine first wave sites across London, funded for two years, to form the Older People's Collaborative. This approach was then further piloted in 19 other areas as part of the National Primary Care Contracting Collaborative. The evaluation of this pilot service had demonstrated a number of weaknesses in the rest of the health and social care economy and it was decided by the Brent POPP partners that building on the success of this service was a priority. The POPP programme was therefore partly designed to build on existing good practice at the co-ordinated care service (CCS), developed through the LOPSDP.

In addition, the POPP programmes of three pilot sites were in part built on their experience of the Innovation Forum (IF). This commenced in April 2004 and also sought to encourage partnerships between statutory and non-statutory agencies in order to achieve a 20% reduction in unscheduled bed days for older people over 75. These pilot sites had already established IF Steering Groups, comprising directors and senior managers from health trusts, social services and CVS organisations, which acted as a vehicle for testing project ideas and ensuring wide coverage of statutory and voluntary agency views.

Two other pilot sites identified evidence from challenges in the design of other particular projects as influential on their programme design. One site noted that Active Living Centres (ALCs) had proved popular and successful in other parts of the country, but that these had for the most part been in

urban areas. The challenge, therefore, was to develop a model of ALCs that would respond to local needs within a large rural area, including resolving problems of access to services and transport. Within another POPP site, the programme aimed to build on the Sure Start initiative (ODPM 2006), originally designed for tackling social exclusion experienced by children in deprived areas. Initially, Sure Start had aimed to improve outcomes for children by bringing together a range of services to focus on early intervention. The POPP programme in this site aimed to '*test whether a Sure Start approach to developing preventative services for Older People is a cost-effective way of achieving the following outcomes – improved quality of life, reduced pressure on intensive services, sustainable shift of resources towards preventative services*' (SSA, p11, Site 67).

Staff and service user consultation to determine priorities

All pilot sites stressed the importance of consultations with both staff and service users in the generation of ideas for the design of their local POPP programmes. For example, the POPP programme in Site 13 reported that the impetus for its programme began in April 2004 when the PCT and social services convened a major 'Speak Up' consultation event for older people. This event was attended by over 350 older people '*whose views placed a challenge to statutory agencies to redesign services in a manner which enabled the active engagement of older people and the progression of a healthy living agenda*' (Site 13 SSA, p3). As a consequence, an Older People's Strategy Group (POPSG) was established, comprising volunteer older people and facilitated and financially supported by a partnership of the PCT, the local NHS Trust, and social services. This group was reportedly central to the design of the POPP programme in Site 13, and its very local and iterative nature.

The POPP programme in Site 19 also reported that it selected the interventions and approaches that comprised its POPP programme based on a needs analysis and consultation with older people and staff through a number of methods. First, a 'POPP workshop' was held in April 2005 in which older people were reportedly able to share their views and ideas alongside staff and community members. The SSA for Site 19 stated that '*[o]lder people were then able to help choose the theme of the [site] bid, and made suggestions on innovative interventions, all of which have been encompassed within the bid. Existing consultation feedback was also drawn upon that came from previous Elderly Person's Liaison Group minutes, BME forum minutes, Home Care surveys, quality of life questionnaires, user and carer feedback on the LTC and Support Strategy, and CSCI reports identifying high demand for domiciliary care service for people with dementia*' (SSA, pp11-12, Site 19).

It should be noted here that there are inherent difficulties in evaluating the degree to which such reported public consultations, which took place prior to the commissioning of the National Evaluation, actually influenced project design. Indeed, there may have been some dissonance in some sites between the issues raised by older people through the consultation process and the shape of the programme as it was implemented. Further discussion of the involvement of older people can be found in Section 3.5 below.

3.2.2 POPP pilot site partners

One of the central aims of the overall POPP initiative was to encourage the development of partnerships within pilot sites that reached across all sectors involving the delivery of health and social care services: primary health, adult social care, acute health care, independent service providers, and small and large voluntary and community organisations (VCOs). The POPP partnerships therefore encouraged a greater depth and breadth of partnership arrangements than had previously existed, and it was one of the objectives of POPP to test the effectiveness of such partnerships.

Table 6 indicates the broad range of organisations acting as partners to the POPP programmes. It can be seen that there has been a large number of partners: 522 organisations across 29 pilot sites, an average of 18 'partner' organisations per site. The range of partners would seem to incorporate all types of organisations, with the weight of partnership being with voluntary organisations: two thirds (66%) or 347 separate organisations.

Table 6. Total number of organisations involved within the 29 POPP pilot sites

Sector	Numbers involved (% of total)
PCTs	29 (6%)[2]
Secondary care trusts	61 (12%)
Ambulance trusts	10 (2%)
VCOs	347 (66%)
Other statutory organisations (Fire Service, Police etc.)	57 (10%)
Housing association	4 (1%)
Independent/private sector	14 (3%)
Total	**522**

3.2.3 POPP pilot site grants

Table 7 shows the size of the POPP funding grants made available to each of the pilot sites within both Round 1 and 2. It can be seen that the grant sizes varied greatly, with Poole council receiving £796,000 and Leeds receiving £4,046,000. The median grant size among the 29 sites was £1,847,000. The variations in the size of funding grant between sites was dependent upon a wide range of factors, including: the focus of POPP programmes; the number of projects within those programmes; the number of staff needed to be recruited or seconded to deliver POPP services; the geographic coverage of programmes; and the demographic and socio-economic contexts within which they were to be implemented.

[2] Since the reconfiguration of PCTs, in October 2006, each of the 29 pilot sites has had a single PCT partner providing primary care for their area.

Table 7. POPP pilot site grants

Round 1 POPP pilot sites	Grant
Bradford Metropolitan City Council	£2,360,000
Brent London Borough Council	£1,650,000
Camden London Borough Council	£1,546,000
Dorset County Council	£2,394,000
East Sussex County Council	£3,188,000
Knowsley Metropolitan Borough Council	£1,226,000
Leeds City Council	£4,046,155
Luton Borough Council	£861,000
Manchester City Council	£2,601,000
Norfolk County Council	£3,640,000
North Lincolnshire County Council	£870,000
North Yorkshire County Council	£3,000,000
Northumberland County Council	£2,030,000
Poole Borough Council	£796,000
Sheffield City Council	£3,876,000
Somerset County Council	£1,374,000
Southwark London Borough Council	£1,847,000
Wigan Metropolitan Borough Council	£1,768,000
Worcestershire County Council	£2,000,000
Total	**£41,073,155**

Round 2 POPP pilot sites	Grant
Calderdale Metropolitan Borough Council	£943,000
Croydon London Borough Council	£605,000
Devon County Council	£3,831,000
Gloucestershire County Council	£2,597,000
Kent County Council	£1,500,000
Leicestershire County Council	£2,388,000
North Somerset County Council	£977,000
Rochdale Metropolitan Borough Council	£1,038,000
Tameside Metropolitan Borough Council	£1,150,000
West Sussex County Council	£3,402,279
Total	**£18,431,279**

3.3 Pilot site projects

Each of the 29 pilot site programmes comprised a number of separate workstreams or projects, which often were integral to an overarching programme vision. However, there was some complexity with the calculation of the total number of POPP projects in a consistent way across all 29 programmes. The way in which pilot sites themselves defined what constituted individual projects differed between sites and changed even within sites over the course of the funding period. These differences were reflected in the pilot site documentation and activity returns for their programmes. For the purposes of the National Evaluation, schemes were counted as separate 'core' projects if they fulfilled the following criteria:

- Had been set out within the SSA/original bids
- Involved a separate team

- Provided a discrete service focus
- Was line-managed by a separate organisation

In addition to the core projects, several pilot sites counted as one of their projects the development, funding or commissioning of a number of low level preventive services from third sector organisations. Table 8 indicates the total number of projects that were funded or commissioned as part of the 29 POPP programmes.

Table 8. Total number of POPP projects: May 2009

Pilot site	Round 1 sites	Round 2 sites	Total
Core Projects	108	38	146
Commissioned (LLP) services	377	153	530
Total	**485**	**191**	**676**

3.3.1 Core POPP projects

Table 9 and Table 10 show that there were a total of 146 core projects between the two rounds of pilot sites: 108 within the 19 Round 1 sites and 38 within the ten Round 2 sites. It should be noted that six projects within Round 1 pilot sites, and three within Round 2 sites, involved the development of a network of low level prevention services within their areas, commissioned from local VCOs.

Table 9. Number of core POPP projects: Round 1

Round 1 pilot sites	Core projects
Bradford	5
Brent	1
Camden	8
Dorset	3
East Sussex	14
Knowsley	6
Leeds	10
Luton	4
Manchester	3
Norfolk	9
North Lincolnshire	1
North Yorkshire	9
Northumberland	6
Poole	2
Sheffield	6
Somerset	2
Southwark	2
Wigan	14
Worcestershire	3
Total	**108**

Table 10. Number of core projects: Round 2

Pilot site	Core projects
Calderdale	6
Croydon	1
Devon	4
Gloucestershire	6
Kent	3
Leicestershire	1
North Somerset	5
Rochdale	7
Tameside	2
West Sussex	3
Total	**38**

3.3.2 Low level prevention (LLP) projects as part of CVS development

As noted above, in addition to the core projects, there were a large number of small – often very small – low level 'upstream' services commissioned from the third sector. It can be seen from Table 11 that, over the lifetime of the POPP initiative, the proportion of these commissioned POPP projects increased from 40% of the total projects in May 2007 to 63% in May 2008, and to more than three quarters (78%) of all POPP funded and tendered projects in May 2009. This represents an ongoing success within the nine sites committed to developing the network of VCO-provided preventive services in increasing the number and variety of services provided by the third sector.

Table 11. Low level prevention services funded as part of CVS development

Pilot Site	May 2007	May 2008	May 2009
Brent	N/A	6	6
Devon	N/A	N/A	10
Dorset	11	94	51
Gloucestershire	N/A	N/A	14
Luton	14	19	19
Manchester	33	33	20
North Lincolnshire	5	13	151
North Somerset	N/A	N/A	18
Rochdale	N/A	24	74
Somerset	21	51	94
Tameside	N/A	N/A	37
Worcestershire	37	36	36
Total	**121 (40% of all projects)**	**276 (63% of all projects)**	**530 (78% of all projects)**

3.4 Partnerships within the POPP programmes

Any attempt at defining the concept of 'partnership' in the planning and delivery of social and health care is inherently difficult, because it involves a multitude of varied and complex issues (Leathard 1994, Ling 2000), and covers a wide spectrum of relationships (Glasby & Dickinson 2008, Banks 2002). There have been a number of reasons that partnerships have been promoted in recent years,

including the need to deliver co-ordinated packages of care, to address 'wicked issues' that transcend different agencies, to avoid duplication between those agencies, to bid for new resources, and as a consequence of statutory requirements (Audit Commission, 1998). To achieve these aims, individual partner agencies must have shared aims, and be prepared to negotiate relationships that involve a degree of trust, reciprocity and equality (Glendinning et al 2002, Sullivan & Skelcher 2002). As noted in the previous section, the POPP pilot sites were expected to develop partnerships that included a broad range of partners drawn from across health and social care, including voluntary and community organisations (VCOs) and other third sector providers. Although the specific partners involved in programmes were to be determined locally, depending on the nature of the proposal, each of these relationships involved different opportunities and challenges depending upon the particular local contexts and the priorities of the partner agencies.

The breadth and depth of the pilot site partnerships depended heavily on the local context within which POPP programmes were to be developed as well as the nature of the programmes themselves. The KIQ sought the views of key informants within all 29 pilot sites as to the potential effectiveness of partnerships between different health and social care agencies. It was found that an overwhelming majority of staff and managers involved with POPP programmes believed that strong partnerships were indeed possible between both statutory and non-statutory organisations. When respondents in the KIQ were asked for their opinions about the potential efficiency of partnerships between separate health and social care organisations, both statutory and non-statutory, the great majority (86%, n=484) either strongly agreed or agreed that two or more organisations could jointly manage services in an effective way. In contrast, a very small proportion (4%, n=17) of respondents believed that such joint management could not be effective, although a tenth of respondents (10%, n=53) answered that they did not know.

There was also support among KIQ respondents for the idea that two or more statutory and non-statutory organisations could jointly share financial risks in an effective way. Two thirds (66%, n=343) of the respondents agreed with this proposition. Nevertheless, there was also a slightly larger degree of doubt amongst respondents, with 11% (n=59) either disagreeing or strongly disagreeing with the question, and over a fifth (22%, n=116) neither agreed nor disagreed. This would indicate that there is a definite distinction made among respondents between the effective joint management of services between agencies and the sharing of the financial risks that such joint management might entail.

The KIQ also found that key informants were generally supportive of the position that partnerships between different sector organisations had been strengthened by the POPP programmes in their area. As noted below, the partnerships that appear to have been strengthened most were those that existed between local authorities, PCTs and VCOs.

3.4.1 Partnerships between pilot sites and the Department of Health (DH)

Pilot sites were provided with ongoing support from the DH and CSIP, both with peer support for each pilot site from named CSIP representatives and through the Project Leaders and Evaluators Network (PLEN) meetings. There was a consensus among project managers that these facilities were helpful, and that the general approach and project management style of the DH was facilitative:

> '*We were very keen to learn from other areas. The DH were facilitative towards bringing learning across from elsewhere which was very helpful.'* POPP Project Manager (Site 47)

> *'The PM team had the mood and pace absolutely spot on. Exceedingly well managed, and I say that relative to another DH programme which I would be very critical of because it is so*

nationally prescribed. POPPs had very clear aims and outcomes, but the process was very much left up to a local flavour.' POPP Project Manager (Site 13)

Where there were criticisms of the project management style, it often involved a lack of feedback and involvement, especially when projects seemed to be progressing well:

'We did always feel that there were certain pilot sites that the DH were interested in and others that they weren't really. ... It was that distant....Perhaps because we achieved on everything' POPP Project Manager (Site 52)

'There tended to be more contact with them when there were problems. When things were going quite well we did not tend to get the feedback.' POPP Project Manager (Site 19)

In particular, there were some pilot sites that felt that the reporting they were required to do on their projects by the DH could be onerous, particularly once they had become mainstreamed:

'*What has been really difficult has been trying to get across the complexity of the local situation. Obviously they have to have a particular reporting format. I found that not particularly helpful in helping me to get across the local issues. I can see that from their point of view, trying to get hold of information that they can aggregate and use, their format has been useful. But it has felt like a bit of a blunt instrument. But I think that is in the nature of these kinds of things*'. POPP Project Manager (Site 47)

'*There was sometimes a tension there with us sending stuff to the DH saying "Well can you give us more evidence of that?" and we'd send stuff back and say "Well we'd like to talk to you about the way you want it done", and not much came back. There were times when you felt a bit like it was a slightly onerous process. And there was a slight tension when we were mainstreaming when they still wanted us to provide this stack of information, but we were unable to because we just didn't have the structure anymore*.' POPP Project Manager (Site 67)

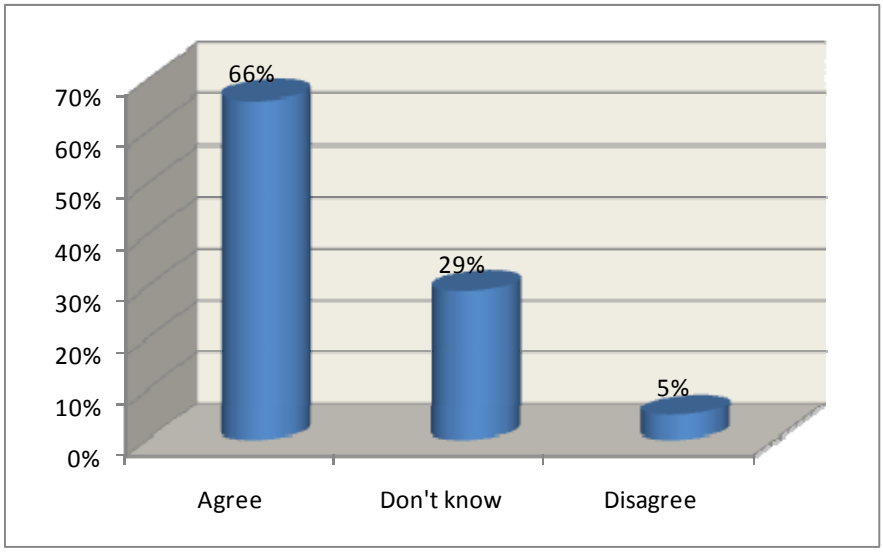
There was also sometimes a perception among pilot sites that the DH did not fully understand the complexity of the local context within which the POPP programmes were being developed:

'*There was an assumption that we could report on all our schemes even those that had effectively discontinued. But a lot of them had been rolled into mainstream services, so we couldn't therefore*.' POPP Project Manager (Site 47)

3.4.2 Partnerships between local authorities and primary care

Fundamental to the success of the POPP programmes was the development of good partnership arrangements between primary health and social care agencies. Within the KIQ, two-thirds (66%, n=214) of respondents agreed that the POPP programme had strengthened the existing partnership between the local authority and the PCT, with only 5% (n=23) believing that it had not.

Figure 6. Extent to which KIQ respondents agreed that partnership working between local authorities and PCTs had been strengthened by POPP

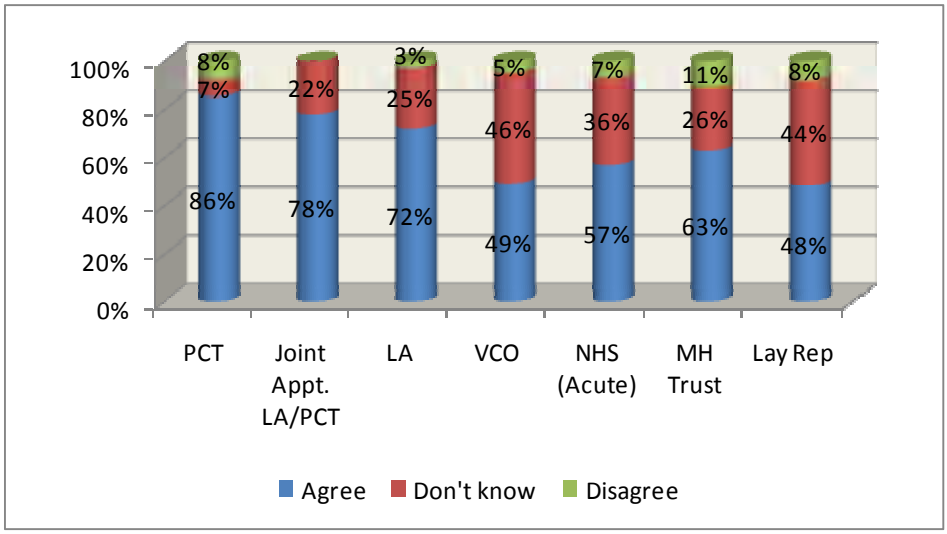


As Figure 6 indicates, 29% of KIQ participants responded that they did not know whether the POPP programme had strengthened the partnership between the local authority and the PCT. However, if we view the responses to this question against the organisations for which respondents worked, it can be seen that those employed by either the local authority or the PCT were more likely to report that the POPP programme had strengthened that particular relationship than participants employed by other partner agencies. Moreover, as Table 11 and Figure 7 also show, respondents from organisations other than the local authority and PCT were proportionately more likely to respond that they did not know whether the partnership had been strengthened. This is unsurprising as they did not work for either.

Table 12. Extent to which respondents agreed that POPP had strengthened the partnership between the PCT and local authority: Views of respondents by their organisation

Organisation	Agree	Don't know	Disagree	Total
PCT	73 (86%)	5 (7%)	7 (8%)	85 (100%)
Joint Appt. PCT/ LA	18 (78%)	5 (22%)	0 (0%)	23 (100%)
Local Authority	103 (72%)	36 (25%)	4 (3%)	143 (100%)
VCO	64 (49%)	60 (46%)	7 (5%)	131 (100%)
NHS Acute	8 (57%)	5 (36%)	1 (7%)	14 (100%)
MH Trust	12 (63%)	5 (26%)	2 (11%)	19 (100%)
Lay Representatives	12 (48%)	11 (44%)	2 (8%)	25 (100%)

Figure 7. Extent to which respondents agreed that POPP had strengthened the partnership between the PCT and local authority: Views of respondents by their organisation



p=<0.001[3]

From the qualitative data, it was found that among project managers in particular, there was general agreement that relationships between local authorities and PCTs had on the whole been based on an equal footing, and there was a good level of commitment and engagement from both parties:

> '*Everybody has been very committed and people have gone out of their way to find solutions to difficulties or to come up with options, I would say that the partners within, everybody is determined that it'll work and everybody's putting in 100% to make sure it does*' KITI Participant (038)

Nevertheless, there were statistically significant (p=<0.001) variations in the extent to which respondents in the KIQ agreed that partnership between the PCT and local authority had been strengthened, with a range of 100% (n=17) in one site to 36% (n=4) in another. This variation between pilot sites in the degree of engagement between these organisations was reflected in the qualitative data, with project managers reporting difficulties trying to engage PCTs:

> '*The first year was very much trying to engage with the PCT at all sorts of levels and POPP was part of that. And other than at a local operational level, we did not get significant buy-in by the PCT*.' POPP Project Manager (Site 47)

Where difficulties were perceived, the primary reasons cited by project managers and other key informants were the ongoing financial constraints among some PCTs and the immediate effects of the 2006 reconfiguration. There were also differing funding priorities between the two agencies:

> '*It's fair to say that we haven't had total delivery on some of the agreements that have been made, mainly because the PCTs' funding crisis continued and the senior management team*

[3] There was found to be statistical significance between the following two variables: the organisation within which respondents were employed and whether they agreed with the statement that partnership working between the local authority and PCT had been strengthened by POPP. Note, also, the low number of respondents among NHS acute trusts and mental health trusts.

that we were engaged with at that time has now left – and is now in the process of being changed again.' POPP Project Manager (Site 47)

'*There was a positive relationship with the PCT. The difficulty was that there are different funding priorities between the PCT and local authority*.' POPP Project Manager (Site 19)

The difficulties a minority of pilot sites had with PCT sign-up was often reflected in the minutes of governance bodies, charged with the responsibility of overseeing the development of the POPP projects:

'*One of the messages from the County Steering Group to the Programme Board concerned the engagement of the PCT, which is weak in some parts of the county and particularly at county level – the consequence of paralysis associated with still evolving staff and management appointments during re-structuring*.' POPP Programme Board Minutes (November 2006), p2 (Site 47)

'*Discussion held regarding the Board not being quorate, i.e. absence of a PCT representative. Sustainability issues are coming onto the agenda which makes this important. The Terms of Reference may need to be amended, but it is important that we have representatives from the PCT at the Board meetings.*' Site 88 POPP Programme Board minutes (January 2008)

One important factor that affected the strength of the POPP partnerships was the degree of partnership working between the organisations prior to the start of the programme. Even where there was a history of partnership working between local authorities and PCTs, and where good partnership working arrangements were developed during the POPP programme, the length of time and effort that needed to be invested to build those relationships was often unexpected:

'*We did struggle with getting effective partnerships, but we always underestimated the amount of time we had to invest in that*.' POPP Project Manager (Site 04)

'The PCT have only just appointed a person to work with us at a strategic level...so that's a bit late in the project, but at least somebody is now there. There was a big gap in terms of PCT [involvement] so within the PCT itself there was no strategic co-ordination about how they would be able to cope with POPP.' FG1 participant (Site 56)

In contrast, where consistent engagement between PCT and local authority managers was invested from very early on in the programme, and where there was a recognition that shared aims and objectives were essential within any partnership, greater progress could be made despite such difficulties as PCT reconfiguration and ongoing financial constraints:

'*The PCT were in a turn-around position and the POPP Project Manager had been invited from the start to the Turn-Around meetings. Thus, a good relationship had been developed, making the links between individuals, and worked with 50+ organisations*.' POPP Project Manager (Site 52)

'*If you're clear about the reasons why there is a partnership, what that partnership is set up to deliver, and you've got a way of making sure you're on track in terms of delivering that, then, as we've seen, all the individuals within the PCT have changed and it hasn't mattered because as a group we've had that clarity about what we're trying to do*.' KITI Participant (075)

An important feature of an effective POPP partnership between local authorities and PCTs was strong governance, with clearly understood lines of responsibility and accountability from the beginning of the programme:

> '*Aligning the POPP and the governance through the health and well being board. When we started off the proposal for POPP, it was taken to the full Board which was chaired by the leader of the council and the PCT. The ongoing governance went through that Management Board and we gave regular updates there. Our reports were signed off there. That helped the whole strategic agenda, because of the people around that table. It was fully supported and championed by the PCT chair and the leader of the council*.' POPP Project Manager (Local Pilot Site)

It should be noted that almost all project managers agreed that, by the end of the POPP programmes, the strategic partnerships and working relationships between adult social care and PCT managers had been strengthened as a consequence of the initiative. To some degree, the importance of these particular partnerships was dependent on the focus of the programme. For example, some programmes were more health focused, with projects involving PCT-seconded staff, while others were more centred around the local authority and the voluntary sector, with local networks of VCOs being commissioned to provide low level preventive and well-being projects. A weak partnership between the PCT and local authority had greater impact and proved a greater challenge for more health focused programmes

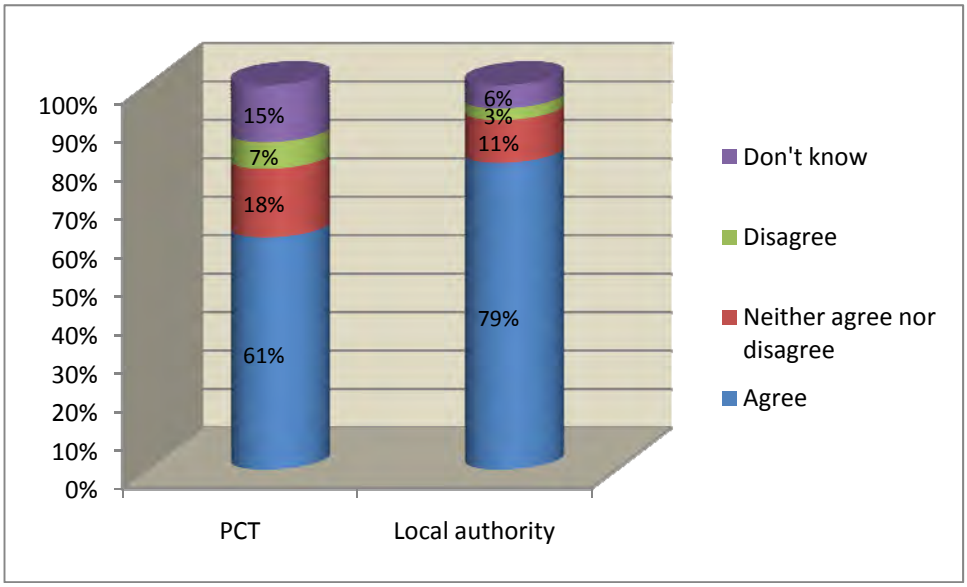
It should also be noted that in order for POPP projects to be effective, it was necessary for strong strategic partnerships between senior managers to be translated into good operational partnerships 'on the ground' between staff delivering POPP services. Further discussion of partnerships at the operational level can be found in Figure 8.

3.4.3 Partnerships between local authority/PCT commissioners and voluntary sector providers

A central aim of the POPP initiative was the development of partnerships with the voluntary and community sector and, as noted above, there were 347 voluntary and community organisations (VCOs) involved as partners within the 29 POPP pilot sites. These groups comprised both local older people's groups, such as pensioners' forums, residents associations and local voluntary action groups, and national organisations, such as Age Concern and the Alzheimer's Society. Many of these VCOs had been commissioned by either the local authority or the PCT to provide low level preventive and well-being services to older people. As a consequence of the large numbers of such partners – and their differences in size, capacity and focus – the nature of their partnerships with both local authorities and PCTs varied greatly.

Nevertheless, as Figure 8 demonstrates, there was strong support among KIQ respondents for the proposition that POPP had strengthened local partnerships between voluntary and community organisations (VCOs) and both the local authority and PCT. The proportion of respondents that agreed that partnership working had been strengthened between the local authority and VCOs was particularly high, with 79% (n=370) agreeing with the proposition and a very small number disagreeing (3%, n=14). Between the PCT and VCOs, partnership was also perceived to have been strengthened through the POPP programme, although to a less extent (61%, n=286), and with a slightly larger proportion disagreeing with the proposition (7%, n=34), and one third of respondents being unable to agree or disagree (33%, n=150). This is perhaps unsurprising, given that fewer PCTs within the overall POPP initiative were commissioning services from VCOs than were the local authorities.

Figure 8. Extent to which KIQ respondents agreed that partnership working between VCOs had been strengthened with local authorities and PCTs by the POPP programme



In addition to VCOs, there were also a small number of private profit-making organisations involved within POPP partnerships and commissioned to provide services. However, as noted above, pilot sites themselves indicated that there were very few such organisations involved as POPP partners, and within the KIQ only 2% (n=11) of respondents indicated that they worked for private organisations.

Within the context of partnership, there is a presumption of a degree of equality of influence upon decision-making. However, it would appear from the qualitative data in particular that the relationships between VCOs and local authority or PCT commissioners often involved less than equal relationships from the early stages of the POPP programme. Nevertheless, where statutory organisations were perceived to be dominant partners within POPP, it may often have been an unconscious attitude, and could be altered, with negotiation, to the benefit of all parties:

> '*The bid was done by health and social care in a bit of a hurry. The deadlines were quite short. They had a good sensible idea of what they wanted to do, it came to a partnership board that I and some voluntary sector colleagues were at as representatives, and there was an immediate recognition that they'd completely forgotten about the voluntary sector and what role it could play. They wanted the voluntary sector to sign it off, obviously. ...we said 'What do you think you're doing? why would [the voluntary sector representatives] sign this off when (a) we haven't had a chance to look at it properly, because it's been such a rush, and (b) it's not really involving the voluntary sector? And because we have quite a mature relationship with statutory services, they ...went back to the drawing board. And the result was a much, much more robust POPPs bid*.' KITI Participant (028)

It is perhaps unsurprising that hierarchical relationships should exist between statutory commissioners and VCO providers, as they do in any relationship that involve inequalities of commissioning and purchasing power. Indeed, all participants within the key informant telephone interviews (n=19) recognised that an unequal relationship existed between VCOs and commissioners, and this was also reflected within the focus groups with operational staff:

'*You have this feeling that actually you're not an equal partner, because you don't have all the money and you don't have all the power*.' KITI Participant (074)

'*I think there may be psychologically the "well, we're the master – you're the slave" in some ways. "We hold the money, so we have the right to say where it takes*."' FG1 participant (Site 56)

It is when VCOs perceived statutory commissioners to be persistently dominant and inflexible, and unwilling to listen or re-negotiate that relationship that difficulties between the organisations tended to occur. Within one pilot site focus group, comprising VCO staff commissioned to provide a POPP service, there was a strong perception that the local authority wished to adhere to the original service specifications in the bid '*at all costs*', and did not wish to discuss problems that were emerging as a consequence of this perceived inflexibility:

'*The project is a pilot project and, to me, a pilot project is looking at if they have a viable project, We tried to feed back the true message to the county, but they all want to pick off the bits they pick off – I think there is some pressure*.' FG1 participant (Site 56)

'*The bid became a document which had to be fulfilled at all costs*.' FG1 participant (Site 56)

Difficulties can also arise within relationships where commissioners' expectations of what VCOs can provide are too high. This problem could occur if commissioners assumed that voluntary service providers adopted the same values, priorities and working practices as statutory organisations:

'*We engaged with voluntary organisations, which wasn't successful ...because the local authority officers expected voluntary organisations to do much more for much less money – usual problem – and they also expected the voluntary organisations to work at a pace that the integrated team were working at. And there's very different cultures*.' POPP Project Manager (Site 13)

Where VCOs perceived that their commissioners were dominant, inflexible and had an inability to listen to their concerns and suggestions, there was unlikely to be an effective partnership. However, despite the inherent inequality of the relationship between PCT and local authority commissioners and VCO providers, when there was transparency around the decision-making process, a disparity of economic power was not seemingly perceived as an obstruction to the partnership:

'*What you want to do is participate in a transparent and open process around how financial decisions are come to, and service development decisions are come to, and commissioning decisions are come to. It's the transparency about the way you're allowed to give the input right from the beginning which gives an element of equality*.' KITI Participant (076)

One way that pilot sites were able to facilitate such transparency in partnerships with their VCO providers was by ensuring they were included within the governance bodies of the POPP programme:

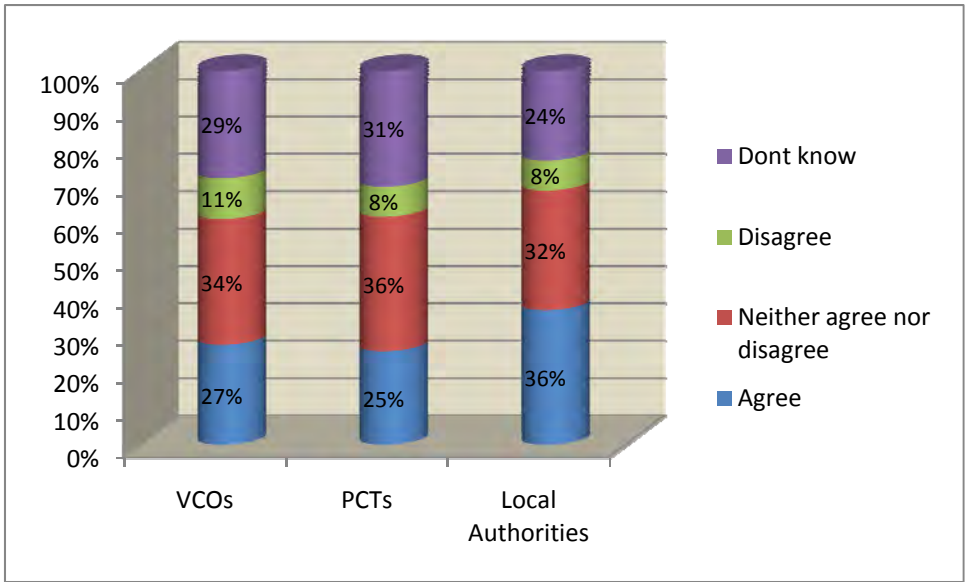
'*In terms of the voluntary sector, we had a project group and a steering group and from the beginning we got them [VCO providers] involved at a higher level, including Age Concern, represented at a higher level, managers and chief executives. We took them on the journey, as it were*.' POPP Project Manager (Site 19)

3.4.4 Partnerships involving secondary sector partners

As indicated above, the POPP programmes included a total of 61 secondary trusts as partners, representing 12% of all POPP partners. However, there were very few respondents to the KIQ who were employed within either an acute trust (4%, n=24) or mental health trust (3%, n=19). Indeed, among the respondents of 12 pilot sites (40%), there were no representatives from secondary trusts, and a further seven pilot sites (24%) had only one such respondent. The sites with the largest proportions of secondary trust employees in the KIQ were, not surprisingly, those POPP programmes with projects addressing more complex levels of need. There were eight such respondents in both Site 48 and Site 73, who respectively represented 44% and 27% of their total respondents. Similarly, among those sites with no secondary sector respondents to the KIQ were sites that concentrated on the development of the local voluntary sector and encouraging community engagement (i.e. Sites 15, 52, 56 and 67). This finding reflects the focus of the majority of POPP programmes towards low level community orientated prevention projects, and that within those sites the involvement of secondary trusts was relatively minor.

Where programmes were more health focused, and where services were designed to address higher levels of need, secondary trusts had a greater role. Within these sites the evidence suggests that partnerships between them and other partner agencies were strengthened as a consequence of the POPP programme. As Figure 9 shows, one quarter of respondents (25%, n=116) agreed that, as a consequence of the POPP programme in their area, the secondary trusts had strengthened their partnerships with PCTs, 27% (n=125) agreed they had been strengthened with local VCOs, and over a third (36%, n=166) agreed they had been strengthened with local authorities.

Figure 9. Extent to which KIQ respondents agreed that partnership working between local authorities, PCTs, VCOs had been strengthened with secondary health trusts by the POPP programme



3.4.5 Challenges to strategic partnerships

Within any partnership between social and health care agencies, there will be a myriad of contextual factors, both national and local, that have an impact on its effectiveness. From the qualitative data, several specific challenges to the POPP partnerships were found to be prevalent.

National policy influence upon partnerships

A number of research participants reported a perception of certain paradoxes within the national policy agenda, which had affected the POPP programmes. There appears to be an inherent tension

between the direction of policy towards increasing partnership between the health and social care sectors, of which the POPP initiative was part, and the continuing emphasis on competition between those same agencies. The former policy encourages co-operation between commissioners and providers, while the latter emphasises the ongoing split between them, with the aim of ensuring best value for money. The effect of these conflicting requirements on managers within different health and social care agencies seemed to be to make strong partnerships more difficult to develop and maintain:

> '*A big issue about tensions between partnership and procurement. DH and others would ask us to work in partnership. Our auditors would say "No! We have to procure things, so don't go telling your partners you can do this and that, because at the end of the day, it has to be tendered*."' POPP Project Manager (Site 13)

> '*Actually saving money is a big agenda for us all. We are actually in a system where we have a very strong market economy as a very large rhetoric from the government – that we should actually be setting up systems to be cost effective and in a way rivalrous, competitive, arguing about money, at the same time set along parallel to a partnership ethos*.' FG2 participant (Site 73)

This perceived conflict of interests appeared to be particularly acute where POPP partnerships extended beyond primary health care to incorporate secondary health trusts. There was a perception among primary health and social care managers that the reduction of acute admissions, one of the fundamental aims of POPP, ran counter to the interests of managers within the acute sector:

> '*There's an inherent contradiction between what POPPs is about and PBC is about and payment by results. I can distinctly remember the senior officers in the local hospital saying "This is all great, and we're happy to sign up to reducing the length of stay, but we actually want the people to come in. That's where our money comes from. We need the emergency admissions*." POPP Project Manager (Site 13)

There was also a perception among social care managers in some pilot sites that the responsibility for driving the early intervention and prevention agenda fell too heavily upon social care, rather than health, agencies. Although there was an emphasis on these areas within the White Paper *Our health, Our care, Our say* (DH 2006a), it was felt by more than one senior adult social care manager that the DH should take a more proactive, forceful approach to drive the community agenda:

> '*There isn't a fully joined up approach to prevention and early intervention, which has a whole system ambition, which we need to try and work up. I think [the POPP project] has contributed a bit to that, because it's given us evidence, a basis to work this up, but I don't think it's pushed on policy terms as much as it might have done from DH, I think they've just left it out there which local communities need to pick up on. I do think it could be more driven by DH right across that primary and secondary prevention agenda to alter the balance between community and acute care*.' Director of Adult Social Care (Site 33)

> '*The way that's [the prevention and early intervention agenda] now come through, as a domain within personalisation which is seen as an adult social care led thing, it still doesn't seem to be placing it at the heart of NHS priorities. A stronger voice [is needed] through the DH in SHAs and PCTs, whereas at the moment the main driver for personalisation projects is through adult social care.'* Director of Adult Social Care (Site 48)

Some POPP project managers also felt that a clear understanding of the benefits of partnership working was still lacking among both health and social care managers, due to an ongoing focus on the short-term priorities of their respective agencies rather than the long-term gains that might otherwise be collectively achieved. Although collective social and health care targets were promoted within *Opportunity Age* (2005) and *Putting People First* (HMG 2007), it was felt by research participants that greater emphasis should be placed upon them, and that stronger encouragement from the government was also necessary:

> '*I think they're getting better in terms of World Class Commissioning, because they have to work with one another, but I just don't think they have the basic understanding about what each other can do for each other. We don't seem to have this shared awareness of collective targets*.' POPP Project Manager (Site 52)

Short duration of POPP initiative causing difficulties for partnerships

One set of contextual factors reflected universally by research participants was problems created by the short duration of the POPP funding period. First, the short time period between the pilot receiving notification that it was to receive POPP funding and the requirement to get the pilot programme 'off the ground' meant that decisions regarding project implementation had to be taken very quickly, especially with regards to recruitment:

> *'Being given the money in April – and then expecting us to get up and running in April – was unrealistic.'* POPP Project Manager (Site 67)

> '*That was extremely annoying, having to appoint someone so very quickly – you're prone to mistakes when you're working to that kind of speed. We were told you had to have your project manager in post by March for a May start. All of that was at just galloping speed – having been told that we have the money, that we're a successful site, we then had to have our implementation plan and project manager in post in double quick speed. That actually was really difficult, and it led to the wrong appointment – very, very clearly the wrong appointment – very quickly*.' POPP Project Manager (Site 22)

There were reportedly problems in two pilot sites where senior managers had been recruited into the POPP programme too quickly and were then found to have been the wrong choice. This necessitated further time-consuming processes related to the replacement of these staff:

> '*We only had two people applying for the job – we felt that we had to go for one of them, the least worst option. It was a total mistake. We should have gone out to re-advertise it, but in fact we didn't have the time. So the speed really contributed to that. It's one of the problems with short term projects where you've got to find findings very, very quickly*.' POPP Project Manager (Site 22)

Lessons were learnt over the course of the POPP initiative, however, and the experience of Round 1 sites with regards the short period available for recruitment was fed into the funding structure of Round 2 sites. As a consequence, monies were made available to Round 2 sites three months earlier than had been the case for Round 1 sites, in order to provide them greater opportunity to recruit project managers and other key personnel.

In addition to staff recruitment, there was also found to be a problem in the retention of staff, again related to the short-term nature of the pilot projects. While it took longer than anticipated for many sites to recruit the necessary staff, those same staff would often be looking for alternative employment months before the end of the funding period. This problem of staff retention was also

partly related to the fact that the sustainability of POPP services was guaranteed in very few sites until late into the pilot period:

> '*As soon as they knew [POPP funding] was coming to an end, staff started to leave. In fact, that's probably one of the problems with the whole POPP programme – the short-term nature of it*.' POPP Project Manager (Site 04)

> '*Towards the end of the two years, people are beginning to go. So you don't have many staff at the beginning and you don't have many at the end*.' POPP Project Manager (Site 67)

Another problem raised by research participants was that the short lead-in to the commencement of the POPP projects after funding had been announced meant that agreements between partner organisations might sometimes not have been as firm as they should have been, and there was a lack of clarity within some partnerships as to what exactly was expected from each partner:

> '*The projects had to get off the ground very quickly in terms of bidding and what have you, so to get everyone on board there was a real dilemma between getting things going and getting everyone signed up to what their contribution is going to be. I'd have liked to have had more time to get agreements firmed up prior to the POPP funding period, agreeing the way of working as well as the funding issues*.' POPP Project Manager (Site 73)

The fact that the funding period was only two years also affected the degree to which VCOs and local older people's groups were willing to engage with the POPP programmes, because they had doubts as to whether they would be sustained beyond that period. Several sites reported difficulties initiating programmes that involved community engagement for this reason, and these problems often existed throughout the pilot period until it became clear towards the end that they were to be sustained:

> '*POPP, being a two year project, it was difficult to get buy-in from the third sector and the community to a certain extent. Obviously, they thought, a two year pot of money, they'd seen it all before – we were going to put something in for two years and then it was going to disappear, so that buy-in was quite difficult to achieve at first. It was not until the latter part of the two years that they could see that we weren't just going to switch off the lights, that it was something that was going to be sustained in some format or other*.' POPP Project Manager (Site 38)

The short run-in to the setting-up of projects, and the optimism with which pilot sites drafted their initial bids, may also have meant that locally set POPP activity targets and performance indicators were overly optimistic. Very often pilot sites found it necessary to alter the targets initially set when they were found not to be achievable:

> '*It was agreed that targets [in the bid] may have been over optimistic, and should be reconsidered.*' POPP Board Minutes (15th January 2008), p3, (Site 22).

> '*[Named VCO] are ceasing to deliver [a POPP] service on 31st March 2008. They were unable to meet targets (30% only). From 1st April 2008, it is being brought in-house. Targets to be re-assessed to see if they were unrealistic*.' POPP Programme Board minutes (February 2008), (Site 88).

'*There were areas where we still needed to achieve some outcomes/outputs. [Name] noted some changes made to performance indicators to be more realistic*.' POPP Project Management Board Minutes (May 2008), (Site 82).

Over-optimistic targets may partly have been a consequence of the fact that most pilot sites were developing new and innovative projects, with no baseline activity by which to judge more realistic targets, although more time for the preparation of project plans might have ameliorated this problem. An alternative reason for over-optimism may also have been in part a feature of pilot sites wishing to submit impressive project plans that more likely to receive funding:

'*I think the bid was over ambitious and I can see why – when people are chasing money, they think that the more they say they'll do, the more likely they are to get the money*.' KITI Participant (039)

PCT reconfiguration

A reconfiguration of the geographical boundaries of the PCTs in England took place in the autumn of 2006. The purpose of these structural reconfigurations, proposed within *Commissioning a Patient-Led NHS* (2005c), was to reduce management and administration costs and to facilitate the goal of universal Practice Based Commissioning (PBC). Within their initial POPP bids, six sites noted that these reconfigurations would also improve the potential for the programmes to be sustained:

'*The transition to a single PCT in Site 48 should help with POPP implementation to the extent that organisational sign-up and mainstreaming of outcomes should be more straightforward with one PCT than when having the ownership from five*.' Implementation Plan, p12, (Site 48).

However, there were problems for the development and maintenance of the POPP partnerships related to this reconfiguration, inasmuch as the personnel within the PCT were often initially unsure about whether they would have jobs, contacts between managers within partner agencies temporarily broke down as personnel changed, and PCTs were often perceived to be too preoccupied with reorganisation to concentrate upon the POPP programmes:

'*The PCT within six months of the start of the project went into turnaround and probably for 18 months was effectively of action. It was totally inward-turning – and having to deal with difficult financial circumstances was cutting, rather than increasing, services. That has shifted enormously, so there is a new energy out of the PCT. But the relationships between health and social care were damaged during that period, which has not made it easy in the aftermath to come together terribly effectively*'. POPP Project Manager (Site 03)

'*The relationships at the programme level were affected by the reorganisations, so that at times there was a programme that felt like it did not have a strategic home*'. POPP Project Manager (Site 10)

'*The PCT was reorganising itself when we got the money. It didn't help the discussion, putting five areas into one, and everyone changed their jobs and nobody knew what they were doing*.' POPP Project Manager (Site 04)

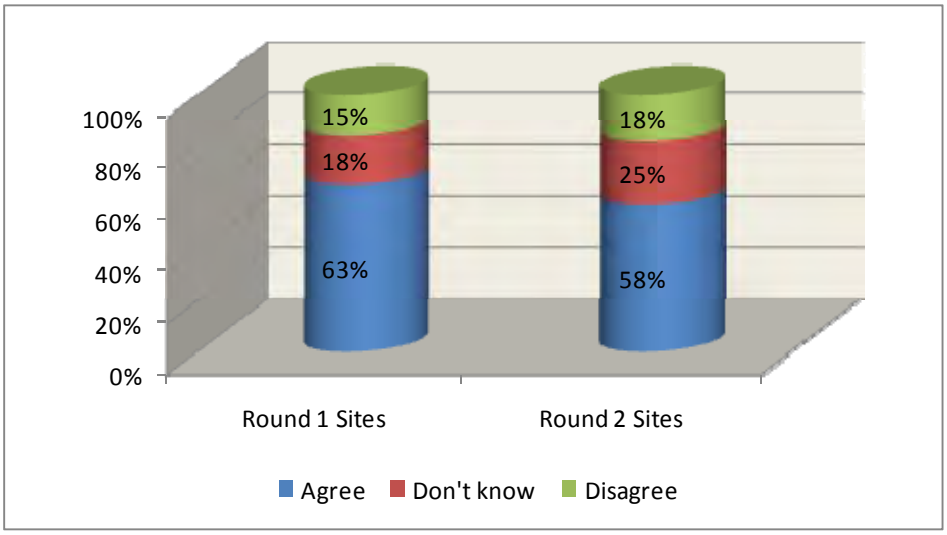
'*We found that people we were working with were there – and then they were gone*.' POPP Project Manager (Site 47)

It should be noted that problems associated with PCT reconfiguration impacted upon pilot sites within Round 1 to a greater degree than those within Round 2. As Figure 10 and Table 13 indicate, the KIQ found that 63% (n=171) of respondents employed within Round 1 sites agreed that the PCT reconfiguration had created difficulties for partnership working compared with 58% (n=110) of Round 2 respondents.

Table 13. The PCT reconfiguration created difficulties for partnership working

Pilot Site Round	Agree	Don't know	Disagree	Total
Round 1	171 (63%)	49 (18%)	39 (15%)	259 (100%)
Round 2	110 (58%)	47 (25%)	34 (18%)	191 (100%)
Total	281 (62%)	96 (21%)	73 (16%)	450 (100%)

Figure 10. The PCT reconfiguration created difficulties for partnership working



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3.5 Categorisation of projects

In order to ensure as robust a comparative analysis as possible of the POPP programmes, the projects that comprise them were categorised in several different ways by the National Evaluation team. The diversity in the nature of the POPP projects meant that a single classification would limit analysis of possible outcomes, and a plurality of categorisations was therefore adopted. This section summarises the three categorisation methods: the Needs Levels addressed by projects; whether projects were Hospital Facing or Community Facing, and project typologies. For each of these categorisations, examples are provided to illustrate the concepts involved. Also, the proportion of total project spend on projects within each of these categorisations has been calculated, along with the number of projects that fall within them.

3.5.1 Needs levels

The individual projects developed within POPP pilot sites addressed a broad spectrum of levels of need. Several POPP programmes focused interventions entirely on low level 'upstream' services (Dorset, Manchester, North Lincolnshire, Rochdale, Somerset and Worcester), which can be

[4] There was found to be statistical significance between the following two variables: the pilot site round within which respondents' sites were located and whether they agreed that the PCT configuration and created difficulties for partnership working in the short term.

described as Primary Prevention Such interventions sought to encourage social contact, befriending, exercise and volunteering among older people, and were targeted at the relatively more healthy and active population than was perhaps the norm for older people accessing POPP services. A smaller proportion of programmes addressed more complex health and social needs of those 'at risk' of admission to acute or residential care (Southwark, Leeds, Poole), and were focused upon admission avoidance. These are often termed Secondary and Tertiary Prevention. Finally, there were those programmes that sought to develop interventions that addressed needs levels across the spectrum (East Sussex, Norfolk and Knowsley). As part of the evaluation process, it was necessary to categorise projects by the level of needs of the target population. That scale of needs is outlined below, with case studies provided for each level.

Level U: Underpinning projects

Projects that were categorised as underpinning where they did not themselves involve the provision of services to older people, but supported the development and ongoing maintenance of such services. The category therefore contains projects that were very different in terms of their objectives and levels of professionalism. Examples of such projects were: staff and carers' training, business development teams, care home and course accreditation schemes, the development of web-based information services and building improvements and upgrades.

> #### Case study: Leading and Teaching in mental health (Bradford)
> Bradford POPP, in partnership with the University of Bradford, devised an accredited training programme that equipped mainstream social and health care practitioners with the knowledge and skills to become older people's mental health practice champions, known locally as 'peer educators'. The course provided participants with both mental health training and training and leadership styles. The project also involved the creation of a Peer Educator Resource Pack, providing evaluative tools that could be used by peer educators to cascade mental health training to their peers.

Level 1: Primary prevention/Well-being services

Primary prevention, or health and well-being, projects were 'upstream' community orientated interventions, designed to support older people in maintaining independent lives within their own homes and to improve their general well-being. These services were universal in the sense that they were aimed at all older people and their carers within the programme sites. Examples of such projects were: gardening/handyperson/befriending schemes, crime prevention and awareness services, internet facilities, learning, leisure, libraries, teleclubs, teleshopping, housing and welfare benefit advice, and sign-posting services.

> #### Case study: Gardening, handyperson and care and repair schemes (Wigan)
> The project was provided by three voluntary organisations and was linked with existing schemes within Wigan. Referrals to the service could be made by older people themselves as well as project staff working within other POPP projects. Work that did not require the skills of professional craftsmen were undertaken for older people, within their homes and gardens, at reasonable cost rates. Such work included minor housing repairs, fitting hand and grab rails, and cutting grass and bushes and improving access to the garden.

Level 2: Secondary prevention

Secondary prevention projects involved higher level services to support older people who were 'at risk' of admission. Such services included: social contact/hospital aftercare, carers' support, holistic assessments, medicines management, peer mentoring and support, contacting and prompting, falls prevention and falls follow-up services.

Case study: Integrated Locality Teams (North Somerset)

The redesign of North Somerset's community health and social care services will involve joining up the Council's ASS, the PCT's community nursing services, and the Avon & Wiltshire Partnership's Mental Health services for Older People into four, fully integrated and co-located, jointly managed teams, based around clusters of GP practices. The service provided joint case management and self-management, and those older people thought to be 'at risk' of admission, and other frequent users of services, were provided with intervention services to prevent complications of diseases and the deterioration of social circumstances.

Level 3: Tertiary prevention

Tertiary prevention projects involved services that were designed to support older people at serious risk of imminent hospital admission, perhaps due to an exacerbation of chronic conditions, accident, or social or carer crisis. Examples of such services included community rapid response teams, hospital at home/intensive home support teams, case management/proactive case finding.

Case study: Community Mental Health Rapid Response Service (Leeds)

This project involved the co-location of the mental health and intermediate care teams within the PCT. The community based service provided rapidly deployable rehabilitative and therapeutic services to older people with mental health needs and their carers within their own homes. The service was deployed where a breakdown in an older person's existing care arrangements might otherwise have led to a hospital admission.

3.5.2 Proportional project spend against needs levels

Overall, the 29 pilot sites spent £50,745,818 on the POPP projects developed during the pilot period. As Figure 11 shows, the largest proportion of this money was spent on projects addressing tertiary prevention, representing 35% of the total spend. Primary prevention projects represented almost a third (31%) of total spend, secondary prevention projects represented almost a quarter (24%), and underpinning projects represented 10%.

Figure 11. Total project proportional spend against needs levels

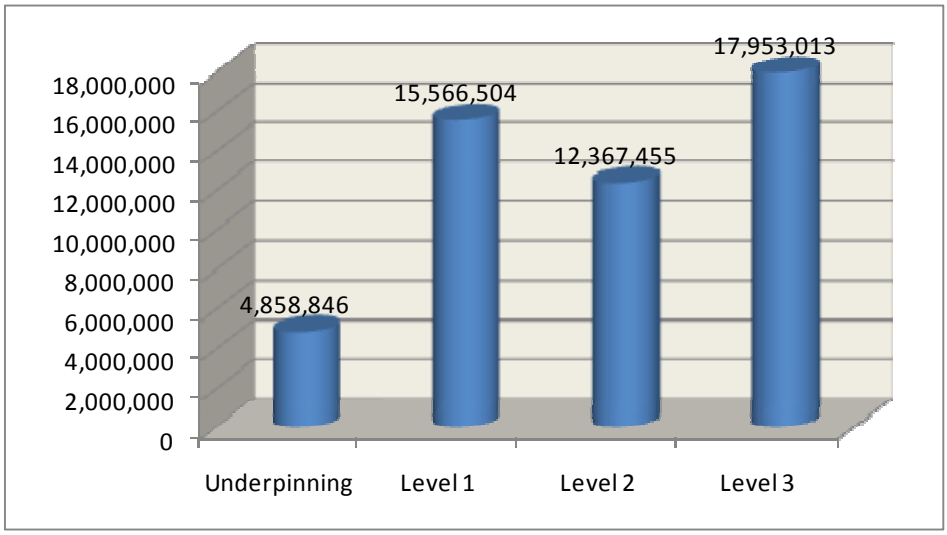
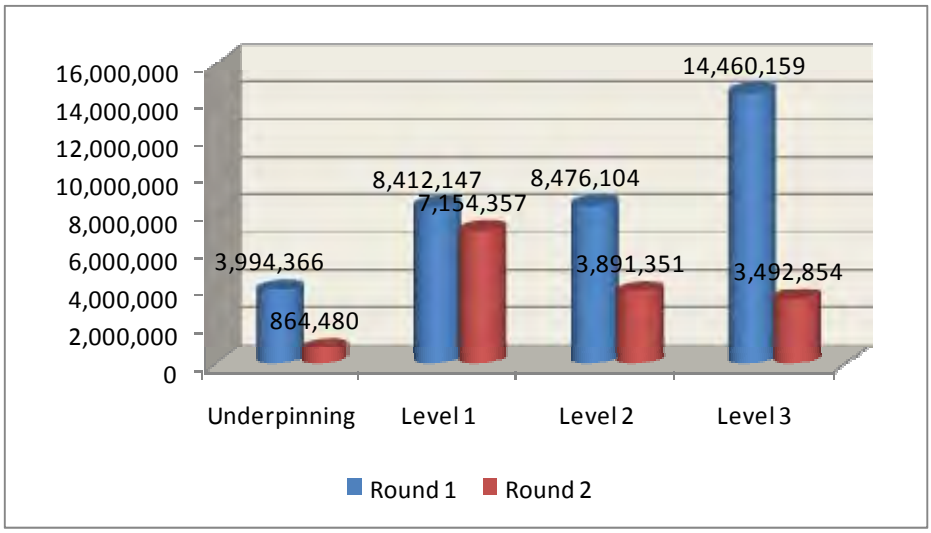


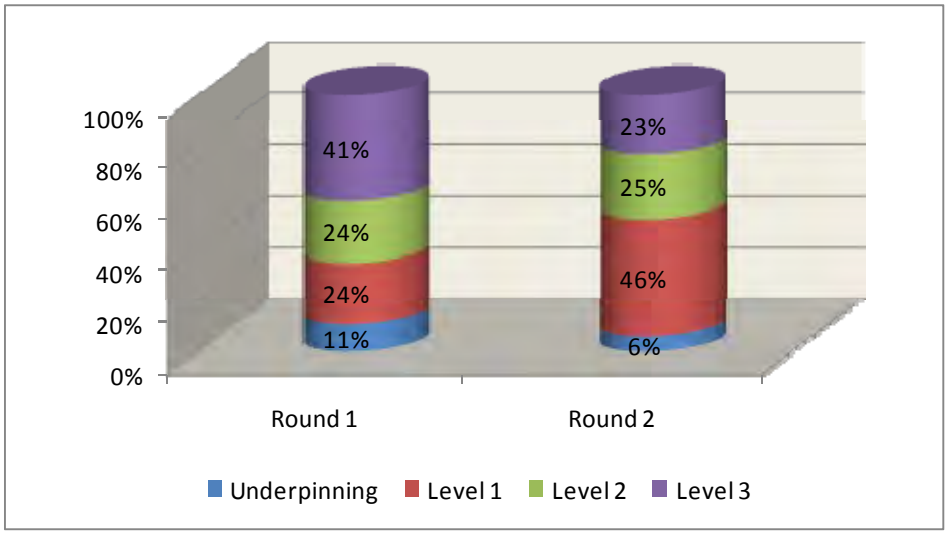
Figure 12 shows that the total spending within each of the project rounds on projects addressing the different levels of need. The total project spend for Round 1 sites was £35,342,776 and the total spend for Round 2 sites was £15,403,042.

Figure 12. Proportional spend on projects by needs level: Round 1 and 2 sites compared



As Figure 13 shows, within Round 1 sites the largest proportion (41%) of spending was on projects addressing Level 3 needs or tertiary prevention, while for Round 2 sites the largest proportion (46%) was spent upon primary prevention projects. The second largest proportions of spending, almost a quarter for both Round 1 and 2 sites (24% and 25% respectively), was on projects addressing secondary prevention.

Figure 13. Proportional spend on projects by needs level: Round 1 and 2 sites compared



3.5.3 Needs levels and project count

In addition to an analysis of the proportion of project spend allocated to projects addressing the different categories of need, the actual number of projects doing so was also calculated. Figure 14 and Table 14 show the needs levels addressed by the core POPP projects developed by pilot sites. As can be seen, more than a third (34%, n=49) of core projects were focused upon primary prevention, while 27% (n=40) addressed secondary prevention services, and a quarter (24%, n=35) supported tertiary prevention services. When the two POPP pilot site rounds are compared, it can be seen that a larger proportion of Round 1 projects addressed the higher levels of need than did Round 2 projects.

Figure 14. Needs levels addressed by POPP projects: All core projects

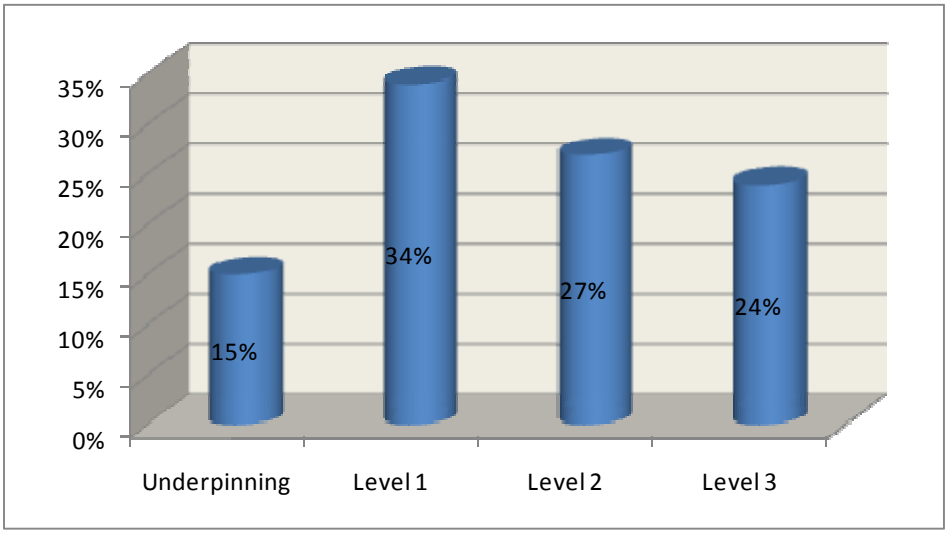


Table 14. Needs levels addressed by POPP projects: All core projects

Round	Level 1	Level 2	Level 3	Underpinning	Total projects
Round 1	32 (30%)	32 (30%)	30 (28%)	14 (13%)	108 (100%)
Round 2	17 (45%)	8 (21%)	5 (13%)	8 (21%)	38 (100%)
Total	**49 (34%)**	**40 (27%)**	**35 (24%)**	**22 (15%)**	**146 (100%)**

If these findings are compared with those for proportional spend against needs levels, it can be seen that although less than a quarter (24%) of the core POPP projects addressed tertiary prevention, these projects constituted well over a third (35%) of total project spending. In contrast, while 61% of projects addressed lower levels of need, either primary or secondary prevention services, they constituted 55% of total project spend.

3.5.4 Community facing and hospital facing

A second categorisation adopted by the National Evaluation team was to determine whether projects were primarily 'hospital facing', focused on and located within more acute, and predominantly health care services, or whether they were primarily community facing, involved with improving community engagement and development. This categorisation differs from the

categorisation of 'Needs Levels', in that it addresses the nature of the service rather than the condition of its target population. These categorisations have been defined in the following ways:

Hospital facing projects

An intervention was classified as Hospital Facing if its primary aim was admission avoidance, for instance to prevent the need for older people to attend A&E or be admitted to hospital or residential care. These services required immediate input on the part of those who delivered them to prevent admissions, to rehabilitate those in hospital, or to assist people to go home from hospital and be supported at home. Hospital Facing services included those located within primary care, or those that had hospital in-reach, but they also included some services provided by VCOs. An example was a Home from Hospital service provided within Site 88, which although it did not involve professional staff or provide specialist care, nevertheless allowed older people to go home from hospital or residential care more quickly than would otherwise have been possible. Hospital Facing services thus included such projects as the rapid response team and hospital in-reach falls prevention service in East Sussex, the proactive case-finding project in Poole, and Southwark's community and hospital discharge pathways.

Community facing projects

Community Facing projects are those that were fully located within the community, focused towards building the capacity of the community sector, addressing social isolation and exclusion, or promoting healthy living among older people over the longer term. Community Facing services thus included North Somerset's Community Development Workers, the low level services commissioned by Rochdale's Township Older People's Partnerships (TOPPs), and Somerset's Active Living Centres (ALCs).

3.5.5 Proportional project spend and community/hospital facing projects

As noted above, the 29 pilot sites spent a total of £50.7m on POPP projects over the lifetime of the initiative. As Figure 15 shows, £32.3m (64%) of this total was spent on projects that were Community Facing, with £14.6m (36%) being spent on Hospital Facing projects.

Figure 15. Total project spend on community and hospital facing projects

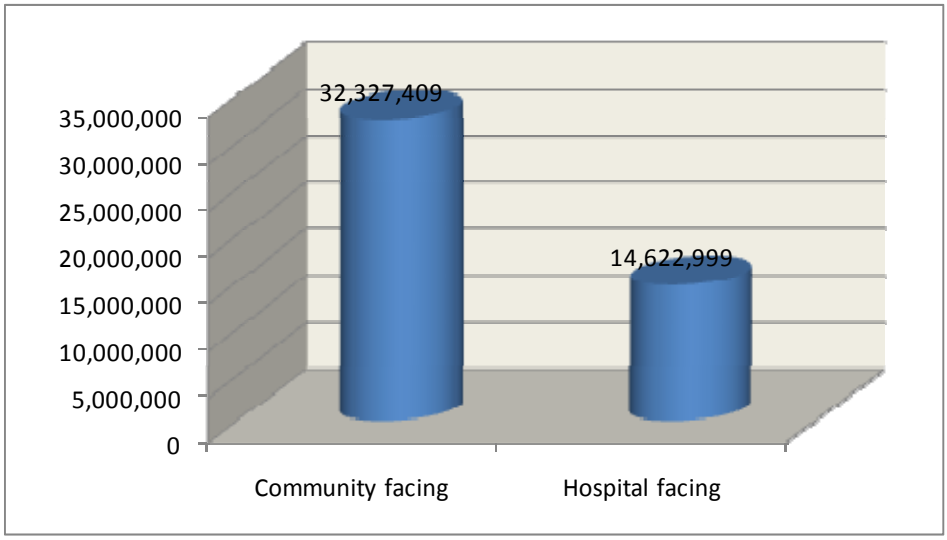
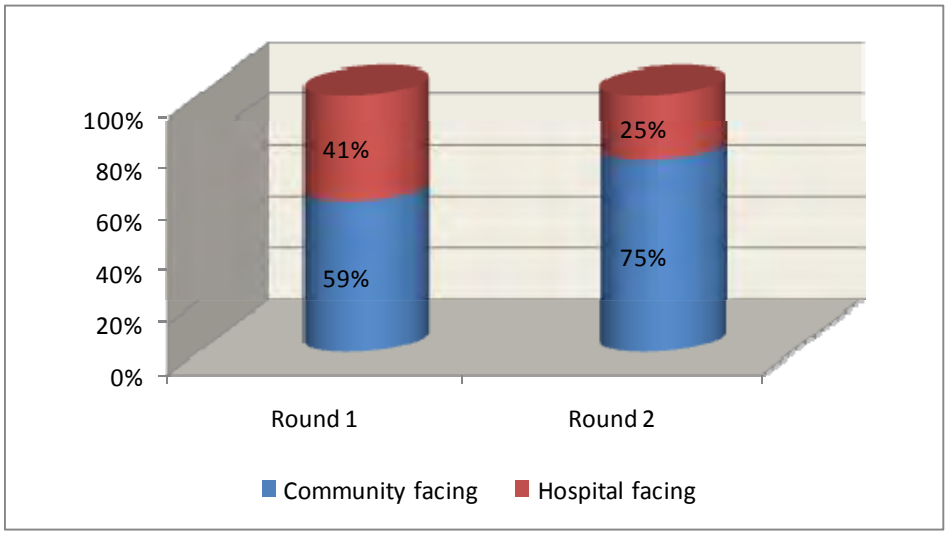


Figure 16 shows the proportional spend each round of pilot sites invested into both Community Facing and Hospital Facing projects. As can be seen, although the greater proportion of total project spend was invested in Community Facing projects, 41% of Round 1 project spend was for Hospital Facing projects as opposed a quarter (25%) of Round 2 project spend.

Figure 16. Proportional spend on community and hospital facing projects: Rounds 1 and 2 compared (%)



3.5.6 Community/hospital facing projects and project count

As with the categorisation of Needs Levels, the number of projects categorised as either Community Facing or Hospital Facing was analysed. Table 15 shows the categorisation of the 146 core POPP projects. It can be seen that three quarters (75%, n=110) of projects were categorised as primarily Community Facing, and a quarter (25%, n=36) as Hospital Facing. These findings indicate that while the major focus of many pilots was towards community-orientated projects, a proportion was also focused towards admission avoidance. A full list of the pilot projects, coded in this way, can be found in Appendix R.

Table 15. Categorisation of core POPP projects: hospital/community facing

Pilot site round	Community facing 1	Hospital facing	Total
Round 1 pilot sites	78 (72%)	30 (28%)	108 (100%)
Round 2 pilot sites	32 (84%)	6 (16%)	38 (100%)
Total	**110 (75%)**	**36 (25%)**	**146 (100%)**

If these findings are compared with those given above for proportional spend, it can be seen that although a quarter (25%, n=36) of projects were Hospital Facing, these projects comprised over a third (36%) of total project spend. In contrast, while three quarters of POPP projects were Community Facing services, they constituted just under two thirds (64%) of total project spend.

3.5.7 Project typologies

The third categorisation method used by the evaluation was based on the type and nature of the service itself. The projects categorised in this way are only those that were involved with the administration of the standardised questionnaire (see Sections 2, 6 & 7). Pilot sites were requested to administer this with a sample of the POPP projects they were developing, in order to monitor any changes among their service users in their subjective self-reported quality of life, their health-related quality of life, and their levels of particular service use. The projects involved were then categorised into ten typologies. Further details on the number of projects and responses within each categorisation can be found in Sections six and seven.

Well-being-Practical

This typology encompasses ten projects focused toward providing practical help to support the user to remain at home. The projects included small housing repairs, gardening, limited assistive technology and shopping.

> Case study: Gardening Project (Wigan)
> A 'garden squad' of local volunteers was developed to undertake basic gardening work for older people that did not require professional skills. A quote would be provided and the work then done once the amount had been agreed. Such work included lawn mowing, hedge cutting, and path clearing and laying.

Well-being – Emotional/Social Isolation

Twenty-two projects were directed toward reducing social isolation and improving user 'mood'. These included lunch-clubs, hobby or educational based classes (e.g., photography or computer classes), specific BME-focused social centres and those services providing lower level counselling or 'talking therapies'.

> Case Study: Age Concern Ageing Well (Manchester)
> An Ageing Well group was established in North Manchester with an aim to encourage social interaction between older people and promote a positive attitude to healthy living. The group offered activities such as arts, crafts, games, quizzes and knitting, and provided an opportunity to meet new people and make new friends.

Well-being – Physical

This third category encompassed time-limited (e.g., eight to 12 week) exercise classes focused toward improving overall health or with some rehabilitation focus (e.g. stroke association classes).

> Case Study: Exercise at Home (Camden)
> This project, provided by the Active Health Team, provided exercise to older people with mental health needs and their carers, with the intention of increasing mobility and boosting self-confidence. Anyone over 55 years was eligible for the service, and referrals were accepted from older people themselves, their carers, and social and health care staff from either statutory or non-statutory organisations.

Well-being – Community

Within this typology, a mixture of projects were included ranging from direct interventions to specific localities as well as projects that set up neighbourhood schemes, strengthening and taking forward inclusive communities.

Case study: Somerset Active Living Centres (Somerset)

The POPP programme in Somerset established more than 50 very local Active Living Centres (ALCs) throughout the county, based within community centres, church and village halls. Each ALC became a 'hub' for the full range of preventive and well-being services already provided by statutory agencies and VCOs. The ALCs provided a café-style environment while hosting a variety of well-being activities, and providing information and referral to other locally available services. The ALCs were mainly supported by local volunteers, supporting a person-centred selection of services for maintaining independence, and were to serve as vehicles for community development and empowerment.

Information, sign-posting and access – includes advocacy

These services included: advocacy services; counselling; benefit checks and sign-posting of clients to other services within the local social and health care economy.

Case study: Community Information and Liaison Assistants (Kent)

Community Information and Liaison Assistants (CILAs) provided two key services in Kent. Firstly, they worked with a district locality forum to create an information resource: 'Who can help me?' Information Directory. This resource was sited within community hubs and was directly accessible to community members. Secondly, CILAs facilitated ad-hoc forums in which the needs of groups of individuals were addressed. These forums supported the direct delivery of health promotion advice and information to targeted groups of the population, and supported local information gathering in regards to incidences of population need.

Proactive Case Co-ordination

The two foci of these projects were the identification through case-finding of those people who were at most risk of admission to hospital or long-term institutional care and case (or care) management. These projects involved jointly managed teams of social and health care staff working across boundaries and providing a seamless care pathway for older people.

Case study: Integrated Care Co-ordination Service (Brent)

The Integrated Care Co-ordination Service (ICCS) was an extension of an existing care co-ordination service (ICCS), which became a fully integrated team of staff from social and health care agencies and VCOs. The aim of the ICCS was to move from reacting to case referrals to proactive case finding to maximise prevention. On referral to the service an older client/patient was provided with a nominated care co-ordinator (CC) who would undertake a single holistic assessment of need, and co-ordinate a range of interventions to respond to identified needs. The ICCS also provided specialist assessments from mental health liaison workers, and was able to provide rapid flexible support and short-term care for six weeks to vulnerable older people to avoid admission. The CCS also provided 'in-reach' into hospitals to ensure appropriate community support, thus facilitating timely discharge and so reduce length of stay (LOS).

Long-term conditions

Projects within this category provided services to those older people with identified long-term conditions and other complex needs. The services were provided through integrated teams of social and health care and VCO staff, or staff from the separate agencies working across boundaries and providing a seamless care pathway.

Case study: Complex Care Teams (Devon)

The establishment of complex care teams (CCTs) consisted of a coherent integrated service across the whole of Devon incorporating staff from adult social care, PCT, Devon Partnership Trust community staff and VCOs. The aim of CCTs was to provide a seamless care pathway, for the full spectrum of needs from low level to intensive urgent care across the services that were previously provided by the separate agencies. The overall Devon-wide service and approach were delivered via 23 integrated health and social care 'clusters' organised alongside groups of care practices. A core service of integrated health and social care front-line practitioners was aligned to a grouping of primary care practices to include staff with specialist roles 'dedicated' to the cluster. Each cluster has an integrated central co-ordination function for inter-professional co-ordination across agencies, and delivered face-to-face assessments utilising the single assessment tool (FACE).

Specialist falls services

These services included those fall services that provided specialist skills to address the needs of older people who were either at risk of falls or who had already sustained a fall.

Case study: Falls Follow-Up Service (East Sussex)

A specialist physiotherapist, occupational therapist (OT) and support worker worked within the community with the existing Falls Specialist Nurse within the A&E Department of the local hospital to provide a comprehensive and dedicated service for older people who had fallen. The project involved the development of a local falls care pathway by facilitating safe discharge with the existing interface team, and providing active rehabilitation/re-enablement programmes and education.

Involving older people

These projects focused on encouraging older people to become involved with the decision-making processes, governance and evaluation of POPP services.

Case study: Expert Elders (Sheffield)

A network of older people was established as co-partners in the implementation of the whole POPP programme in Sheffield, and as decision-makers through the local strategic partnership. Expert elders were involved in service reviews, contractor evaluations, quality assurance, and the gaining of patient-user opinions on services.

Carers services

These services targeted carers and provided them with support, advice, exercise, information and social contact.

Case study: Cares Services (North Somerset)

A range of carers services were provided via Crossroads that helped to support them in their caring role. Such services included learning sessions for carers such as finance management, cookery skills and stress management courses. There was also a redesign of the way that respite care was delivered, with weekend breaks, home respite and sitting services being provided.

3.6 Implementation of pilot projects

During the process of setting up POPP projects, all pilot sites encountered obstacles and challenges that needed to be addressed in ways appropriate to their local contexts. The National Evaluation used a multi-method approach to identify as many of these obstacles as possible and to understand the various approaches adopted by pilot sites to overcome them. In this section, particular issues are examined relating to the structure of POPP projects, the staffing of services, and processes of working across organisations.

3.6.1 Project structure

A fundamental aim of the POPP initiative was to build partnerships between agencies in order to build greater joint working relationships and to provide more integrated health and social care services. For this to be achieved, high levels of trust and communication was needed between operational staff from different organisations, encouraging greater understanding of one another's professional roles. The way in which a service delivery team is structured has a fundamental impact on the degree to which it can function in this way.

Integrated multi-agency teams

The majority of pilot sites developed projects that involved staff employed by more than one agency, and several adopted multi-agency teams. Such teams ranged between those that were 'virtually' integrated to those that were fully co-located with a single line management. This section examines some of the contextual factors that have emerged from the evaluation process.

Within all integrated multi-disciplinary teams (MDTs), the closer working practices between professionals from different agencies enhanced the understanding and respect individuals had for one another. This was the case whether or not they were integrated:

> '*One of the outcomes for me is the trust between professionals. ... something about professional trust, where you can trust your colleagues' assessment of the situation. Because across boundaries of professions, we always have our little…. Whereas one of the things that MDT has done – and we can talk about it quite openly as well – is say well how do you make that out? Its not taboo to talk about*.' FG1 participant (Site 73).

> '*It's definitely broken down barriers. You have more respect, and there's bits you learn about somebody else's profession,...It's about really understanding each other's priorities*.' FG1 participant (Site 73).

Closer working practices between professionals allowed advice to be sought more easily between professionals, for referrals between agencies to be timelier, and with greater benefits for patients:

> '*Where you have very difficult situations, people with multiple needs, you actually can take those to the MDT and say "Help! This is what social care can offer, but what can you offer?" That was a really good departure from trying to rush the GP and not getting hold of him or her, trying to get the OT referrals and they've got a backlog of three months etc. and literally trying to up the reins. So what the MDT has done is it's given us a platform to actually identify those people who we know have such complex needs, and to be able to holistically do something about it on their behalf*.' FG1 participant (Site 73)

Moreover, such closer joint working practices between professions often revealed the extent of existing problems for older people, such as over-medication, of which social and healthcare professionals had not been aware prior to the POPP initiative. Such problems had often been

created in part by a previous lack of communication between organisations. Once such problems were revealed, they could then be addressed to the benefit of older clients/patients:

> '*The interesting thing for me was when there were people getting medications from different sources – that's one of the things that really shocked me, finding that people were getting medications from GPs and then going to hospitals and getting different medications, and actually being on quite high doses of similar medication…We were able to actually go back and say to the GP well, she shouldn't be taking that as well as this etc. It was based on relationships. I think MDT has highlighted this as an area where older people can become quite confused, quite befuddled, take different things, overdose, underdose – or are actually taking things that are not compatible with each other*' FG1 participant (Site 73)

Co-located and 'virtually' integrated teams

One of the purposes of integrating teams of professionals from different health and social care agencies, and from statutory and non-statutory sectors, was to break down the barriers between these sectors, agencies and professionals. A feature of 'virtual' multi-disciplinary teams is that there remains a physical distance between different agency staff that may be 'integrated' into a project team and yet be in different buildings. The costs involved with co-location may be prohibitive, and a virtual team may be one way of integration that avoids such costs. Nevertheless, the physical distance involved with virtual teams may compound the already existing cultural and professional distance between professionals from different statutory and non-statutory agencies. Very often, staff will fail to identify fully with the team of which they are members, and the objectives of the project on which they are employed to work. This may be reflected in poor attendance at meetings:

> '*I was very much involved in POPPs right from the beginning. I've been to every POPPs meeting. There have been times in the last three or so months, we've had meetings where there is no district nursing representation. If we are taking ownership of something, for us dealing with a patient, MDT, every professional who's meant to be there is meant to be there*.' FG1 participant (Site 73)

Thus, although virtually integrated teams often encouraged greater trust between health and social care professionals, and understanding of one another's roles, there could sometimes be a temporal quality to these benefits. Close day-to-day contact seems to be necessary to maintain good working relationships between professionals from different organisations over the long term. The alternative to the 'virtual' integration of team members is the co-location of staff. Among participants of the focus groups, it was found that the close proximity of professionals from different backgrounds, working on the same project, enhanced their working relationships which, in turn, ensured better outcomes for older service users of the intervention. Each team member had a good knowledge of their own agency, and knew who to approach within partner organisations in order to get things done. It was felt that such a knowledge base within a team could ensure a more efficient process, achieving outcomes more quickly than if members of separate organisations, or a non-co-located 'virtually' integrated team, were trying to achieve the same thing:

> '*You can wade through your own speciality a lot quicker than anybody else would. ...I know who to talk to – not that it's anything spectacular – I just know which desk to go and bang on and say "We need to do this",... everybody brings that in*.' FG1 participant (Site 22)

> '*It's important that we all have specialist skills in our area and that one person's from adult care, the other's from NHS, the third person is from voluntary – we've all got different ethoses and beliefs and we all bring them together and we're able to complement and discuss [it]*.' FG1 participant (Site 22)

'*I just think it works really well that we've got that working relationship that we know we can just immediately go to that person say "I've got this problem", or "This person needs this, how can we work it out?", we work together really well*.' FG1 participant (Site 22)

Nevertheless, the cultural boundaries that exist between professions and organisations are strong. Co-location of operational staff by itself, therefore, may not be sufficient to ensure that team members identify with the objectives of the service provided by an MDT, or to guarantee seamless care for patients:

'*Attempts to integrate nurses and social workers in the same office failed and people sort of gravitated back towards their professional kind of parochialism*.' POPP Project Manager (Site 13)

Such professional 'parochialism' may persist despite co-location, and what may also be required for multi-agency teams to work efficiently in addition to shared aims and objectives is that all team members be accountable to a single line manager:

'When you work to a clear set of shared targets, and when you also work to those targets at a locality level the professional parochialism that is often the devil in joint working seems to recede into the background.' POPP Project Manager (Site 13)

'Single line management. In the Joint Finance days you'd get a physio, a nurse, a social worker and OT all sat in the same room, but they all still had their lines of management and it failed because everyone just gravitated back towards their start positions.' POPP Project Manager (Site 06)

Challenges for integrated team managers

There are, of course, specific challenges that arise within integrated teams which need to be balanced against their perceived advantages. Managers of integrated teams have the challenge of managing a number of individuals from different professional backgrounds, but often also face issues regarding the different working conditions of individuals from different organisations. It often took operational managers some time to become accustomed to the many new demands of their new roles:

'*As a manager managing an integrated team, you've got people on different pay scales, people with different threats to their job. You're dealing with three different human resource departments – we're just doing our appraisals at the moment, you're doing three different appraisal documents. There is a challenge in that integrated team, absolutely*.' FG2 participant (Site 73)

'*When somebody phoned in sick I had to think "Right, who employs them? What's the process? Who do I need to tell?" – just basic things like that… At Christmas, some of the organisations are finishing on one day, some of them are working in-between Christmas and New Year. We've not got any equity amongst the team in the hours that they're working – some work 37 hours, some work 34 ½, –When you first work with all the different salary scales and rates of pay and get paid on different days, all that kind of thing – for me, to have to learn all those processes was quite a challenge*.' FG1 participant (Site 22)

Challenges for integrated team members

Individual members of integrated teams may also experience challenges if they find themselves answerable to more than one manager or more than one organisation. Individuals employed by one organisation may be seconded to a second organisation and then work on a project funded by a third organisation. Each of those organisations may have different expectations from those individuals, and it may be difficult for staff to manage those diverse expectations:

> '*I've got a further complication in that my post is funded by another agency entirely from the one that employs me – they got their funding from another pot of money, so I'm accountable to them as well – and they have a completely different way of judging whether you're successful*' FG1 participant (Site 22)

> '*Coming from adult care to the POPP project, I felt that I was tied three ways, because I had the association who were supposed to be my employers, then I had my line manager over at [adult social] care, and then [Name] was my other line manager – so I felt answerable to three, so you felt a hold in different directions*,' FG1 participant (Site 22)

Such problems would appear to be inherent while team members continue to be employed by separate agencies.

Key new roles to enhance integration of services

In addition to MDTs incorporating professionals who normally work within different organisations, the achievement of effective joint working and provision of seamless care to patients or clients may be assisted by the development of key new roles that seek to link organisations more closely. In this way, the aim of closer working between agencies can be taken beyond the co-located MDT itself. Within POPP, a number of research participants acknowledged that such key link posts had greatly enhanced the effectiveness of joint working practices and the achievement of outcomes. For example, within one site, a multidisciplinary hospital discharge team, including members from social services, primary care and the voluntary sector, had an excess bed day worker, employed by adult social care, who worked within an acute hospital to link the MDT to the secondary sector. The role involved identifying potential barriers to the timely discharge of patients from hospital and the development of strategies to overcome these problems involving the other members of the MDT:

> '*I think a key role [for] integration is the excess bed day worker... That's someone whose remit has been to link a lot of those roles together and link a lot of the community people in the hospital teams together. That's a role that's only come in since POPPs, it never existed before – and that's been a huge change for us, that's been an absolute key role of integration for us.*' FG2 participant (Site 73)

Another key role identified through the focus groups was a voluntary sector key worker. Again, the role links the voluntary sector to an MDT, with the remit of overcoming potential problems for the timely discharge of older patients from hospital:

> '*We've had a key person funded through POPPs as a voluntary sector representative – she comes to team meetings and she meets the specific worker, so we've had much better links to the voluntary sector now through her role. She's been really, really helpful*.' FG2 participant (Site 73)

Link roles between sectors within integrated teams helped to strengthen operational partnerships and encourage further changes within the respective organisational cultures. Particular link roles between the third sector and statutory organisations also encouraged local VCOs to develop an

increased perception of what their role could be within the local health and social care economy. These also developed a greater awareness among statutory operational staff of what local VCOs could provide for clients and, in so doing, served to enhance the overall service provided to clients:

> '*It's also the heightened awareness of what the third sector is doing, because a lot of the organisations were already out there, it's just that we've got a link person now that knows exactly what each agency is doing and has a much better way of linking in to get people set up with a befriender or a lunch club – she just knows the services a lot better and it's made it a lot more streamlined*.' FG2 participant (Site 73)

Having that link with the voluntary sector meant that professionals were more confident that their assessments could be truly holistic. They became more aware of what could be provided, and so started to evaluate areas of people's lives that they had not considered previously, because they had not been aware of the possible ways of addressing the issues:

> '*It's more quality of life issues that we wouldn't really have considered before…we make someone safe and that's our main focus, but now we've just broadened our scope of what we look at with someone*.' FG2 participant (Site 73)

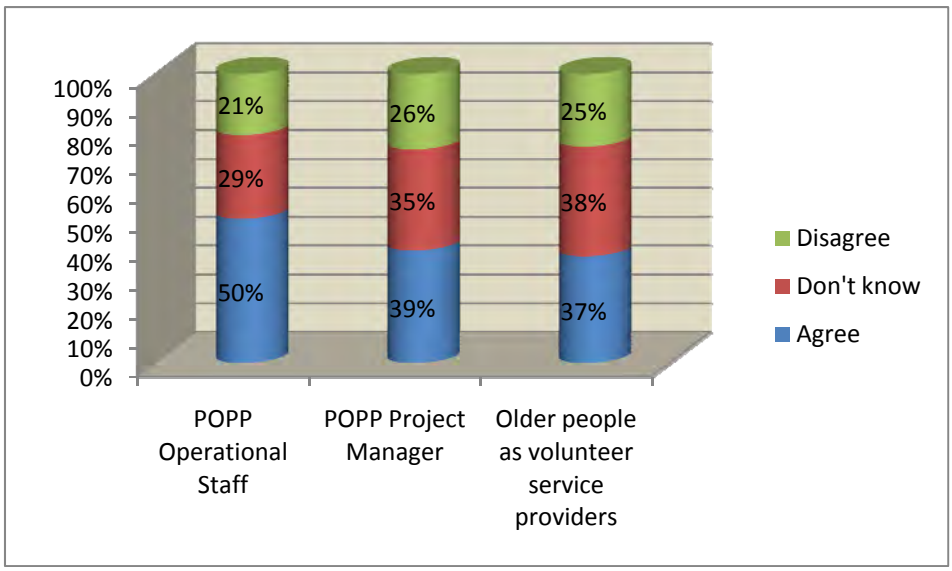
3.6.2 The implementation process

The process of project implementation moved from the initial recruitment of staff, through to the direct provision of the service. There were several challenges that faced the POPP pilot programmes with regard to staffing of services, most notably the problems of recruitment, staff training, and the time necessary for newly appointed staff to become accustomed to the demands of their new roles.

Recruitment and ongoing support for staff

The recruitment of staff for POPP programmes proved to be a difficult process within most pilot sites. The key informant questionnaire (KIQ) found that 50% (n=131) of respondents agreed with the proposition that the recruitment of operational staff to projects had proved a key challenge. Some 39% (n=112) agreed that recruiting a project manager was a key challenge, and well over a third (37%, n=106) agreed that there had been difficulty in recruiting volunteers to provide service delivery (Figure 17).

Figure 17. Key challenges to setting up POPP projects: Recruitment



The main recruitment challenge seemed to be the length of time necessary to recruit staff, which was often far longer than had been anticipated and longer than allowed for within the bid and pilot site Implementation Plan. The effect of the consequent delay was to slow down the whole process of project implementation. It was therefore often voiced by research participants that the recruitment processes for project personnel should have been initiated earlier:

> '*When [they] started at the very beginning, they took about 3 to 4 months before they got the first Outreach Worker and that's what held us up. The interviews should have gone in place and all that should have gone in place before they started the commissioning*.' FG3 participant (Site 22)

The problems experienced with recruitment extended beyond the key project management personnel and operational staff to the volunteers necessary to provide many of the low level prevention services. A particular problem related to the use of volunteers is that once they were recruited, an effort needed to be made to retain them. This process of retention could be exacerbated if other elements of a project were delayed:

> '*Retaining volunteers is another problem, because when we started the [Mental Health] café…we thought we have x amount of volunteers, x amount of people – we didn't start by having so many clients, so therefore our volunteers drifted away...and then, after a few months, we got more clients and suddenly no volunteers...*' FG4 participant (Site 10)

The need for timely training

The implementation of services often required specific training for newly recruited or seconded staff. Very often, the exact roles of staff were still being developed, and there needed to be balance between the training itself and how the individuals themselves perceived how that training might be effectively utilised within the new service:

> '*At the beginning, [we had] a very intensive two week package of induction. None of us really knew what the [POPP] service was about, we'd just started work – we had two weeks of intensive training and it was a bit of a brain sting for two weeks. But now it's become clear, after all this time, that if they'd have done that training two months in, we would have been able to have handled it better*. FG participant'(Site 06)

Time taken for staff to understand their new roles

Operational staff members newly recruited or seconded to posts within POPP projects often found they were undertaking different roles from those they had been used to. Service specifications were often vague, and the nature of the individuals' roles evolved with the project over time. It therefore took time for staff members to 'find their feet' and become comfortable with those new roles:

> '*It took us a few months to get into it, because we didn't even understand at first what we were supposed to be doing*.' FG2 participant (Site 10)

> '*It was quite vague to everybody, because the manager's new to it as well, it's a new scheme totally, so she's had to learn a bit really*.' FG2 participant (Site 10)

Assisting local VCOs to become more business-like

Many of the difficulties identified around recruitment, time and training were mirrored within voluntary sector partners commissioned to provide services within the POPP programmes. However, there was also often a cultural dissonance between what the statutory commissioning agencies

expected and what VCOs were able to provide, which required strategies to overcome them. For example, unlike national organisations, many of the local voluntary organisations had little experience with tendering processes; it was therefore necessary, as part of their implementation process, to provide support to local VCOs for them to build their capacity in this area:

> '*Local VCOs are not geared up infrastructure-wise, like the big national organisations that we sometimes commission*.' POPP Project Manager (Site 52)

> '*A lot of the services have been commissioned from the voluntary and community sector who hadn't taken commissioned work before, so it's a new experience for them. They've been able to get support to fill in the application – and for a lot of them, that's helped them to build capacity that previously they wouldn't have been able to do ... They've been reliant on grants, so it's been an organisational shift for them*.' FG1 participant (Site 10)

The support given to small VCOs with capacity development helped to increase their opportunities for securing future funding and ensuring that their prevention schemes became sustainable in the long term:

> '*We have a voluntary sector infrastructure consortium group now, who work with small voluntary sector groups to really help them do fund-raising. We have some support within the county for that*.' POPP Project Manager (Site 67)

Nevertheless, it was sometimes found that, even with such support, existing commissioning processes were too bureaucratic for many of the smaller charity organisations and older people's groups. Some work was therefore necessary to reduce the bureaucracy:

> '*We found early on that our standard procurement and continuity processes were overly bureaucratic for what we wanted to achieve – we did end up streamlining it, but it was an initial barrier.* POPP Project Manager (Site 67)

3.6.3 Getting the systems right

The POPP projects were new and innovative, which meant that projects often evolved iteratively. As projects were implemented, they encountered a number of issues that needed to be resolved to ensure services were effective and sustainable.

Translating the POPP bid into practice

As projects were set up, it often became apparent to operational managers and staff that there were new and unanticipated problems to be faced. For example, there was a consensus among research participants that the structure of POPP programmes as they evolved 'on the ground' in practice did not look entirely like the original bid, service specification or programme plan. It was therefore felt by participants to be necessary for some flexibility to be built into project plans to allow for adaptation and change in the face of unexpected barriers to the original specification:

> '*If you have grand aims and objectives on paper, what that means in reality can be very, very different things for a team. And you're talking about quite complex networks. So to try and translate something that's quite theoretical into something quite practical, that's where the difference lays. Maybe people were aware, on paper, but what actually that meant for your role, what that meant for the clients, depending on where you fitted into the puzzle, we weren't sure how those changes were going to look. You were bringing the team along on the journey, but you sometimes weren't ready to introduce the change until you really knew what that change was – and sometimes you didn't know what that change was going to be.*

So you knew what you were trying to achieve, but you didn't know how that was going to look. ..Trying to translate that stuff from theory into practice can go so many different ways.' FG2 participant (Site 73)

Ensuring sufficient resources for the administration of projects

Statutory agencies and VCOs within pilot sites often initially underestimated the level of specific resources that would be necessary in order to plan and prepare for the delivery of POPP services. In particular, many research participants noted the unexpected level of administrative support required and, without separate provision for that resource, the burden of administrative roles fell heavily upon project managers:

'*Administration has been flagged up – if you've not got somebody to actually take the lead, its actually very time consuming for the team managers and for senior practitioners*.' FG1 participant (Site 73)

'*The administration of all of that has gone solely on us. If we had an additional person to co-ordinate all of that, an assistant, that would have been great. Identifying the cases, sending out the information, sending out the action plan, getting the information back – it's been done piecemeal*,' FG2 participant (Site 73)

If staff members were expected to take on new responsibilities in addition to their existing roles, without sufficient administrative and other support, they could feel 'overloaded'. This problem could reduce both staff morale and the efficiency of the service, and ultimately reduce the chances of justifying sustainability:

'*The central problem was I felt overloaded. … There was no extra resource within district nursing per se and within social care. So we had to look at how, within our statutory responsibilities, we could actually continue to carry out our day job, and fit this [administration] into it*.' FG1 participant (Site 73)

As noted above, many local VCOs commissioned to provide low level preventive services had little prior experience of the tendering and commissioning process. One consequence was that VCOs sometimes found that, within the agreements secured with commissioners, they had underestimated the resource costs involved in both setting up the service and its ongoing delivery:

'*When we got to running the [mental health] café, we allocated something ridiculous like ten hours, because that's what we believed it would take. So far this week, I've spent six and a half hours preparing letters, getting them posted, sending them out and all that. I spent all day Friday ringing every single one of them to see if they needed a lift, then Monday morning I will spend another two and a half hours confirming that they're still going, because quite often they're poorly. So we must spend something like 25 hours just getting ready – not even running the café, just preparing them to come for the café*' FG4 participant (Site 10)

'*We knew there would be a lot of extra background to begin with, but we thought once we're up and running, that would have taken back step – and actually it hasn't*.' FG4 participant (Site 10)

Ensuring data sharing

If health and social care workers from different agencies are to work more closely with one another, there are issues to be addressed with regards data sharing. Many research participants cited the sharing of electronic data as a major obstacle to the effectiveness of multi-agency working. There were both practical and logistical problems, such as different agencies using different e-mail and

data storage systems, as well as ethical problems related to patient confidentiality and data protection. These problems needed to be resolved as early as possible within the implementation of a project:

> '*The other challenge is how you get this information across email, because actually we have a social services email and a PCT email. Once it hits the email system, we've got issues around data protection, confidentiality*.' FG1 participant (Site 73)

Ensuring inter-agency referrals and sufficient resource provision for service publicity

It takes time for new services to become established and embedded within health and social care economies and for the professionals from other referring pathways and organisations to be fully aware of what those services can provide for their clients. These professionals, including GPs, community matrons, district nurses, hospital discharge teams, also need to be provided with evidence of the effectiveness of these services. It was necessary, therefore, for the POPP services within many sites to maintain an ongoing publicity exercise to raise and maintain their profile locally. Several sites found that there were insufficient resources initially available for this function, which meant that the project budget had to be re-balanced and that staff members initially dedicated to providing the service had to take on additional publicity roles:

> '*In the original bid, there wasn't any allocation for publicity and profile, so we didn't have things like leaflets and we didn't have a POPPs style to sell. That's quite difficult. We spent a lot of time in the early days as a team going out talking to groups and we didn't have anything to give them, we didn't have leaflets to leave. We've had to manoeuvre budgets to allow for that, because we weren't doing the job that we needed to do. It's getting a balance, but it was a bit of a pull in the early days of how much do you do of this publicising and how much do you do of the getting on with the job? We could have done with more resources in the early days for that, particularly as we had to move it pretty quick*.' FG1 participant (Site 22)

Ensuring equality of access of services

Services need to meet the needs of patients and to be both physically accessible and culturally relevant. Many of the low level prevention services commissioned from VCOs were designed to encourage older people to be more active and health conscious. However, there was often a need for these services to be carefully 'pitched' to make them relevant to the target age group. The term 'older people' may apply to a large range of individuals, and activities designed to involve the older part of that range may not interest younger or more active older people:

> '*Trying to accommodate the 50 to 100 years old is a huge range. We wanted to make things equally attractive to a 50 year old as a 90 year old, but there were obvious things that you weren't going to get a 50 year old coming to*.' FG2 participant (Site 56)

> '*How do we engage the younger ones is very difficult, because the activities you provide for the older ones are not really suitable for the younger ones, particularly exercise classes. If you have an active exercise class, the older ones can't join in, if you provide an older class, the younger ones feel well, what are we doing here*?' FG1 participant (Site 56)

Service users characterised as 'hard-to-reach' (HtR) are those who do not normally come into contact with health and social care services, but who can often nonetheless have great difficulty remaining independent in their own homes. From the qualitative data collected by the National Evaluation team, it would appear that some VCOs providing low level prevention services had

particular difficulty engaging with older HtR individuals. Socially isolated people might not have sufficient contacts to know that preventive activities are being developed in their area:

> '*Hard to reach is hard to reach, because half the time we don't even know they're there, which is a shame, but you don't*.' FG2 participant (Site 56)

> '*Some of the people in their own homes who are isolated and probably not getting enough exercise, we haven't been able to reach. We put leaflets in doors, we've put adverts out, we've had things in the paper, but we still know that there are a lot of people in their own homes who don't come and don't seem to know anything about us*.' FG2 participant (Site 56)

Awareness of the existence of services may not be sufficient for some older people to access them without further encouragement, although they might well benefit from them. For people who have been socially isolated for some time, the psychological step necessary to access a service may be particularly difficult. The problem for older people's services was to engage with these older people without being intrusive:

> '*I think that they lack the will to make the effort – it is an effort from their point of view*.' FG2 participant (Site 56)

> '*A lot of these people, they don't really want to mix. ...They stay in their flat and they'll stay there all day long and all night long*.' FG1 participant (Site 10)

Ensuring equitable access to services also involves ensuring that they are relevant and culturally sensitive to older people from black and minority ethnic (BME) communities. Such communities are usually concentrated in metropolitan areas and/or within particular localities. Across the pilot sites, there was a wide variation in the size of local BME populations, and in a number of county councils containing large rural areas, BME communities were small in number. From the qualitative data, it was clear that where BME communities did exist in numbers, operational staff could nevertheless find it difficult to encourage BME older people to engage with the newly developed POPP services. This apparent failure was often despite determined effort on the part of the POPP managers and operational staff to raise the profile of POPP within BME communities, and staff were often perplexed by this apparent failure:

> '*We gave out lots of leaflets, we had our leaflets printed in other languages, but still, there was very little take-up of our services [from within the BME communities]. We tried.*' POPP Project Manager (63)

However, older people from BME communities did become involved within POPP programmes when there was the opportunity to secure funding to set up culturally specific groups and activities, such as lunch clubs, befriending and exercise groups, and advocacy services.

Some pilot sites encountered problems with accessibility, even when services were popular with older people, due to the lack of transport. Many older people do not drive and many services, despite enjoying a high demand, found that potential clients were unable to access them because bus links were poor and alternative forms of transport unavailable. This problem was particularly prevalent within rural areas, but also existed within urban areas:

> '*Transport is always the big issue for a lot of people, appropriate transport. I get quite a lot of referrals of older people from [Locality], that seems to be a bit of a backwater.... And we've*

got quite a few men who are really lonely and isolated. And a lot of it is due to transport: the bus doesn't pass where they live and they can't walk very far.' FG1 participant (Site 10)

'*We had a group come once and they've not been able to come again, because there's nobody to drive them*.' FG2 participant (Site 56)

Ongoing adaptation of projects

Once POPP projects had been implemented, it was nevertheless thought by many operational staff and managers that ongoing flexibility and adaptation of those projects would be necessary. Project management staff had to be flexible in the face of emerging and unanticipated obstacles to project implementation, side effects and consequences of the projects:

'*We do have processes and we do have systems – it's not that we're all over the place. But we started at a point and we've developed it as we've gone along, so something's worked or something's not worked, we've thought about it. We've been adjusting things as we've gone along, so we do have processes, but we've been able to adjust those so that they work more effectively and quicker*' FG2 participant (Site 73)

3.6.4 Operational partnerships

The development of new POPP programmes and services often involved professionals, operational staff and managers from different organisations working together in new ways for the first time. One obstacle to be addressed was the time and commitment necessary to develop good working relationships at the operational level.

Securing the engagement of GPs

One group of professionals found to be particularly important to the success of POPP programmes was general practitioners. GPs were often necessary for referrals, whether into low level preventive services or high intensity services designed to address more complex health and social care needs. Older people tended to have a strong culture of deference to GPs, and when GPs were involved with services and referred clients into the POPP services, they were successful. Nevertheless, within the KIQ, 41% (n=111) of respondents agreed that a key challenge to the setting up of the POPP projects was the reluctance of GPs to become involved. The challenge to engage GPs with the POPP projects in the early stages was recognised at all levels and within all health and social care sectors, from directors of adult social care to project managers through to operational managers and staff:

'*If there was a frustration in the whole of the POPP programme, it was about GPs. It's really hard to engage them. I don't know what the trick is to that*.' Director of Adult Social Care (Site 56)

'*Getting GPs signed up to things was my biggest problem with the [POPP] project. They weren't interested at all. I could barely get them to speak to me. I sent a questionnaire with three questions on and a pre-paid envelope to every GP practice in the city – and I got three responses back...out of seventy*.' POPP Project Manager (Site 04)

'*I think we could probably count on one hand the number of referrals from the GPs*.' FG3 participant (Site 06)

It was recognised that the new POPP projects needed to be strongly publicised among GPs over time, and GPs often required evidence of the effectiveness of new services and of the benefits they offered, before they would routinely refer patients to them. Once GPs began to recognise the value of the POPP services, the referral rates tended to increase:

'*At first GPs didn't send referral letters in, but as the projects have carried on, the number of referrals from GPs have increased dramatically*.' POPP Project Manager (Site 63)

It was also thought that the reticence of GPs to use POPP services may have been due to a concern about their long-term sustainability, as there was a risk that these services would be transient.

GP reticence was not universal across all sites; indeed, within a minority, GP sign-up seemed to be successful from early on in the POPP programme. Moreover, although it was not confined to 'upstream' services, the challenge to engage GPs was found to be greatest among projects delivering low level preventive services designed to encourage health and well-being, often commissioned from VCOs. It would appear that where such GP sign-up was more successful, GPs themselves could see how the POPP projects would directly have an impact on the health of patients and the reduction of admissions:

'*GP engagement worked, because social workers were talking – and their managers were talking – the same targets: hospital avoidance, reduction in length of stay. And that's the two principal kind of statements that GPs get attracted to, because they are their own financial framework through the PCT*.' POPP Project Manager (Site 13)

'*We got the engagement, because we were talking the same sort of language, had the same priorities. They were interested in getting around the table, because they could see a gain for their own agenda, rather than talking some airy fairy social care issue that they couldn't relate to*.' POPP Project Manager (Site 13)

It was therefore necessary in many pilot sites to undertake a concerted effort to publicise the services and their benefits for patients, to encourage GPs to refer patients to the POPP services. Again, this process required greater time and other resources than had been anticipated within the original project plans.

Securing engagement from other health and social care staff

The engagement of most professionals within the health and social economy, beyond the POPP service delivery teams themselves, was of a high level, with relatively few problems. Indeed, even within GP practices, while GPs themselves were sometimes difficult to engage, the other primary health professionals more readily became involved:

'*The district nurses and the practice nurses got engaged, so I suppose we got to people in that way. ...It's not a question of the whole primary care team not being involved. They are. It's just whether the GPs just disengage from that and let the district nurses and practice nurses sort it out.'* Director of Adult Social Care (Site 56)

Nevertheless, some pilot sites did encounter some lack of engagement from these health care professionals, and referrals from them to low level preventive services appeared to be initially patchy. Thus, resources needed to be invested in publicising services and providing evidence of effectiveness to professionals working in a variety social and health care agencies:

'*District nurses are some and some. It's the personality thing again – how they do their job is an individual thing. It's the same as the community matrons, you might have ten community matrons based in one place, five will probably use us and five don't. But they all know about us. So it's a personal choice, it's how that person does their job, I believe*.' FG3 participant (Site 06)

Interface between POPP and mainstream services

Several pilots developed time-limited POPP services, providing more intensive support to people in their own homes for a period of up to three months. Following this period, it was expected that traditional services would follow them up and provide them with care. Operational staff from both sides had some concerns over the interface between the POPP services and traditional services. This was primarily due to the disparity of time available. Whereas the POPP services were designed to have more time to meet the holistic requirements of service users, the traditional homecare and social services taking over the later care of individuals had fewer resources and less time to spend with the client. It is possible in these circumstances for a 'revolving door' to develop, whereby clients who had been helped to become more independent within the POPP service might then become more dependent again, once referred on to traditional mainstream services. Although there was no empirical evidence to suggest such a scenario existed within any pilot site, it was nevertheless a concern sometimes expressed by staff:

> '*You're thinking, well maybe they could ruin the work that you've done, because you've built it up so that they're a little bit more independent, but now they've got home care, maybe they won't be – they'll do their breakfast for them. So it makes you wonder whether it could backslide*.' FG2 participant (Site 10)

> '*Sometimes, you'll have families or service users ring up and something's gone wrong or they need input from the team again., They should be going onto the community teams, and you'll often find me scurrying up the hallway looking at my team saying, "can we just take this one back?" – even though it's actually not meant to come back into our team – because we are worried that they're not going to take the same approach to the case. They haven't got the multidisciplinary team, they haven't got the access to therapists and intermediate team and the other things that we've got on our team*.' FG2 participant (Site 73)

3.6.5 Wider relationships assisting project implementation

In order to facilitate the implementation of POPP projects, pilot sites were able to utilise wider relationships and partnerships beyond the local statutory and non-statutory partners to the programme. These included the Department of Health project management team, local elected politicians, and older people themselves. These three separate groups of individuals could be used by pilot sites as levers or mechanisms to help raise the profile of services and encourage both strategic and operational partnerships.

Ongoing support from the Department of Health

The partnership between pilot sites and the DH project management team was intended to be collegial and facilitative. While the DH required activity data and progress reports to be provided on a regular basis by sites, they were also available to assist when difficulties arose. It was felt by most project managers that there was the right level of scrutiny and requirements from the DH project management, and that when it was necessary for pressure to be applied to encourage greater partnership working 'on the ground', to free up obstacles between agencies, the DH project management team were effective in that role:

> '*The drive that they gave us was really beneficial. To get something like this through and to recognise some of the things about system change, you need that kind of scrutiny and that kind of push, because I could use that as a lever locally*'. POPP Project Manager (Site 10)

> '*We had a very good relationship with the Department of Health. We have not had any problems. It has helped having the Department of Health flag to wave when there has been resistance at the ground level*.' POPP Project Manager (Site 11)

The involvement of local councillors

Securing the involvement of elected council members proved to be another important way of ensuring that the POPP programme was able to raise its profile and become embedded within the local strategic agenda for health and social care. In a few instances, it was found to be difficult to engage particular elected individuals, but the issues in these cases appeared to be one of personalities. However, where councillors did become engaged, especially the holder of the Older People's Portfolio, their influence could be very effective:

> *'[Local councillors] have been real advocates. They're one of the main driving forces [for the POPP programme]. Most of the local councillors are very well connected to their local communities and, in this case, a lot of the time it's the local county councillor or the district councillor that's saying you could have an [POPP project] here, these are the sorts of things it could do for you. Sometimes they've put some of their own community budgets into helping that process along. So they're important and we have tried to plug into them as community leaders – and with quite a bit of success.*' Director of Adult Social Care (Site 56)

> '*The engagement of the portfolio holder and the Older People's Champion, they were fully up to speed, seeing at first hand and hearing the experiences of older people themselves the value of POPP*'. POPP Project Manager (Site 13)

> '*The townships have had good support from councillors, definitely, and they are encouraging them to feed in to the township [council] structures more and more*.' FG1 participant (Site 22)

Community engagement and the involvement of local older people

The involvement of older people, either directly on governance boards and community engagement or indirectly as part of local publicity, had an important impact on the degree to which POPP projects became priorities within the local strategic agenda. Older people's involvement within governance is discussed in 4.7.1. But older people were also involved in other ways. A number of sites publicised their programmes with the use of DVDs featuring older people who had accessed local POPP services. These DVDs could be shown to staff and managers of both statutory and non-statutory services to raise the project's profile and improve referrals, as well as to senior managers and commissioners to ensure it became a priority for future funding:

> '*We were able to bring the older people closer to senior managers, we didn't have to have them in the room, you didn't have to go through that tokenism that often happens when you're trying to engage different groups of people. We were able, through DVD, to get these older people into the room. Managers and commissioners get so much information. The DVDs were able to give an immediate impact*.' POPP Project Manager (Site 52)

3.7 Involvement of older people

Underpinning the aims of the POPP programme was the requirement that older people be involved within the structure and process of the POPP pilot sites from design to dissemination. Such a requirement has also been embedded within recent policy (See DH 2001a, DH 2004a, DH 2005a, DH 2005b) with an expectation that service users and citizens influence decisions across the health and social care economy. Nevertheless, *'the secret of achieving real participation appears to continue to remain elusive'* (Bochel et al 2007:201).

Increasing involvement in the direction of local health and social care services is based on the assumption that it will lead to services of better quality and of more relevance to the priorities and

needs of service users. The differences in services with a high level of user involvement at service level, in comparison with 'traditional' services, should be clearly recognisable. For example, they should be more democratic and less hierarchical in their organisation, with clear policies and structures for users to influence the '*making and creating*' of the services they receive (Barnes, 1999). However, it has been argued that the '*assumptions made in relation to user involvement are often diffuse, overlapping and lack conceptual clarity'* (Ross et al 2005: 268). The term 'user involvement' has been used to describe a range of activities, which seek to include service users in health and social care for different reasons, from genuine efforts to ensure services are responsive to their users needs to 'rubber stamping' decisions already made.

A useful distinction exists between two philosophical approaches to user involvement: consumerist approaches and democratic approaches (Carter & Beresford 2000). Consumerist approaches to involvement are often about consultation to gather people's views to inform service providers, so that they can then decide strategic direction. The democratic approach is concerned with providing service users a more active role in decision-making. While the consumerist model does not necessarily lead to any transfer in power and control, it is the key aim of the democratic approach. Agency-led initiatives for involvement in the field of social and community care have in the past been based primarily on the consumerist model, and therefore '*it is important to be clear about who controls groups and organisations in which older people get involved*' (Carter & Beresford 2000: 14).

3.7.1 Overarching involvement

The POPP initiative expected pilot sites to involve older people at every level of the POPP process, including: design of the new interventions, recruitment of project management and operational staff; involvement in governance and commissioning roles; service delivery; and programme evaluation. In most sites, there were attempts to go beyond tokenism and to fully involve older people – not simply to 'tick a box', but in recognition that such involvement could bring real benefits to the innovative services being provided:

> '*We've had many conversations of how to [involve older people] meaningfully – even drawing on literature across the world about the council of elders over in America – without just popping in one that we all think is a nice lady to come to our meetings, and tokenistically saying well actually that's all very well. I think that's a waste of people's time and pays lip service and is actually meaningless'*. FG2 participant (Site 73)

> *'They've told us the sorts of services they wanted the money invested in and that affected what we spent the money on. The real test to me of engagement or involvement is that you have to affect one of the two big important things: what you do or what you spend your money on. If it doesn't impact on those two things then it's lip service, simple as that. The involvement of older people in the programme has affected both things directly*' KITI Participant (077_ S)

Table 16 outlines the various ways in which older people were directly involved with the POPP projects. It should be added that, throughout the analysis of older people's involvement in POPP programmes, there has been effort to avoid the pilot sites' conflation of 'older people's representation' with the involvement of organisations that 'represent the interests of older people'. While, in most cases, CVS representatives were themselves older people, this was not necessarily the case. Wherever possible, there has also been a focus on the democratic approaches to involvement.

Table 16. Categories of older people's involvement within POPP projects

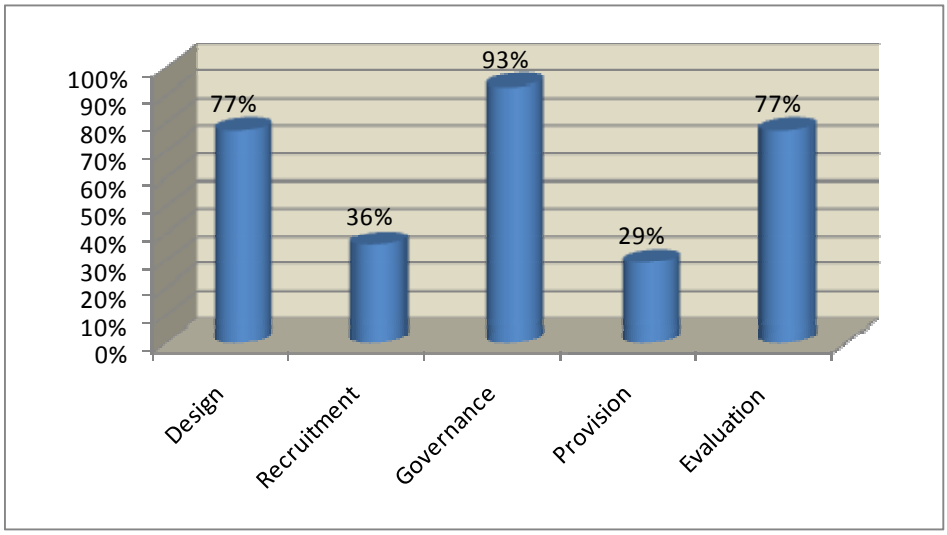
Category	Description
Design	This category designates whether older people and carers have been involved in giving their opinions on the design of POPP programme/projects: the types of services to be provided, the target populations and the need levels to be addressed. The extent of this involvement may vary significantly, and they may be involved in the design of the POPP programme in the following ways: • As participants within a workshop which sought to develop proposals for the POPP bid • As members of advisory/reference groups that existed prior to, or established as part of, the POPP programme • As Elder Experts specifically recruited as part of the POPP programme to be co-partners in the design, decision-making and evaluation of the whole POPP programme.
Recruitment	This category designates whether local older people have been directly involved in the selection panels of POPP programme staff, such as the project manager or service delivery staff.
Governance	Many of the POPP pilot sites have older people on their POPP programme boards and advisory/reference groups. Older people are deemed to be involved in the governance of a project if they have an effective decision-making role over its strategic and operational functioning, and if the providers and managers of the service are in some way accountable to them.
Provision	There are several ways in which older people may be involved in operational service delivery: • As volunteers providing POPP services • As network leaders, wayfinders or Expert Elders • As salaried staff. For example, four pilot sites (Sites 04, 12, 19 and 88) stated an aim within their original bids and IPs to encourage older people to take up paid posts within their POPP programmes.
Evaluation	The evaluation of the effectiveness of POPP projects may also involve older people and carers in the following ways: • Through the use of discovery interviews to ascertain the views of POPP service users. • As members of an older person's reference group. • Recruited as local evaluators.

Figure 18 indicates the level involvement of older people within the five categories for the core POPP projects. The greatest involvement was within governance, and 93% (n=136) of core projects reportedly had older people sitting on their governance panels. Within most sites, a single steering group or other governance body had oversight for all projects that constituted the POPP programme. Thus, if older people were members of this body, they would have had governance responsibility for all POPP project in their area. Within only one pilot site (Site 15) was there no such representation of older people in this capacity.

The involvement of older people in the categories of design (77%, n=112) and evaluation (77%, n=113) was proportionally even. However, to avoid a simple stratification that may over-report involvement, these categories are further broken down in Figure 18 to indicate increasingly democratic forms of involvement within these areas. Some 36% (n=53) of projects had older people's involvement within the recruitment process of POPP staff. In addition, ten pilot sites

reportedly had older people included on recruitment panels for their programme managers and management staff, and at least one site had older people involved with the recruitment of the local evaluation team. Finally, some 29% (n=42) of POPP projects had older people's involvement within service delivery. Such involvement was overwhelmingly as volunteers, but although four sites stated within their original bids that they would seek to recruit older people to salaried posts, it was not possible to verify whether this was achieved.

Figure 18. Older people's involvement within all 'core' projects



If we compare the involvement of older people between the two POPP rounds (Figure 19 and Table 17), we find that there was greater proportionate involvement in all five categories within Round 2 sites than in Round 1 sites. The making of such comparisons is problematic, however, given the very different programmes developed within the 29 sites, and the differing individual contextual conditions. Moreover, as noted in Section 3, a greater proportion of the core projects within Round 1 had an emphasis upon the higher levels of need than those of Round 2, and there tends to be an inverse correlation between the higher the level of need addressed by pilot projects and the level of older people's involvement within them.

Figure 19. Older people's involvement in 'core' projects: Rounds 1 and 2 compared

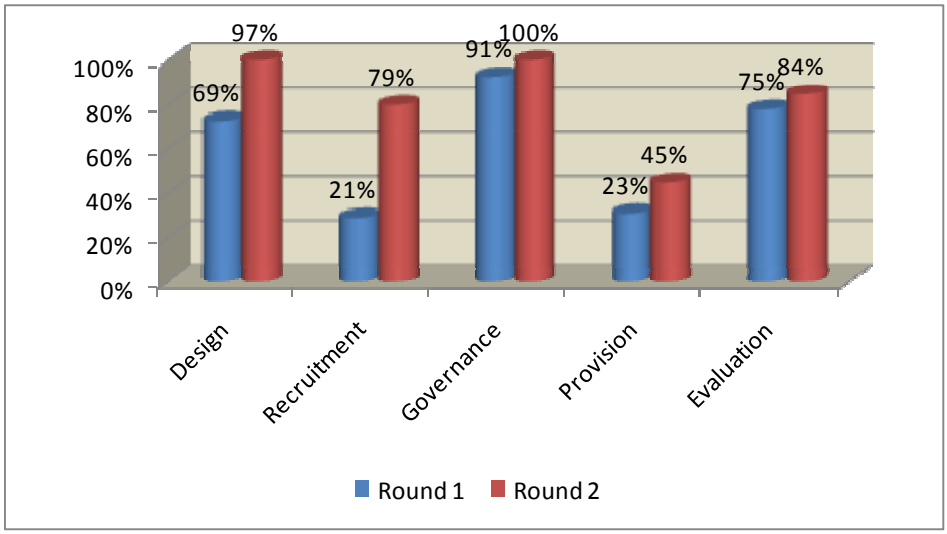


Table 17. Older people's involvement summary table of 'core' projects: Rounds 1 and 2 Compared

Round	Design	Recruitment	Governance	Provision	Evaluation
Round 1	75 (69%)	23 (21%)	98 (91%)	25 (23%)	81 (75%)
Round 2	37 (97%)	30 (79%)	38 (100%)	17 (45%)	32 (84%)
Total	**112 (77%)**	**53 (36%)**	**136 (93%)**	**42 (29%)**	**113 (77%)**

Older people were directly involved in the categories of recruitment and governance. However, within service provision, project design and evaluation the data is sub-divided to reflect more or less democratic, rather than consumerist approaches to involvement.

Older people's involvement within the design of POPP programmes/projects

Older people's involvement in the design of POPP programmes means they had some form of decision-making role in determining the type and focus of projects to be included. To that end, almost one third (31%, n=49) of projects carried out a public consultation exercise, one quarter (26%, n=41) used existing older people's forums and advisory groups, and almost a quarter (23%, n=36) set up specific POPP advisory or reference groups:

> '*We set up an older people reference group, which is mainly representatives from the local older people's groups, the senior forums. We tend to provide them with an update on progress – they meet quarterly – and often we focus on a specific service, so they could really understand the process that these decisions are being made on and how they can then influence those decisions. But it's a good opportunity for them to provide feedback to us about what we're doing and the process we're taking*'. KITI Participant (074_S)

> '*Older people were fundamentally involved in the thinking that led up to the POPPs submission. There was a number of workshops that they were involved in, so they could. There was a lack of investment in older people's mental health, so they crafted and helped to determine some of the theories we wanted to test using the POPP monies. So they were involved in that sense*'. KITI Participant (073)

Such structures ensure a level of engagement and feedback to the project. However, the individuals involved in the majority of the sites were seemingly drawn from people involved with existing organisations, either forums or voluntary organisations. Similarly, the starting point of discussion was not always open, limited by the *'slightly benign imperialism of the council'* (Participant 068):

> '*In terms of involvement in the design, that's difficult actually, because the design fitted very much within the borough strategy for older people – and that had a lot of involvement through the user carer forums, through pensioner organisations, so basically the design of our POPPs is about implementing a lot of the borough strategy. But it was also taken as a draft to some of the pensioner associations, but also a leaders group of pensioners*' KITI Participant (025)

There were opportunities for feedback through workshops and/or fora, but only the participants in one of our five case study sites gave clear examples of a 'feedback loop':

> '*They've told us the sorts of services they wanted the money invested in and that affected what we spent the money on – the real test to me of engagement or involvement is that you have to affect one of the two big important things, it has to affect what you do or what you*

spend your money on. If it doesn't impact on those two things, then it's lip service'. KITI Participant (077_ S)

Older people's involvement within programme governance

The qualitative data suggests a strong conceptualisation of partnership among research participants, with all people interviewed identifying the full range of statutory and voluntary services involved in the partnership and able to identify impact. What was often missing from this conceptualisation was the involvement of older people or the community as a whole. From the key informant interviews, only three individuals (of the 19) defined partnership inclusively:

'*Within my own community, partnership working means that we can reach out to all the smaller groups. We are trying very hard to work not only with the larger groups – Age Concern and Help the Aged and so on – but also the smaller groups we have locally – church groups and things like that. It's about involving everybody really in what goes on in their area*'. KITI Participant (033)

Such a dominant discourse of statutory or voluntary partnerships could well have affected the level of inclusion of older people. Yet of the 149 core projects that reported older people being involved in their governance, all argued that older people were members of their decision-making governance bodies. It would seem that this was either over-reported in some areas or the dominant perception was that older people representation was achieved when a voluntary organisation was involved (e.g. Age Concern), and skewed the reporting:

'*I don't think we've completely cracked how to engage people more at a strategic level. For example, we don't have older people involved in the [POPP] programme board – I'd like to see that as the next development that comes through with the joint commissioning*'. KITI Participant 075

'*While it is acknowledged that [POPP pilot site 15] has a dynamic older population and that the POPP project is partnered with organisations representing older people, there are no key 'older people' in positions of decision-making within the project. This has been a source of debate throughout the duration of the project, but no real solutions have emerged*'. Local Evaluation Report 2008 (Site 15)

It would seem that, for many sites, the 'older people' involved on decision-making boards were drawn, in the main, from voluntary organisation representatives: *'there's someone from Age Concern, the CVS chair is on that who's also over* 65' (Participant 068).

'*Those people that are on our forum, most of them are former professionals, they've had very, very responsible jobs*.' FG3 participant (Site 06)

The types of older people involved with the POPP programmes were not a homogenous group, and certain types of individuals appeared to be attracted to different types of involvement, but within all roles individuals were usually 'younger' old and physically fit. As noted above, the types of older person involved within POPP governance bodies, commissioning groups, steering groups and co-ordinating roles within service delivery tended to be confident, articulate and educated – often recently retired professionals. For example, within a focus group comprising older people involved with the governance of one pilot site's POPP interventions, there was a retired physician, nurse and community care manager, and a retired academic. These individuals were often involved in a number of voluntary and community groups, were fairly well known within their areas, and had

been approached by their council's POPP project management teams to become involved with the area's POPP programme:

> '*I'm in a lot of Committees and a lot of Steering Groups and things, so therefore I know a lot of people*.' FG3 participant (Site 22)

> '*We were first approached by [POPP project manager] from [local authority] to say that they were going to apply to the government for funding and would we like to go to a meeting and listen to what their ideas were? And that's how we started*. ...*She asked would we go on the board and then afterwards, once they knew they'd received the money, because they explained that they had to put a claim in for the money and how they intended spending it*.' FG2 participant (Site 22)

Such involvement can be invaluable, ensuring input from individuals who are cognisant of key issues. Similarly, such 'experts' are able to negotiate the committee structures, recognised as a barrier in involving older people. Indeed, 40% (225) of respondents to the KIQ agreed that the complicated governance structures – '*the slick professional things that go on'* (Participant 074_B) – made it difficult for older lay representatives to be involved. Nevertheless, the majority of the POPP pilot sites did not seem to be involving ordinary citizens over 65 directly in the governance process.

The involvement of older people within the decision-making process was patchy across the 29 sites. This is not surprising. The POPP pilot sites were working under very tight timescales to deliver evidence of the effectiveness (or otherwise) of the interventions. Ensuring that older people outside the complex structure and process of piloting innovative services and structures can have a real voice takes time (Hogg 1999, Beresford 2005), which was not always available to the pilot sites if they were to meet necessary external targets.

Older people's involvement with recruitment

Conflating representation by older people with that of voluntary organisations confuses the analysis as whether older people are involved on recruitment panels. As noted above, over a third (36%, n=53) of core projects reported that older people assisted in the selection of project staff. However, this level of involvement was not always borne out within the qualitative data. Older people either were not included *'so they weren't involved in the recruitment of staff that I know of, certainly not* here' (Participant 028); or interviewees conflated representation across paid council officers, representatives and established voluntary organisations:

> '*We have a [Locality] carers group – it is quite involved with the staff of the POPP project and [council worker] who leads on the POPP project, she was the lead officer for the carers group as well at the time*.' KITI Participant (033)

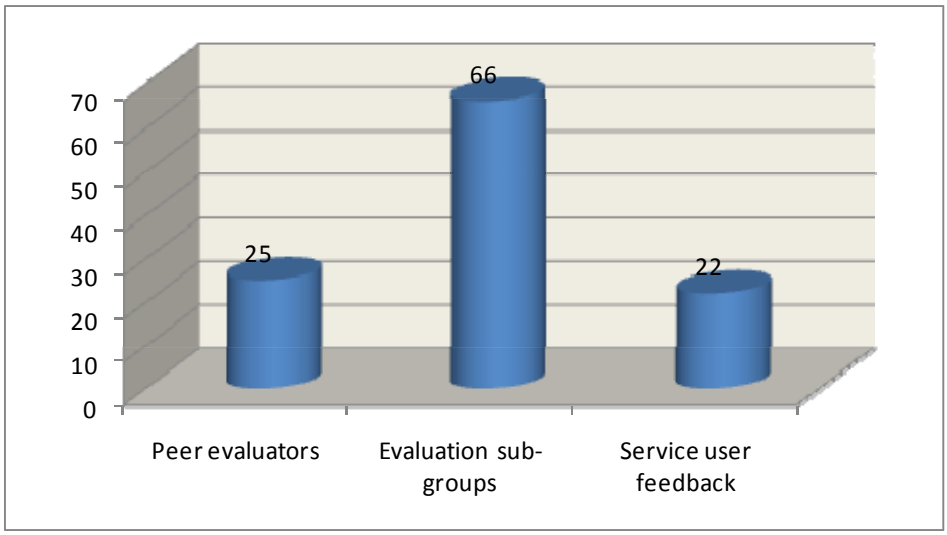
It should be noted that where closer evaluation of the projects took place, within the five case study sites, only one involved older people in recruitment, employing the project management staff and those within the projects.

Older people's involvement in the evaluation of POPP projects

As part of any evaluation, it can be argued that user involvement is essential: '*vulnerable and marginalised people have something important to offer their involvement, not as research participants, but as active partners, collaborators and leaders in research. Without their active input, research that affects them will risk being irrelevant and perhaps even flawed*' Steel 2005: 18). As noted above, 80% (n=126) of the projects stated in their documents that older people would be involved in the evaluation process. However, this understanding of involvement seemed to be

toward the passive end of the continuum. It included evaluation reference groups and service user feedback, and involving older people as research subjects (60%, n=88), with 17% (n=25) of the projects arguing that they were using older people as peer evaluators (Figure 20).

Figure 20. Older people's involvement in the evaluation of the POPP project.



The qualitative data again support this analysis, with only one of the five case study sites (20%) using older people to carry out key areas of the research programme:

> '*In terms of evaluation, we have through the reference group and advertising in our newsletter, we've got volunteers to carry out telephone interviews. For our local evaluation, two of the services we're doing a more in-depth evaluation and so far we've got older people involved in doing telephone interviews with service users and also facilitating focus groups*' KITI Participant (074_S)

Nevertheless, even within this site, there was a conflation of service users as subjects rather than active researchers.

> '*A couple of citizens were involved in the evaluation through the focus groups through service user and carer interviews, so we've had local older people phoning up the people that have enjoyed our services and getting involved in interviews with them. We've developed a quality of life tool where we survey service users before they have the service and then survey them after they've had the service and look at a number of key change areas and the results*' KITI Participant (077)

It could be argued that this lack of involvement was affected by the limited knowledge among those in the pilot sites regarding evaluation *per se*. Almost half the respondents to the KIQ, 40% (225), stated that defining and implementing the local evaluation was one of the key challenges in setting up and initiating POPP projects.

Older people's involvement in service provision

Involvement with the provision of services benefits both the volunteer and the recipient. Community volunteering provides meaningful roles for older people: *'promotes citizenship participation and the social economy in an aging society'* (Narushima 2005: 567). Over a third (37%, n=158) of KIQ respondents agreed that the recruitment of older people as volunteers was a key challenge to the

implementation of POPP projects. However, while there are fewer core projects that have older people involved with service delivery than with other categories of involvement, there are nonetheless 29% (n=42) of projects that do so. Moreover, by May 2009 there were some 530 low level prevention services and activities commissioned from VCOs within twelve pilot sites, and these are overwhelmingly provided by volunteers.

Older people who volunteer to help provide services and activities, such as well-being cafes, active living centres and others, tend to fall into different groups depending on the level of commitment and the nature of the involvement. Many were willing to be involved in an informal and ad hoc way, with fewer prepared to go through any formal recruitment process with either large national VCOs or local councils:

> '*There's been a whole range of different types of volunteers. Essentially, volunteers prior to January this year were Age Concern volunteers, but in addition we've been working with church groups or local community groups, as some of our centres are based around a group who already had their own volunteers*. ...*And then you have the informal volunteers who just come along to make a cup of tea or make a cake, so there has been a whole different layer of types of volunteers. From January, the theory was that all of them should be registered with [Site 56] County Council, the reality is that we've still got informal volunteers*.' FG2 participant (Site 56)

> '*They volunteered for their church or their community centre because they were interested. They're not interested in being a county council volunteer*.' FG2 participant (Site 56)

While numerous older people might be willing to provide a little help towards services, it was much more difficult to recruit older volunteers into the co-ordinating roles that many preventive services require, as these involve a greater long-term commitment and taking greater responsibility in the day-to-day running of services. Such roles were often perceived by older volunteers as 'unpaid jobs':

> '*There are many, many people willing to come along and do little bits of work – making tea, help with cooking, clean up, wash the dishes, put the chairs out and all that kind of thing....But the co-ordination role we've got to perform it is a very different ball game, because I've had to explain to a few of the volunteers ...they have to think about planning a programm.'* FG2 participant (Site 56)

> *'Effectively asking them to do a job, an unpaid job,... they did feel they were being exploited*.' FG2 participant (Site 56)

Older volunteers were motivated to be involved for several reasons. Many were personally committed to improving the circumstances in which older people lived or more generally wished to do something for others in their community, while others found a great deal of satisfaction in being constructively involved with organising and networking in their community:

> '*I have this passion for making sure that older people are treated as well as we treat children*.' FG1 participant (Site 06)

> '*I thought "well, this is my opportunity now to do something for people who can't do anything*"'. FG2 participant (Site 22)

> '*I'm not being funny, but we do get a lot of satisfaction out of what we do…because we're helping people all the time*.' FG3 participant (Site 22)

'*When I retired, I sat there for a month and then I thought "well, is this me for the rest of me life?" and I thought "no way". I joined the Pensioner Group and from then, it's evolved from that. I get a lot of pleasure out of it*.' FG2 participant (Site 22)

'*The secret of a good retirement, there are two rules – one is always to have something to get up for in the morning and the other is to keep involved with people. If you do those two things, then you'll have a happy and successful retirement*.' FG2 participant (Site 56)

3.7.2 Variations of older people's involvement between services

To explore older people's involvement further, we sought to test whether there was evidence that such involvement was higher in services that addressed lower levels of need. As Figure 21 and Table 18 indicate, while there was relatively little difference in the involvement of older people between services that addressed Needs Levels 1 and 2 (Primary and Secondary Prevention), there was markedly less involvement within projects targeting Level 3 Needs (Tertiary Prevention). Moreover, involvement in personnel recruitment and service delivery was much lower within services addressing Level 3 Needs. This finding is unsurprising, given the higher level of expertise that would be required from staff to deliver these services.

Figure 21. Older people's involvement in POPP projects and the needs levels addressed

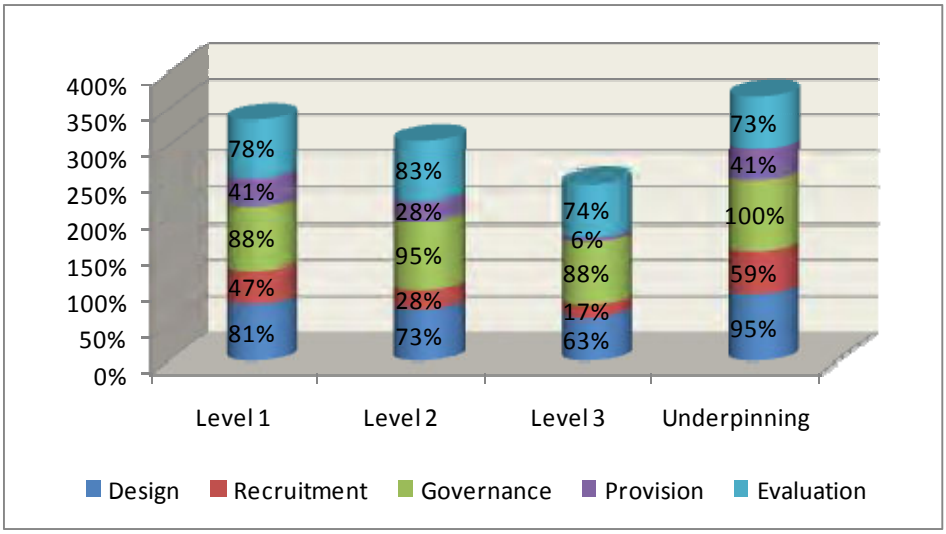


Table 18. Older people's involvement in POPP projects and the needs levels addressed

Involvement	Level 1	Level 2	Level 3	Underpinning
Design	40 (81%)	29 (73%)	22 (63%)	21 (95%)
Recruitment	23 (47%)	11 (28%)	6 (17%)	13 (59%)
Governance	43 (88%)	38 (95%)	31 (88%)	22 (100%)
Provision	20 (41%)	11 (28%)	2 (6%)	9 (41%)
Evaluation	38 (78%)	33 (83%)	26 (74%)	16 (73%)
Total projects	49 (100%)	40 (100%)	35 (100%)	22 (100%)
Mean involvement	(67%)	(61%)	(50%)	(73%)

It was also found that involvement of older people varied greatly between pilot sites. The sites that had most involvement of older people were those that aimed to build capacity within the local network of voluntary and community organisations to deliver a greater variety of 'upstream' low level preventive services. In contrast, those pilot sites that used POPP funding to develop more specialist services addressing more complex social and health care needs, involving NHS and ASC professionals, had less involvement of older people:

> '*Whereas other projects might have suddenly created whole new services, where they liaise with older people, find out what they want for that community area, that kind of thing, we integrated into a team that was already here in intermediate care services. We obviously take their feedback into consideration with then planning how we next move forward with that service'.* FG1 participant (Site 73)

However, there was no simple divide between levels of involvement and the needs levels addressed. Even among those sites that aimed at 'upstream' interventions, a minority found it difficult to engage with older people and to find meaningful roles for them within their POPP programmes:

3.7.3 Challenges to involving older people

Most recruitment of older people within pilot sites, as noted above, occurred through existing older people's forums. These groups were in the main approached by project management teams and very few individuals were recruited through adverts directed to the general public:

> '*Once the forum structure was set up, POPP came on the scene and each of the forums were asked if they would like to participate in it and [Locality] certainly did – and hence [Name] and myself from [Locality] became members of the Reference Group*.' FG3 participant (Site 06)

> '*I think we all were contacted through the groups that we run, our management boards on the estate*.' FG2 participant (Site 22)

The number of older people recruited for involvement also varied between localities within sites. Areas with a low number of community voluntary groups found recruiting older people more difficult, while areas with established networks of such local groups found it less so:

> '*In some of the townships, they have more older people's organisations than in some of the others, so you're recruiting from a wider breadth of people really*.' FG1 participant (Site 22)

> '*It's making sure we get the right people on board which adds to the pressure of where do we go to get those people, because there's not enough older people's groups*.' FG1 participant (Site 22)

The recruitment of older people into every level of involvement must be an ongoing process. Older volunteers may experience increasing or sudden periods of ill health and periods when they lack motivation, and as they get older they will be able to do less:

> '*We find that you've got an ageing population of volunteers and they are nearly as old as the clients they serve in some places*.' FG3 participant (Site 56)

In addition, many older people who would otherwise be willing to volunteer were also informal carers for partners, who were physically infirm or suffering from mental health problems:

'*It all depends on your home commitments, unfortunately*' FG3 participant (Site 22)

Older people who become involved with projects such as those developed within POPP tend to be very active individuals, often with a number of interests and volunteering responsibilities elsewhere. The incentive for them to continue being involved with the POPP projects in their areas therefore had to be maintained by project staff. If volunteers did not perceive their time and effort to be valued, they could cease to participate:

'*I am conscious of the fact that we are asking these volunteers to take on a job for which they are not getting paid. We all know that you define problems here, they are not only volunteering for you, they are volunteering for the hospital shop, or the local charity shop of whatever, you're just a little bit of their volunteering activities*.' FG1 participant (Site 56)

The timing of meetings is a very important consideration when involving older people in any way within the POPP projects. Older people are often reluctant to go out after dark, both due to safety concerns and because they may tire more easily:

'*Our volunteers, the average age is probably about 70, 75 and for that, they don't want to come out in the evening. Once it's got dark, they're really not interested…They're older and they're tired*.' FG3 participant (Site 22)

Moreover, if volunteering and involvement within projects required a lot of paperwork and administrative commitments, older people seemed to be less inclined to become and remain involved:

'*I think the difficulty when we're getting older is to put time in, especially for paperwork and things like this*.' FG1 participant (Site 10)

'*If we could get by with less paperwork and form filling.'* FG1 participant (Site 56)

Recruitment of older volunteers from BME communities, either to governance roles or for the delivery of services, was particularly problematic in some sites. Moreover, when local organisations were seeking to recruit BME group volunteers to assist with well-being cafes, activity centres or lunch clubs, they encountered a particular problem with the securing of CRB checks on their volunteers:

'*If I need the volunteer, how do I get about seeing a CRB check? It cannot be done in England, because they're here one year, half a year, two years...I thought even if I get them, they have to have CRB check, well how can I deal with that? I did ask and nobody gave me straight answer because nobody thought about it*.' FG4 participant (Site 10)

Transport has been a recurring issue within all POPP pilot site programmes. Older people are less likely to have a car, or to drive at all, and although they might have much to offer as volunteers for project governance, commissioning, evaluation and so forth, if they lack transport they will not be able to participate:

'*A lot of people will be put off by the fact they haven't got a car or they can't drive for certain reasons, where they could be very, very good at the job*.' FG3 participant (Site 06)

Future involvement

Most of the POPP pilot sites reported a commitment to building upon the engagement of older people developed within their POPP programmes. Managers planned to use their experience and learning from the POPP programmes to further deepen and broaden the involvement of older people, and to include a broader population of individuals beyond the 'usual suspects' and to devise alternative ways in which older people could feed their views into the policy process:

> '*We have significantly strengthened our consultation and older people networks subsequently, and have established older people's partnership boards, which bring in people to influence our commissioning processes*.' POPP Project Manager (Site 47)

> '*I wouldn't have gone for quite the severe structure we had in terms of governance. It was too formal [to encourage user involvement]. It mirrored to much what we had in the LA. I think we could have learnt what we did in community development about if you really want to engage committees, a lot of people don't want to come into a formal committee structure. We tended to attract those people who were very eloquent and were used to committees, who perhaps had been around a long time, but what we have now attracted is people who are using our services, don't want to come to a formal committee meeting, but they're happy to come along and give their ideas and input*.' POPP Project Manager (Site 52)

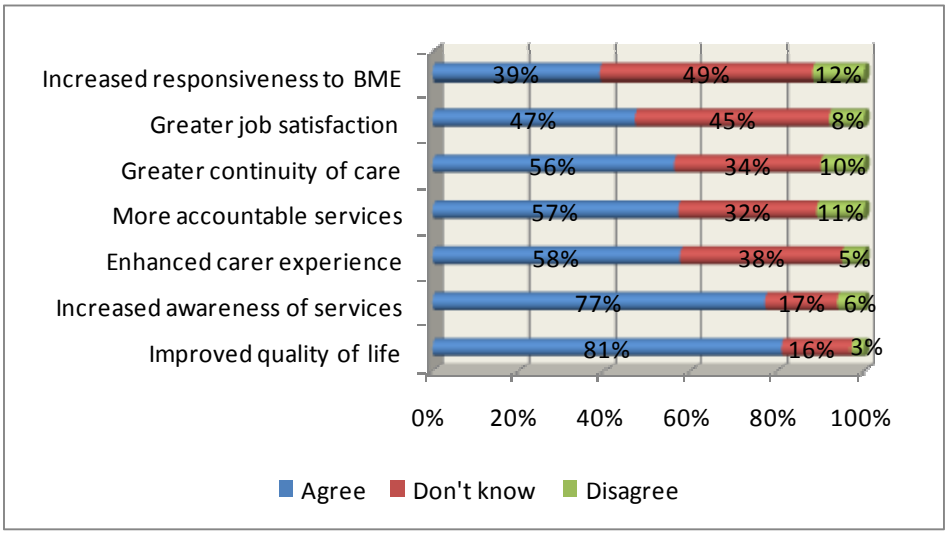
3.8 POPP pilot outcomes

The main objective for developing effective partnerships between health, social care and third sector organisations must ultimately be the provision of better outcomes for service users. However, recent research has shown that such partnerships do not always achieve better outcomes (Peck et al 2002, Davey et al 2005). This may be partly due to the fact that many of those involved with the development, governance and evaluation of partnerships are more focused on process issues rather than outcome issues (Dowling et al 2004, Dickinson 2006, Glasby & Dickinson 2008). In short, partnership may improve relationships between the different statutory and voluntary services, but such structures do not necessarily lead to improved outcomes for users.

3.8.1 Key outcomes achieved within pilot sites

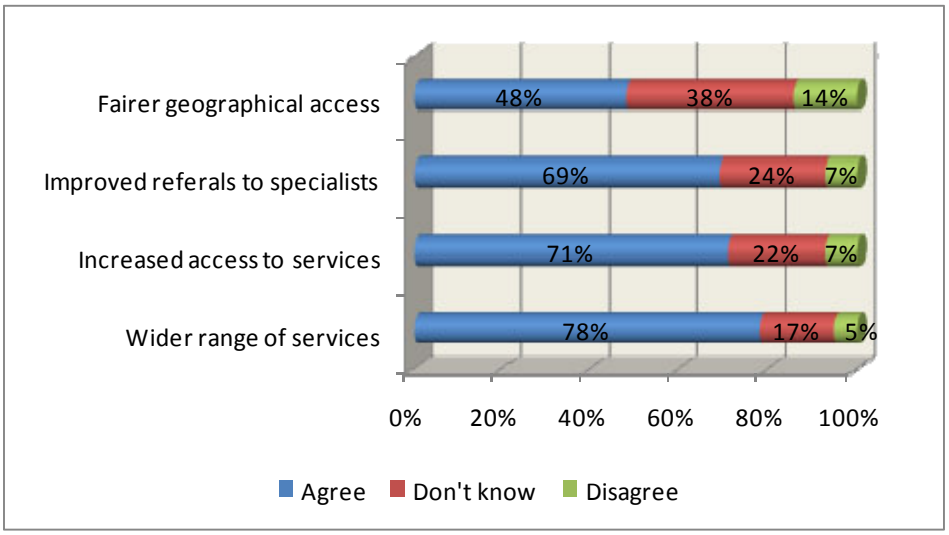
The KIQ therefore asked respondents the extent to which they agreed that a list of outcomes and outputs were in the process of being achieved within their POPP programmes. Figure 22 shows that the great majority of respondents (81% n=346) agreed that the POPP projects had delivered improvements in the quality of life and well-being of older service users. Only 3% (n=14) felt that progress had not been achieved towards this outcome. It was also felt that older people were now more aware of the available services (77%, n=331). There was, however, uncertainty amongst almost half (49%, n=212) of respondents as to whether POPP programmes had led to services that were more responsive to BME communities, although a sizeable minority (39%, n=136) that they had.

Figure 22. Outcomes achieved within POPP sites: views of key informants



Well over three quarters of key informants also agreed that the POPP programmes in their areas had led to improved outcomes. As Figure 23 indicates, large majorities of KIQ respondents agreed that a greater range of services were now being offered to older people as a consequence of POPP (78%, n=335), and that POPP had led to increased access to services (71%, n=305).

Figure 23. Outputs achieved within POPP sites: views of key informants

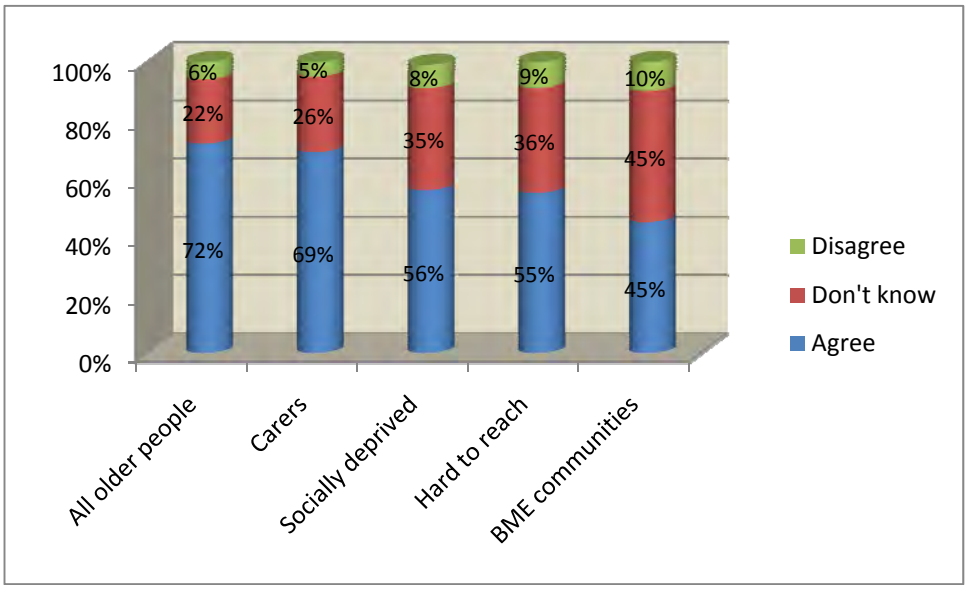


3.8.2 Greater equality of access

Part of the aim of all of the POPP programmes was to ensure accessibility to all communities. As noted above, the outcome that fewest KIQ respondents (39%, n=166) agreed had been achieved was within their pilots was that the POPP services had increased their responsiveness to the needs of black and minority ethnic (BME) groups. As acknowledged above, despite considerable efforts by project staff in some sites, the promotion of POPP services among BME communities was difficult and took time.

Nevertheless, this is not to discount the real progress made overall through the POPP initiative to create greater equity of access to services for older people. Figure 24 indicates the proportion of KIQ respondents who agreed that their local POPP programme had provided improved access to services for older people from various communities. The figure shows that nearly three quarters (72%, n=305) agreed that all older people within their area had adequate access to the POPP projects, with only 6% (n=25) disagreeing. In addition, 55% (n=233) agreed that the POPP services provided adequate access to older people who are normally 'hard to reach' and 45% (n=190) agreed that they provided adequate access for older people from BME communities, with 9% (n=40) and 10% (n=43) disagreeing respectively.

Figure 24. Improved access to services for older people from different groups



3.8.3 Culture change within and between VCOs

As noted above, many of the VCOs commissioned to provide services within pilot sites had never previously been involved with bidding and tendering processes. Within the sites involved with developing the local VCS, support was often provided to VCOs to assist with the commissioning processes. The outcomes of such support were often far greater than both parties had expected. Many supported VCOs broadened their perceived horizons with regard to what it was possible for them to achieve and what services they could provide, as well as being more confident in their ability to secure funding:

> 'A *lot of the services have been commissioned from the voluntary and community sector who hadn't taken commissioned work before so it's a new experience for them; they've been able to get support to fill in the application, the tender and for a lot of them that's helped them to build capacity that previously they wouldn't have been able to do really...they've been reliant on grants so it's been a shift for them, an organisational shift for them*.' FG1 participant (Site 10)

> 'A *whole set of new relationships [have developed] for the drivers of existing groups sometimes, or the drivers of new groups, opening up and seeing opportunities for doing more than they have done before or being excited by the prospect of doing something which they haven't perhaps thought of when they started setting up the group*' FG1 Participant (Site 56)

It was also reported in several of the sites that had commissioned VCOs to deliver a part of their POPP programme that there had been a growth in the networking between local VCOs, developing supportive relationships between organisations that had previously seen one another as competitors. Commissioning agencies can support and enhance this process of collaboration by providing regular meetings between operational staff of commissioned VCOs where networking and confidence building can take place:

> '*Right at the beginning of POPP, there was very little referrals between [VCO] services. So people were just going in, delivering their service and then coming out. But as we started having the subgroup meetings, where all the operational staff met together, they were inter-referring then, and identifying new needs and offering services that could address those needs*.' POPP Project Manager (Site 52)

3.8.4 Culture change among older people

From early on in the local POPP programmes, older people were directly involved with the design and implementation of many of the projects. Their involvement and influence often then 'snow-balled', as their role became progressively more embedded:

'*Right, well we were first approached by [Project Manager] to say that they were going to apply to the government for funding and would we like to go to a meeting and listen to what their ideas were, and that's how we started. She asked would we go on the board and then afterwards, once they knew they'd received the money, because they explained that they had to put a claim in for the money and how they intended spending it. ...And then we went to another meeting for townships and we asked if each township could have their own pot of money to work with and they said yes, so we were each given a certain amount of money according to how many elderly persons you had in the township*.' FG2 participant (Site 22)

The involvement of older people within many pilot sites helped to bring about a culture change among older people within the community. This is especially the case within site programmes that aimed to build sustainable local communities supported by stronger networks of VCOs. Older people have been encouraged to be more involved with their communities:

> '*I think projects such as this, the [POPP] programme, it sort of makes you challenge the notion that just because you're older you have to be lonely and isolated. And I think it makes people think about it a little bit more, doesn't it. It's not inevitable just because you're over 65 that it's going to be ooh, you're going to be stuck at home and miserable*.' FG1 participant (Site 10)

4 Project Activity and Focus

Key points

- Each of the 29 pilot sites completed aggregate quarterly reports on staffing of the projects, the number of users referred and in receipt of a service, their demographics (age, sex, ethnicity) and referral pathway.

- Exploring all projects, volunteers were reported to provide the majority of the staffing of the projects (56%). Further staffing was provided by social services (15%), Health staff (15%), and voluntary organisations (14%). The balance of staffing was dependent on the focus of the project. For example, health and social care staff provided the majority of the care (91%) in those projects focused on Tertiary Care.

- Over a quarter of a million (264,637) people used one or more of the POPP services

- Pilot sites provided a forecast of the likely number of service users within their local programme. In exploring the number of users forecast to use the projects, the first year implementation process seemed to be slower than expected. The first round sites (19) reached 44% of their forecast activity and round two sites, 75%.

- In exploring the age range of users, almost one-third was aged 85 and over, with almost two-thirds (63%) aged 75 and over, with some variation depending on the focus of the service.

- A high proportion (60%) of those aged 85 and over accessed projects providing tertiary care, but one-third (34%) also accessed services offering primary prevention. This suggests that services focused toward early intervention are being used by the total older person population, not simply those in younger age groups.

- Of the individuals referred, one fifth (21%) were referred onto voluntary organisations and over a quarter (27%) to some form of health care, including hospital (6%), GP (6%), other health professional (9%) or mental health provision (6%). Over one in ten (13%) of the referrals were to social care and the same proportion (13%) were to other POPP projects. The latter was particularly strong (17%) in the second year of operation, suggesting that the individual local projects had formed a sense of an overall programme of work.

4.1 Introduction

As part of the quarterly reports to the DH (see Appendix K), each pilot site was required to collect specific aggregate 'activity data' to ensure on-going monitoring of the numbers using each project and the user 'pathway'. The data included:

- Numbers of contacts/referrals to the project
- Referral organisation
- Sex/age ranges of individuals referred
- Number of service users and forecast service use
- Sex/age ranges/ethnicity of service users
- Number of service users referred on to other services and service 'types'.

Analyses of such data were carried out and fed back at the PLEN meetings throughout the project, enabling monitoring of any new developments. For example, through matching information drawn from the documentary analysis against such activity data, we were able to explore the rise (or fall) in numbers of users and staff, indicating at what point full programme activity was achieved. Similarly, by asking pilot sites to record user referrals from, or to, other POPP projects within the pilot site, a rough assessment could be made as to any transition from a POPP project operating as 'stand-alone' discrete service within the pilot site to an overarching 'programme' of activity.

Within this section, we bring together the full activity reported across the three years of the programme. This is first presented as simple descriptive numbers. A comparison across the Needs levels to which projects were addressed and Community/Hospital facing projects then follows, where possible. It was not always possible to carry out higher-level statistical analyses on aggregate data, as we could not look in detail at specific individual use. Similarly, the considerable amount of missing data and data error in reporting meant that any 'higher-level' analyses might simply be meaningless. Where such exploration was possible, it has been carried out to enable some further questions to be answered: for example, the types of projects which have a higher number of volunteers and different patterns in staffing across Community and Hospital Facing projects.

Two further approaches have been incorporated. The full aggregate activity totals have been provided across the three year project activity. We also present comparative data, by bringing together the two formal years of operation from each 'wave' of the projects. For the first round of POPP pilot sites (19), this is 2006/7 and 2007/8, while for the second this is 2007/8 and 2008/9. Owing to slippage, some first round sites extended their activity into the final year with a small number of projects. Nevertheless, not all projects were continued, not all sites continued their pilots and all Round 1 pilot sites requested a shortened data activity collection form. To show activity based on 'years' would not provide the most transparent outcomes, as we would be comparing the Round 2 final year of operation with a 'semi-completed' Round 1 programme. The data in Table 19 therefore match the first year operation of the Round 1 pilot sites (2006/7) with that of the first year of the Round 2 pilot sites (2007/8), with a similar matching of the second year operation.

4.2 Number of projects

The difficulties of providing a simple 'count' of projects have been discussed above and it is not intended to repeat those arguments. However, the number of projects shown in Table 19 does differ from the reported project totals (see Section 4), as analysis can be undertaken only on the specific data forms received.

Table 19. Total number of projects reported within the activity data

	2006/7	2007/8	2008/9
Round 1 POPP pilot sites	131	203	68
Round 2 POPP pilot sites		25	29
Totals	**131**	**228**	**97**

It can be seen that the Round 1 pilot sites reported higher numbers of projects in operation than those in Round 2. This is partially explained by the greater numbers of pilot sites (19) within the first round. However, much of the disparity arises due to variations in which projects the pilot sites chose to report, the organisation responsible for project development and the capacity for such reporting. With regard to the first, Dorset provided funding to VSOs to develop small, locally led projects – and activity across each of these 81 projects (2007/8) was reported. In contrast, although Devon similarly developed over 70 projects over the life-time of the project, no activity data was received for this part of their pilot. It was found that where projects were located within the voluntary sector, there was greater difficulty in obtaining data. Some of the larger VSOs, practised in obtaining bids and providing output data, did not find such reporting a difficulty. Nevertheless, for many large and (particularly) small VSOs, there was seemingly a dissonance between the requirements of the lead organisation (Social Care) to ensure appropriate quality assurance and management and the VSO response:

> *"I [POPP project manager] was knocking on the [VSO] door, demanding performance information and what they were doing with the money – they perceived it as being checked up on and not trusted. It really got in the way and became very difficult to move on"* Exit Interview (29).

Simple capacity within the POPP project team was, perhaps, the main factor affecting the extent of project reporting. In proposing and setting up their pilots, some of the project leads did recognise the need for information analysts or administration staff to support the collection of such basic activity data. Indeed, where these were in place, not only were a greater number of projects reported, but such data was found to be far more robust. Many pilot sites had not considered the recruitment of such staff, so the responsibility of collection fell on either the project manager or operational staff (or both), neither of whom had the capacity to ensure accurate and representative data collection. The impact of the differences and difficulties around data collation and reporting on data integrity has been reported in the section on the methods of the National Evaluation (see Section 2).

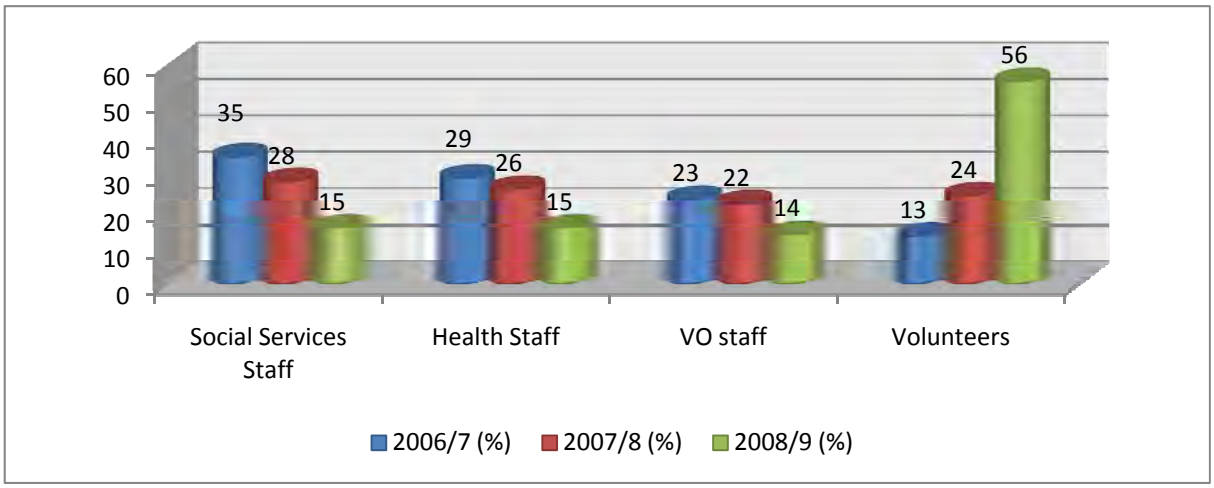
4.3 Staffing of the POPP projects: overall descriptive data

The different focus of the projects not surprisingly led to different staffing structures. The total staffing across the full three years of the POPP pilots (2006/7 – 2008/9) along with the comparable (two years) data are reported in Table 20 and Figure 25.

Table 20. Staffing given for Rounds 1 & 2 across POPP

	2006/7 (%)	2007/8 (%)	2008/9 (%)
Social services staff	35	28	15
Health staff	29	26	15
VO staff	23	22	14
Volunteers	13	24	56
Totals	**100**	**100**	**100**

Figure 25. Staffing given for Rounds 1 & 2 across POPP



The numbers of volunteers involved rose proportionally across the three years, with reductions in statutory and VSO staff. The proportional changes may be due to the inherent impact of the first and last years of operation. That is, in the first year, many of the pilot sites were working to identify the type of projects needed and developing the logistics to put these in place. The projects themselves would only be fully operational in the second year, hence the almost 50% increase (13% - 24%) in the number of volunteers. In the third year, the focus of sites was on ensuring continued existence of the projects and 'handing over' organisational responsibility from the statutory to the voluntary sector, explaining the increase of more than 50% in volunteers in the third year and the consequent 'drop' of almost 50% in the involvement of social services and health staff in the running of any projects. Nevertheless, such a pattern differs when the comparable data are explored (Table 21 and Figure 26, and Figure 27).

Table 21. Staffing reported in the first year of the POPP pilot sites

Staffing type	First year of POPP pilots					
	Round 1 2006/7	Round 1 2006/7 %	Round 2 2007/8	Round 2 2007/8 %	Totals	Total %
Social services staff	253.17	35	54.27	14	342.27	28
Health staff	210.82	29	76.12	19	315.94	26
VO staff	167.91	23	77.43	20	268.44	22
Volunteers	94.95	13	186.5	47	294.51	24
Totals	726.85	100	394.32	100	1221.17	100

Table 22. Staffing reported in the second year of the POPP pilot sites

	Second year of POPP pilots					
Staffing type	**Round 1 2007/8**	**Round 1 2006/7 %**	**Round 2 2008/9**	**Round 2 2008/9 %**	**Totals**	**Total %**
Social services staff	295.17	23	56.65	6	351.82	15
Health staff	255.365	20	96.2	9	351.57	15
VO staff	181.9	14	128.45	13	310.35	14
Volunteers	528.755	42	740	72	1268.76	56
	1261.19		1021.3		2282.49	

Figure 26. Staffing reported in the first year of the POPP pilot sites

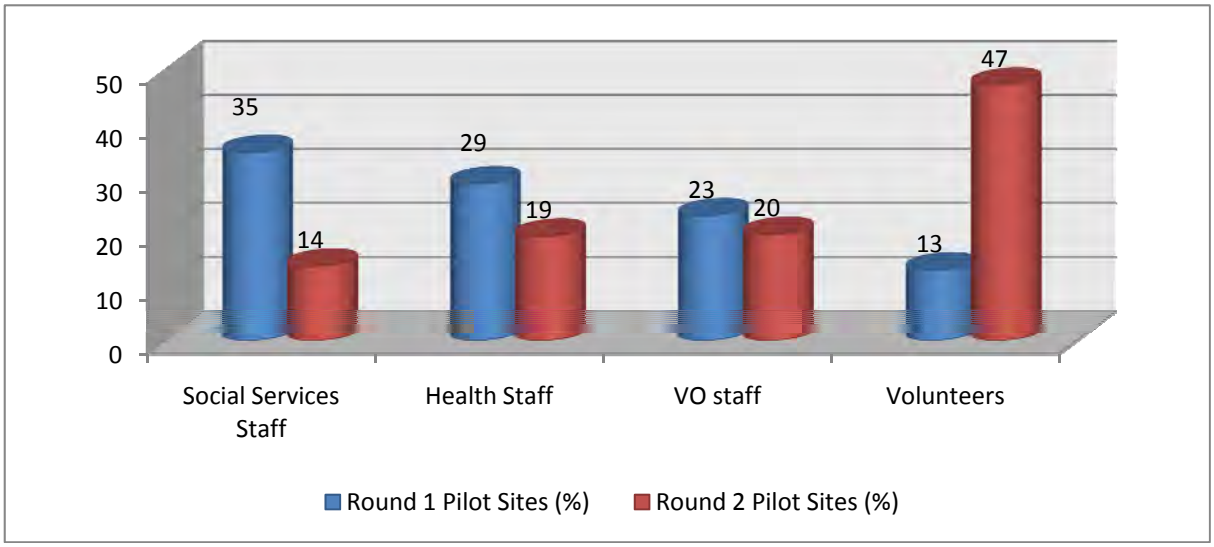
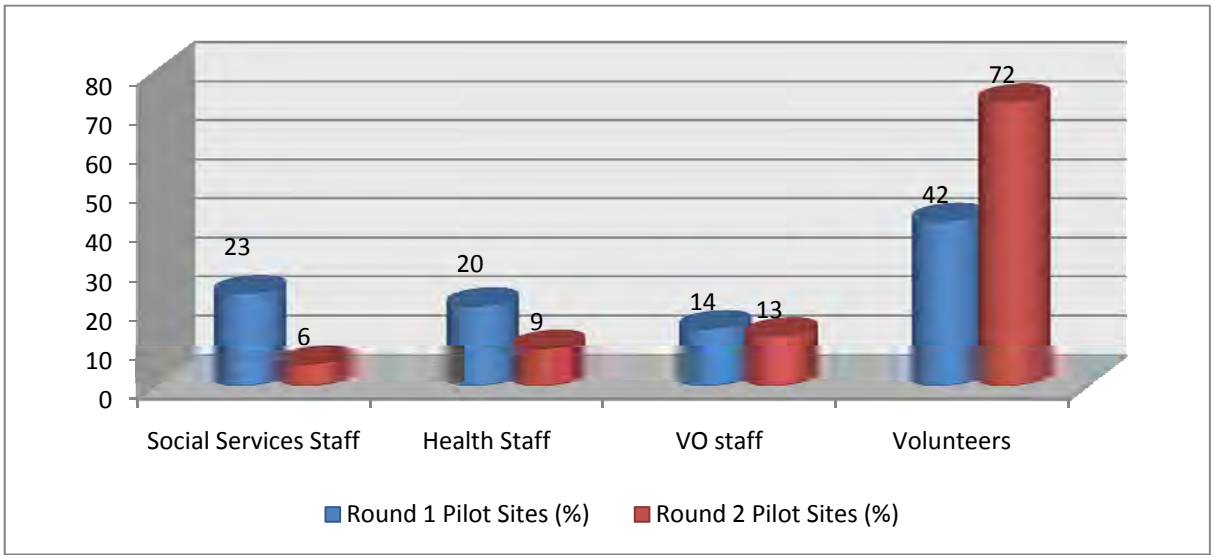
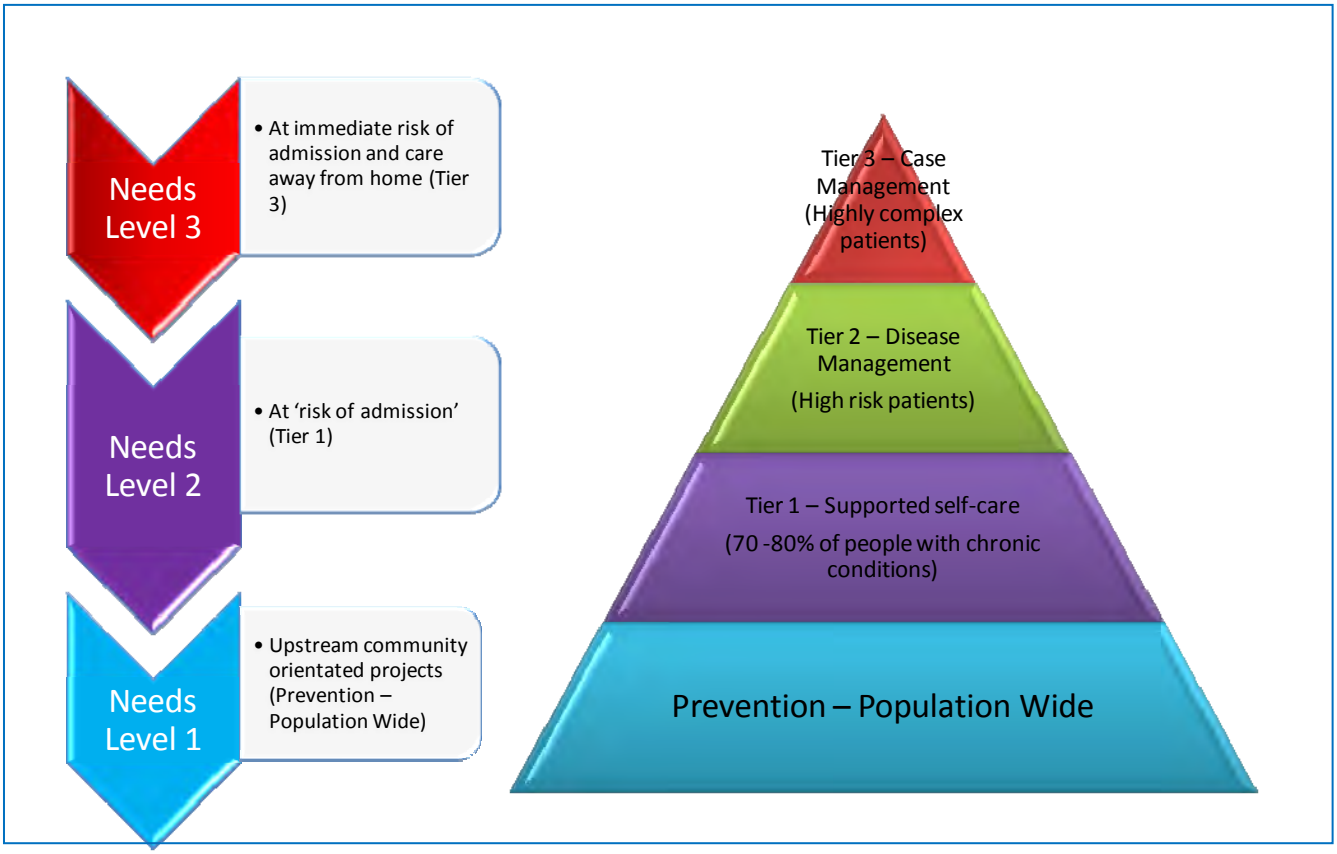


Figure 27. Staffing reported in the second year of operation of the POPP pilot sites



In differentiating between Round 1 and Round 2 pilot sites, it can be seen that while Round 1 sites report a rise in volunteers from 13% to 42%, the Round 2 sites move from almost half of the staffing being volunteers (47%) to over two-thirds (72%). The iteration of the projects over the two years of operation (planning to full development) can partially explain the staffing patterns. Nevertheless, such variation is, not surprisingly, more related to where the projects are located on the Kaiser Permanente continuum and their associated focus on level of Need or 'prevention' (primary, secondary, tertiary)' (see Figure 28).

Figure 28. Kaiser Permanente Triangle and Needs Levels



4.4 Staffing of projects: the 'prevention' continuum

In exploring the continuum of prevention, the projects were brought together into groupings based on the Needs Levels to which they were addressed, with statistically significant differences found.

4.4.1 Needs levels

It could be expected that the higher the level of need addressed by a project, the greater the number of statutory staff that would be employed. For example, ensuring that people are discharged appropriately under a 'home from hospital' project is likely to demand the employment of clinical and social care staff, rather than the involvement of volunteers or voluntary organisations. In exploring the pattern of staffing across Needs Levels, the second year of operation across both waves was included to ensure that full project activity was captured (see Table 23 and following tables, and Figure 29)[5].

[5] Site 12 was excluded from this analysis as inclusion of the numbers of volunteers within their particular site skewed the mean figures.

Table 23. Staffing by Rounds 1 & 2 second year of operation: needs level 1

	Second year of operation: needs level 1					
Staffing type	**Round 1 2007/8 (WTE)**	**Round 1 2006/7 %**	**Round 2 2008/9 (WTE)**	**Round 2 2008/9 %**	**Totals (WTE)**	**Total %**
Social services staff	41.0	9	27.6	5	68.54	7
Health staff	22.2	5	16.9	3	39.12	4
VO staff	88.5	19	70.0	12	158.45	15
Volunteers	315.3	68	471.0	80	786.26	75
	467.0	100%[6]	585.4	100%	1052.37	

Table 24. Staffing by Rounds 1 & 2 second year of operation: needs level 2

	Second year of operation: needs level 2					
Staffing type	**Round 1 2007/8 (WTE)**	**Round 1 2006/7 %**	**Round 2 2008/9 (WTE)**	**Round 2 2008/9 %**	**Totals**	**Total %**
Social services staff	69.2	17	27.1	8	96.33	13
Health staff	54.6	13	23.0	6	77.67	10
VO staff	69.3	17	51.5	14	120.80	16
Volunteers	213.5	52	255.0	72	468.50	61
	406.7	100%	356.6	100%	763.30	

Table 25. Staffing by Rounds 1 & 2 second year of operation: needs level 3

	Second year of operation needs level 3					
Staffing type	**Round 1 2007/8**	**Round 1 2006/7 %**	**Round 2 2008/9**	**Round 2 2008/9 %**	**Totals**	**Total %**
Social services staff	187.0	49	2.0	3	188.95	41
Health staff	174.3	46	56.3	72	230.58	50
VO staff	21.5	6	6.0	8	27.50	6
Volunteers	.0	0	14.0	18	14.00	3
	382.8	100%	78.3	100%	461.03	

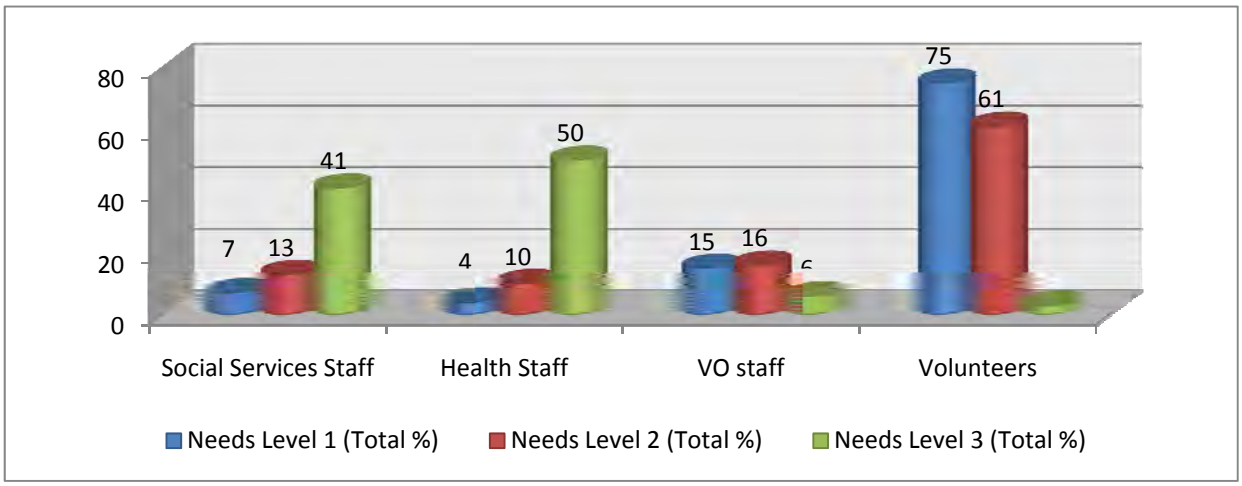
Table 26. Staffing by total (R1 & R2) needs levels (second year)

	Needs level 1 (Total %)	**Needs level 2 (Total %)**	**Needs level 3 (Total %)**
Social services staff	7	13	41
Health staff	4	10	50
VO staff	15*	16*	6*
Volunteers	75*	61*	3*

* K-S, p=<0.001

[6] Totals of percentages in the tables may not sum to 100% due to rounding.

Figure 29. Staffing by total (R1 & R2) needs levels (second year)



As can be seen from these tables and figures, it was found that the lower the Needs Level addressed, the greater the involvement of volunteers and voluntary organisations: a statistically significant finding. Volunteers made up 75% of the staffing within Needs Level 1, in comparison to only 3% in Needs Level 3. Indeed, within Round 1 (see Table 25), no volunteer was involved in any Needs Level 3 project.

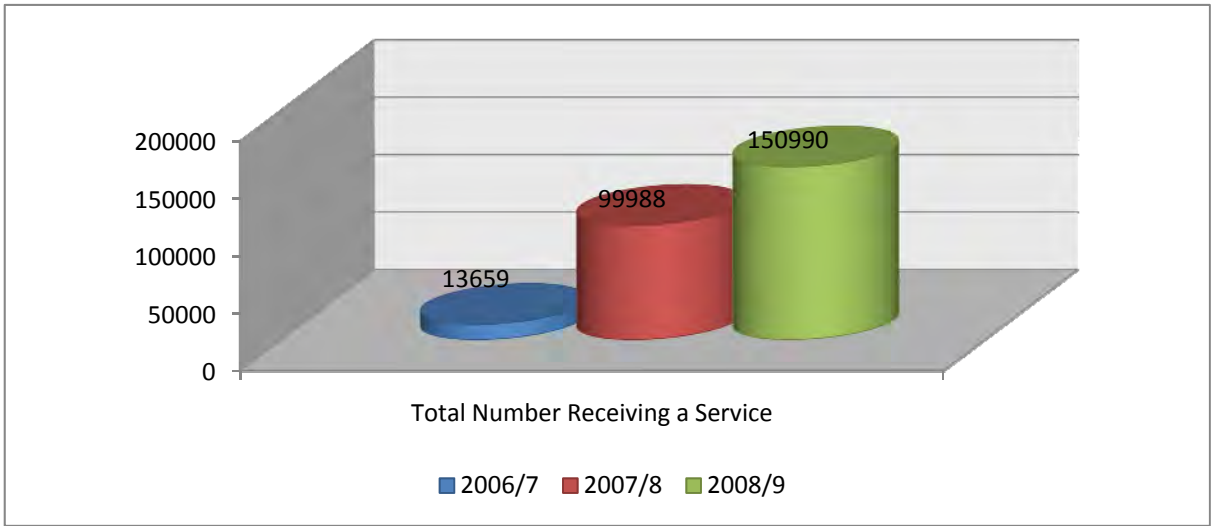
4.5 Total number of users

Using the full three years of data, it can be seen from Table 27 and that the total number of POPP project users reached over a quarter of a million.

Table 27. Users in receipt of a service by year

Year of POPP pilot	Total number receiving a service
2006/7	13659
2007/8	99988
2008/9	150990
Total	**264637**

Figure 30. Total number of users in receipt of a service

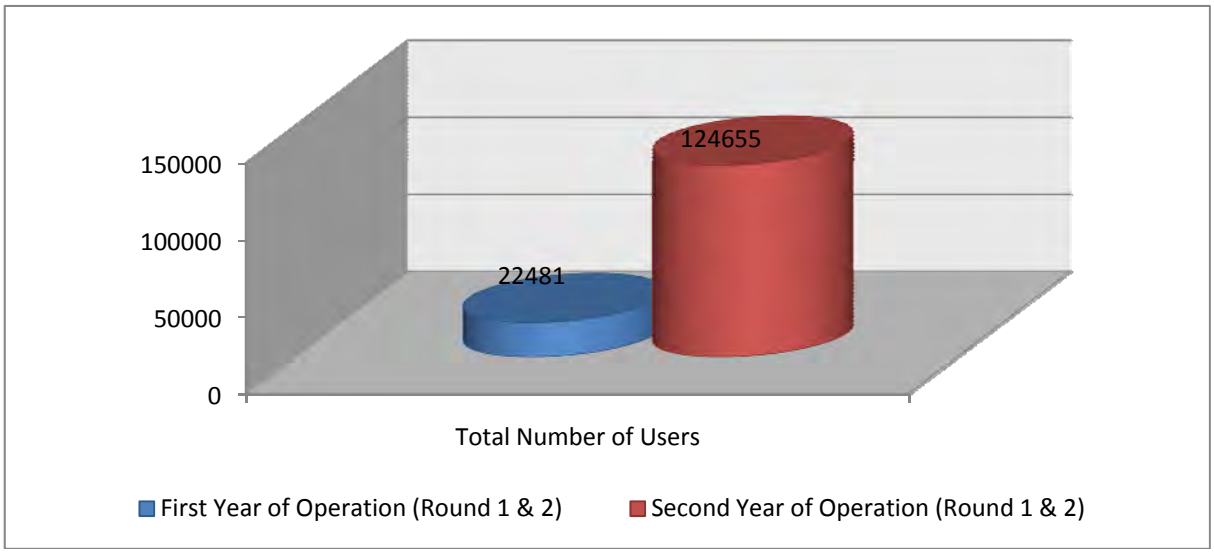


The seven-fold increase (13,659 to 99,988) in numbers in the second year of operation (2007/8) can partially be explained by the fact that the second wave of projects came into operation, thus adding more projects available to potential users. But this is not the full explanation; it would seem that the time taken to plan and start implementation delayed early and continuing 'traffic' through the projects. As can be seen in Table 28, there was a five-fold increase in activity between the first and second year of operation.

Table 28. Total number of users by year of operation

Years of operation	**Total number of users**
First year of operation (Round 1 & 2)	22481
Second year of operation (Round 1 & 2)	124655
Totals	**147136**

Figure 31. Total number of users by year of operation



4.6 Total number of users by forecast receipt

Within the second stage applications, each of the pilot sites was required to list those projects that they would be putting in operation and forecast the expected number of users. Such an exercise can sometimes represent the dominance of hope over reality, an attempt to persuade commissioners in the absence of any empirical data. For some sites, such data were not available in any case, as projects were completely new models (e.g. mental health cafes) with no data on which to base any forecast. From the activity data across the two years of operation, it can be seen that in the first year (
Table 29), the Round 1 sites achieved under half of the forecasted service users, whereas Round 2 sites (Table 30) reached three-quarters of the service users initially forecast.

Table 29. Total number of users by forecast receipt, first year of operation

First year of operation			
Pilot site round	**Total number receiving a service**	**Total forecast receipt**	**Total % of user x forecast**
Round 1	13659	30708	44
Round 2	8822	6660	75
Totals	**22481**	**37368**	**60**

In the second year, sites in Round 1 had achieved two-thirds of their initial forecast, while those in Round 2 had achieved a third more users within their services than had originally been forecast.

Table 30. Total number of users by forecast receipt, second year of operation

Second year of operation			
Pilot site round	**Total number receiving a service**	**Total forecast receipt**	**Total % of user x forecast**
Round 1	91166	138154	66
Round 2	33489	25106	133
Totals	**124655**	**163260**	**76%**

Such differences in the sites cannot simply be explained by the proportional number of projects or users within each service. Rather, it could be argued that the Round 2 sites were able to learn from the experience of the Round 1 pilot sites – and this would seem to be supported by the data (above) and the interviews. For example, the Round 2 sites were advanced monies out of the POPP grant to ensure that a project manager could be in place three months prior to the formal start of the project, enabling a more immediate start than was the case for the Round 1 sites. Similarly, advice provided by the DH and CSIP to the Round 2 sites stressed the need to be realistic rather than 'visionary' in any planning, reflecting the lack of correspondence in some Round 1 sites between the submitted tender bid and outcomes of their local programme (see Section 3).

4.7 Age ranges of users

The DH project team responsible for commissioning and managing the National POPP pilots did not mandate a 'cut-off' age for users to be involved within local POPP programmes or projects. Such a decision was guided by research evidence around preventive work (e.g. younger individuals within

BME communities with higher rates of diabetes) along with necessary sensitivity to local population demographics and underlying need.

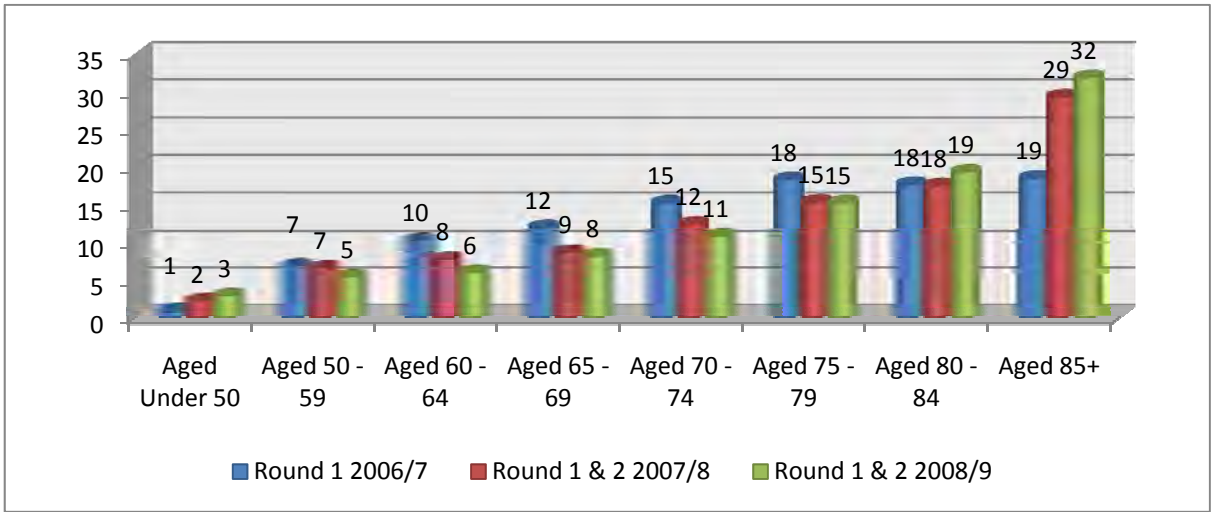
4.7.1 Overarching age ranges

In exploring the age ranges of POPP service users across the three years (see Table 31 and Figure 32), the number of younger people (under age 50) within the overall programme was small, ranging from 1% of the full sample in 2006/7 to 3% in 2008/9. If the total percentages of those under 60 are included, the range is steady at between 8% and 9%.

Table 31. Age range of users, by Rounds

Age range	Round 1 2006/7 (%)	Round 1 & 2 2007/8 (%)	Round 1 & 2 2008/9 (%)
Aged under 50	1	2	3
Aged 50 - 59	7	7	5
Aged 60 - 64	10	8	6
Aged 65 - 69	12	9	8
Aged 70 - 74	15	12	11
Aged 75 - 79	18	15	15
Aged 80 - 84	18	18	19
Aged 85+	19	29	32
Totals	**100**	**100**	**100**

Figure 32. Age range of users, by Rounds 1 & 2



It could be argued that the inclusion within the projects of almost one in ten individuals under the age of 60 negates the focus of POPP, which was on partnerships for 'older people'. Nevertheless, it could be argued that the 'upstream' or preventive projects should include younger people, if there is to be any change in social or health behaviours.

4.7.2 Age ranges by Rounds 1 and 2

In examining the full two years of operation, it can be seen (Figure 33 and Table 32, Figure 34 and Table 33) that there were little proportional differences between the two years of operation, or between Round 1 and 2 pilot sites. There was a spread across age ranges, with no one age range

seemingly being excluded from any of the POPP services. As the data is aggregate, it is not possible to explore whether the age ranges differed according to whether the service was Hospital Facing or Community Facing or focused on a higher or lower need level. However, this is explored in the discussion of the individual outcome level data (see Section 6).

Table 32. Age range by Rounds 1 & 2

	First year of operation					
Age range	**Round 1 2006/7**	**Round 1 2006/7 %**	**Round 2 2007/8**	**Round 2 2007/8 %**	**Totals**	**Total %**
Aged under 50	56	1	171	3	227	2
Aged 50 - 59	460	7	571	10	1031	8
Aged 60 - 64	692	10	490	8	1182	9
Aged 65 - 69	801	12	625	11	1426	11
Aged 70 - 74	1020	15	692	12	1712	14
Aged 75 - 79	1226	18	906	15	2132	17
Aged 80 - 84	1183	18	1041	18	2224	18
Aged 85+	1239	19	1381	23	2620	21
Totals	**6677**	**100**	**5877**	**100**	**12554**	**100**

Figure 33. Age range (%) for Rounds 1 & 2: first year of operation

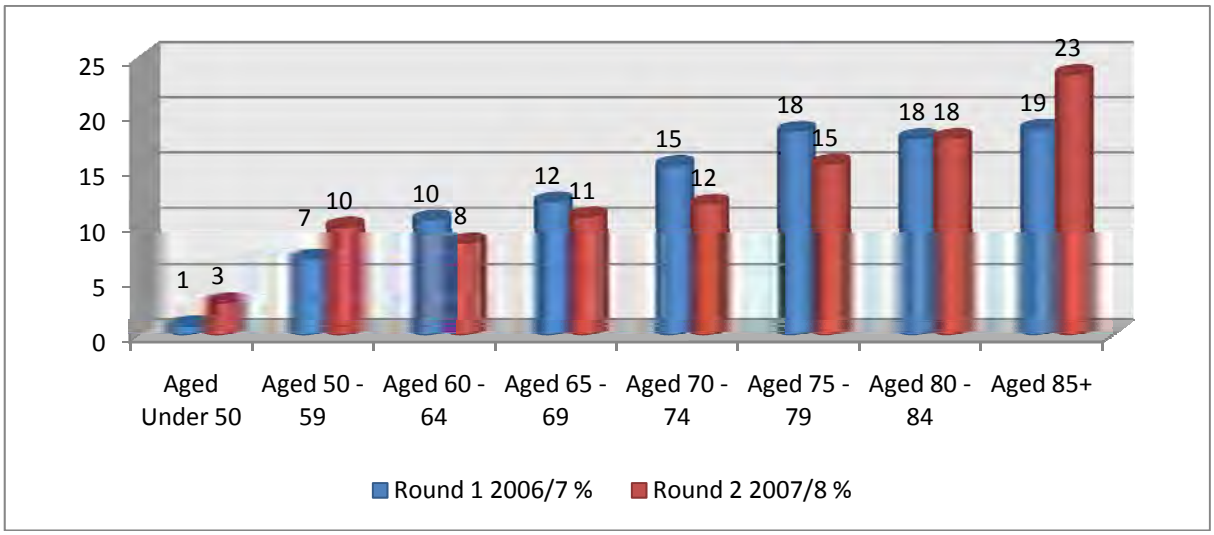
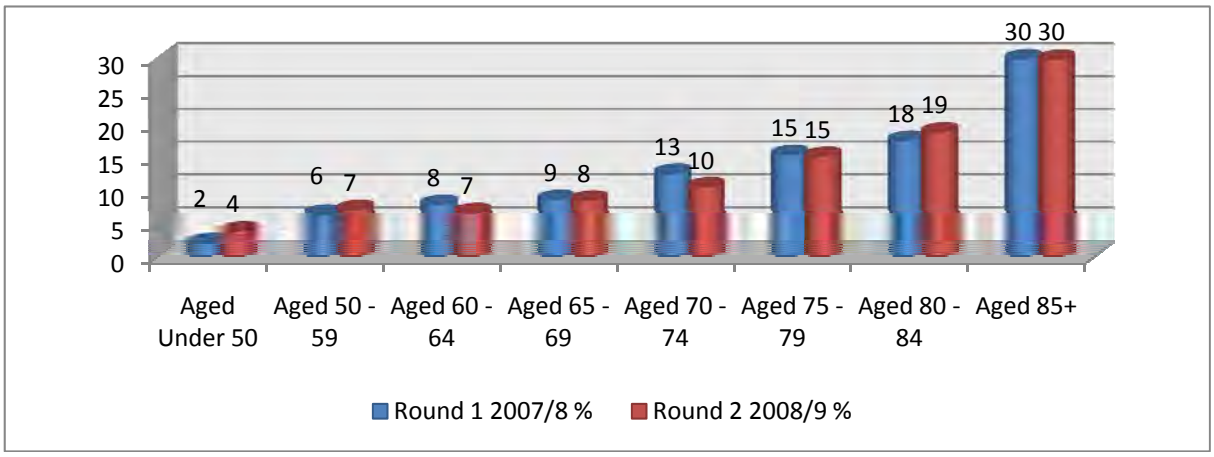


Table 33. Age range by second year of operation

	Second year of operation					
Age range	**Round 1 2007/8**	**Round 1 2007/8 %**	**Round 2 2008/9**	**Round 2 2008/9 %**	**Totals**	**Total %**
Aged Under 50	1174	2	920	4	2094	**3**
Aged 50 - 59	3552	6	1679	7	5231	**6**
Aged 60 - 64	4392	8	1563	7	5955	**7**
Aged 65 - 69	4821	9	2015	8	6836	**8**
Aged 70 - 74	7083	13	2504	10	9587	**12**
Aged 75 - 79	8690	15	3616	15	12306	**15**
Aged 80 - 84	9916	18	4504	19	14420	**18**
Aged 85+	16937	30	7160	30	24097	**30**
Totals	**56565**	**100**	**23961**	**100**	**80526**	**100**

Figure 34. Age range by years of operation



4.7.3 Summary of age ranges across the POPP programme

A summary of the balance of age ranges can be seen (Table 34 and Table 35, Figure 34 and Figure 35), demonstrating that over two-thirds of those involved within the POPP projects were aged 70 and over in the first year (69%), compared to three quarters (75%) in the second year of operation. With respect to 'older old', a fifth of users were aged 85 and over in the first year of operation, compared with almost a third (30%) in the second.

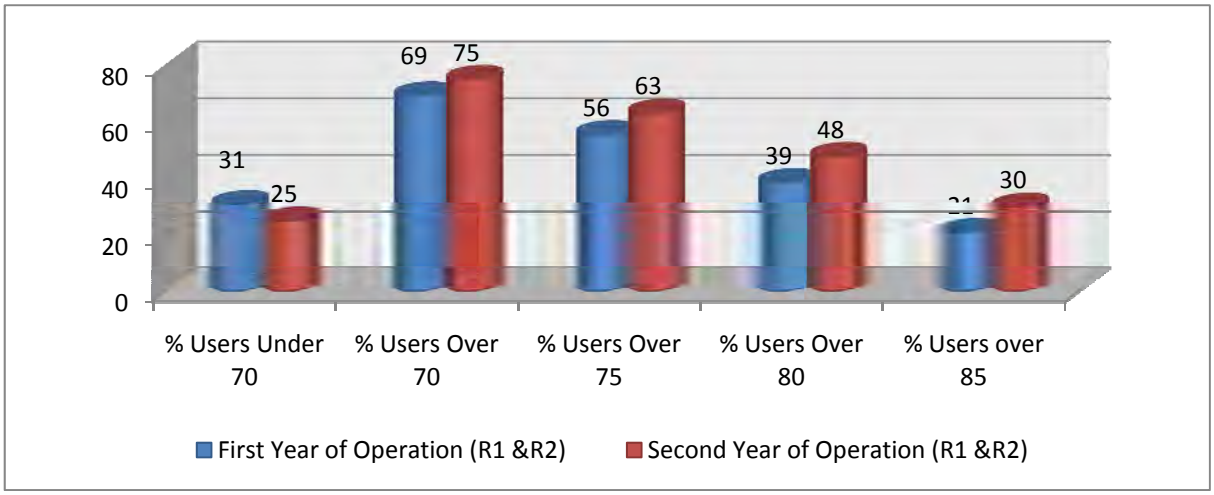
Table 34. Age range by first year of operation

First year of operation: Rounds 1 & 2	
Age range totals	**Total %**
% Users under 70	31
% Users over 70	69
% Users over 75	56
% Users over 80	39
% Users over 85	21

Table 35. Age range by second year of operation

Second year of operation: Rounds 1 & 2	
Age range totals	**Total %**
% Users under 70	25
% Users over 70	75
% Users over 75	63
% Users over 80	48
% Users over 85	30

Figure 35. Age range by years of operation



It can be argued that such changes are due to differences in project activity within the first and second years. In the first year of operation, both Round 1 and Round 2 projects reported (in the Key Informant Questionnaires and interviews) that developing project specification documents, together with tendering and recruitment, delayed set-up of the more formal projects focused toward higher levels of need. Such projects were more likely to be targeted toward the 'older old'. As such projects were implemented, a greater number of users within the older age ranges began to use the services.

4.8 Age ranges of users by needs levels & community & hospital facing

It would be expected that the 'older' old would use those projects categorised as needs level 3 or those services providing specialist support. From an analysis of activity by needs levels, it can be seen that those aged 80 and above are more likely to be within such projects (see Table 36, Figure 36, Table 37 and Figure 37).

Table 36. Age range by needs levels over full three years

	Full three years of operation: Rounds 1 & 2		
Age range	**Needs level 1**	**Needs level 2**	**Needs level 3**
Aged under 50	2	2	2
Aged 50 - 59	8	5	3
Aged 60 - 64	13	6	5
Aged 65 - 69	10	8	6
Aged 70 - 74	13	10	11
Aged 75 - 79	21	15	14
Aged 80 - 84	14	18	24
Aged 85+	20	36	36
	100	**100**	**100**

Figure 36. Age range by needs levels over full three years

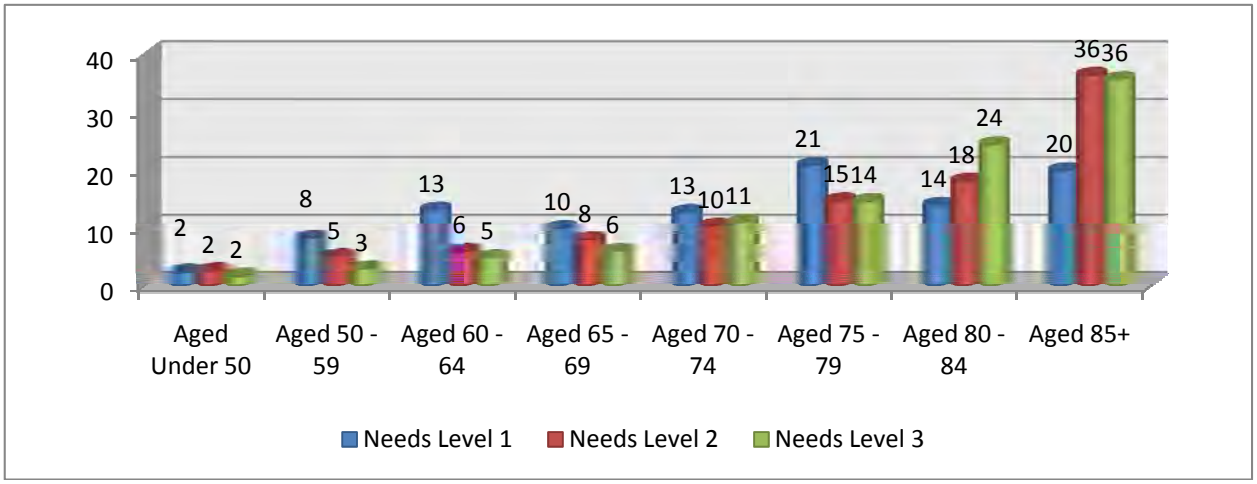
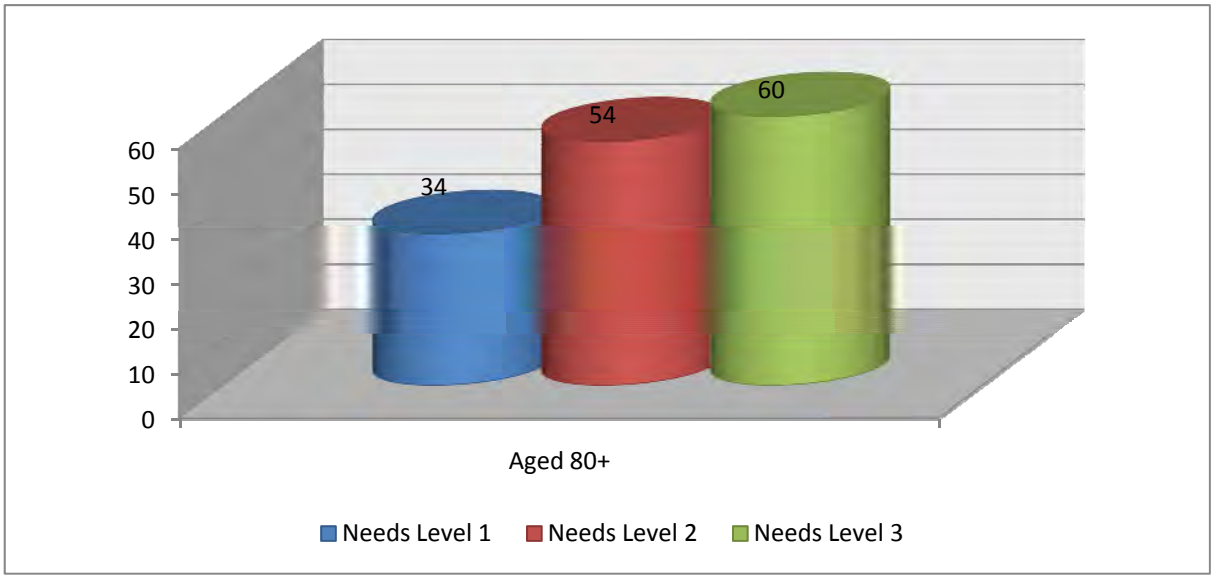


Table 37. Users aged 80 and over by needs levels over full three years

	Full three years of operation: Rounds 1 & 2		
Age range	**Needs level 1 (%)**	**Needs level 2 (%)**	**Needs level 3 (%)**
Aged 80+	34	54	60

Figure 37. Users aged 80 and over by needs levels over full three years



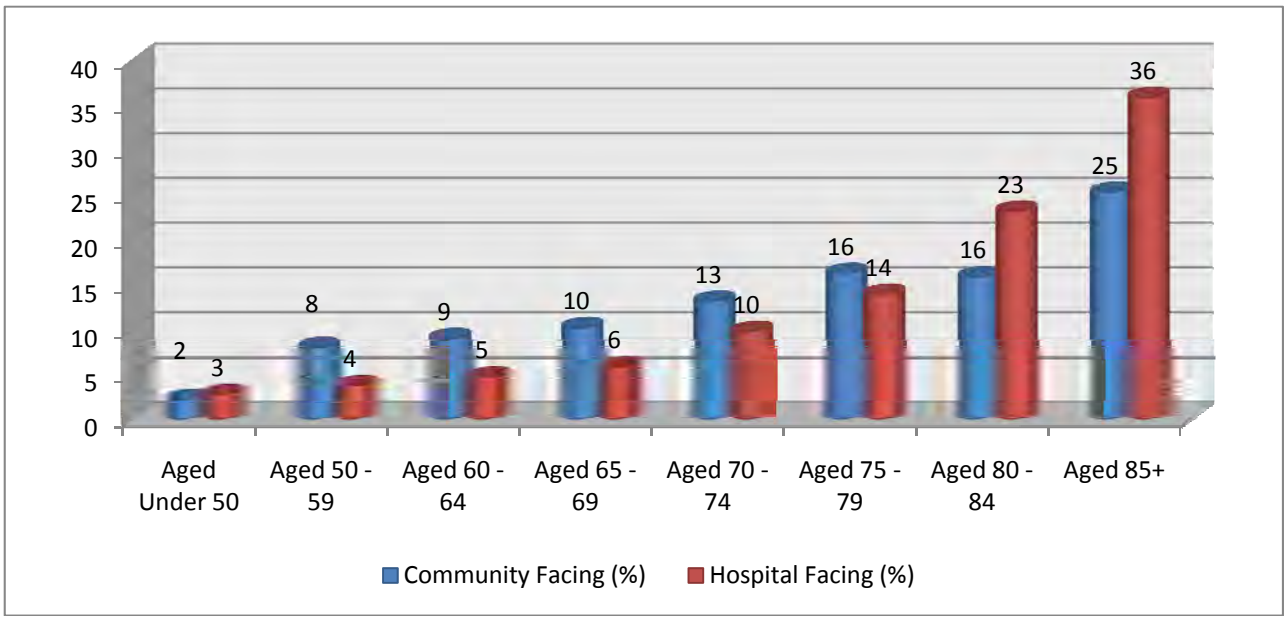
Nonetheless, a third of users aged 80 and over were also in receipt of 'universal services' or Needs Level 1, suggesting that services solely focused toward prevention are being used by the total older person population, not just those in the younger age groups.

Such a picture is reinforced if the division of Community Facing and Hospital Facing projects is analysed by age ranges. Through the full two-year operation, it can be seen that, perhaps not surprisingly, there was a higher number of older users within those projects categorised as Hospital Facing (see Table 38 and Figure 38).

Table 38. Age range of users by community and hospital facing

	Rounds 1 & 2: two years of operation	
	Community facing (%)	**Hospital facing (%)**
Aged under 50	2	3
Aged 50 - 59	8	4
Aged 60 - 64	9	5
Aged 65 - 69	10	6
Aged 70 - 74	13	10
Aged 75 - 79	16	14
Aged 80 - 84	16	23
Aged 85+	25	36
Totals	**100**	**100**

Figure 38. Age range of users by community and hospital facing

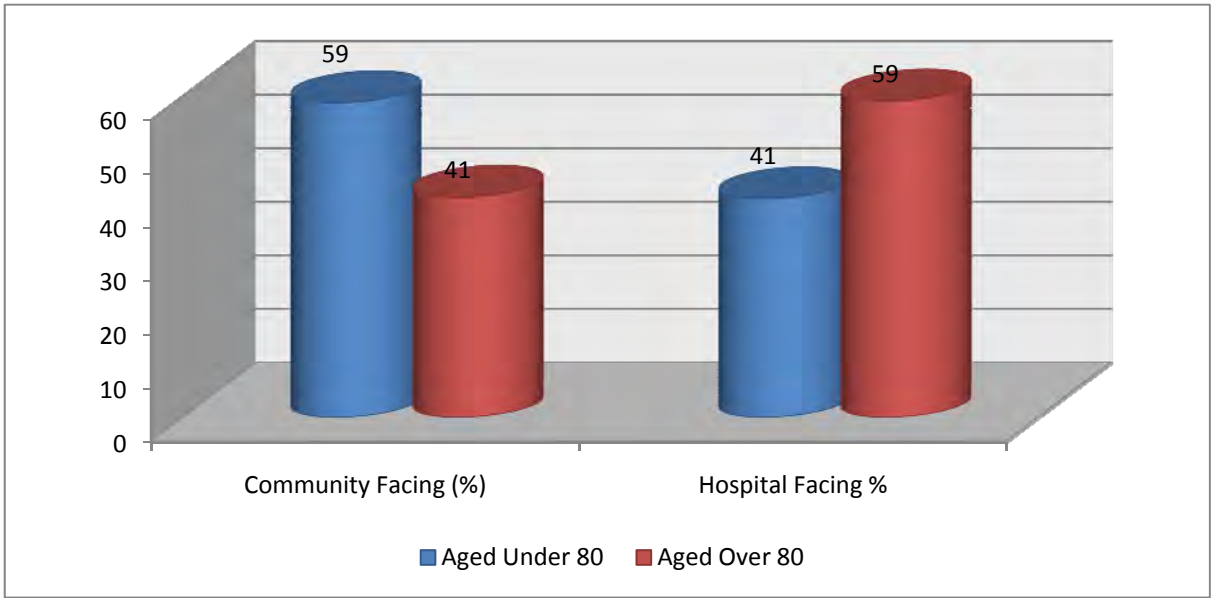


From Table 39 and Figure 39, it can be seen that users aged 80 and over make up almost 60% of the population of Hospital Facing projects, compared with 41% in Community Facing projects. Despite this differentiation, this latter figure is still high, indicating that older users were using the full panoply of services and did not confine themselves to those projects offering a more medical model of support.

Table 39. Users aged under 80 and 80 and over by community and hospital facing

Rounds 1 & 2: two years of operation		
Age Ranges	**Community facing (%)**	**Hospital facing %**
Aged under 80	59	41
Aged 80 and over	41	59

Figure 39. Users aged under 80 and 80 and over by community and hospital facing



4.9 Referral on

The pilot sites reported on individuals' 'service pathway' by recording aggregate data on the number of users referred on either within the local POPP programme (i.e. to other projects) or outside to the wider health, social and third sector economy (e.g. GP, health professional, other voluntary organisation etc).

4.9.1 Referral on: overarching data

In exploring the overarching data, it can be seen that the referral rates range from 15% to 26%. It should, however, be remembered that in the first year (2006/7), only Round 1 of the POPP pilot sites was in operation, while in Year 3, fewer projects were reported, as many had either completed their piloting or had moved into mainstream funding.

Table 40. Referral on by year of operation

POPP time-frame	Total number of users	Total number 'referred on'	% users by referral
2006/7	13659	2018	15
2007/8	99988	25732	26
2008/9	150990	27335	18

To obtain a more accurate picture, it is necessary to examine the two full years of operation by the pilot site 'waves'. Separating out Round 1 and Round 2 data, it can be seen that there was a striking initial difference in the first year of operation in the proportions of individuals 'referred on' from Round 1 (15%), compared with Round 2 (49%).

Table 41. Referral on by first year of operation

Round 1 & 2: First year of operation			
Pilot site 'round'.	**Total number of users**	**Total number of users 'referred on'**	**Total % of user x referral**
Round 1	13659	2018	15
Round 2	8822	4305	49
Totals	22481	6323	28

It is difficult to put forward a compelling reason for such differences. If the numbers of projects are analysed alongside the number of users, there is little proportional discrepancy. Similarly, if the number of projects by Needs Level is examined, Round 1 has slightly greater numbers of projects within Specialist Services or Needs Level 3 (see Table 42) that might be expected to lead to greater, rather than fewer, referrals.

Table 42. Referral on by needs level, first year of operation

First year of operation		
Needs levels	**Round 1 projects %**	**Round 2 projects (%)**
Needs level 1	35	42
Needs level 2	38	42
Needs level 3	27	17
	100	**100**

The argument that Round 1 projects were slightly more delayed in their implementation than those in Round 2 may explain the variance. If the 'referral-on' figures in the second year of operation are considered, there is no difference between the referral rates of Round 1 or Round 2, both referring a quarter of their users on to other services.

Table 43. Referral on by second year of operation

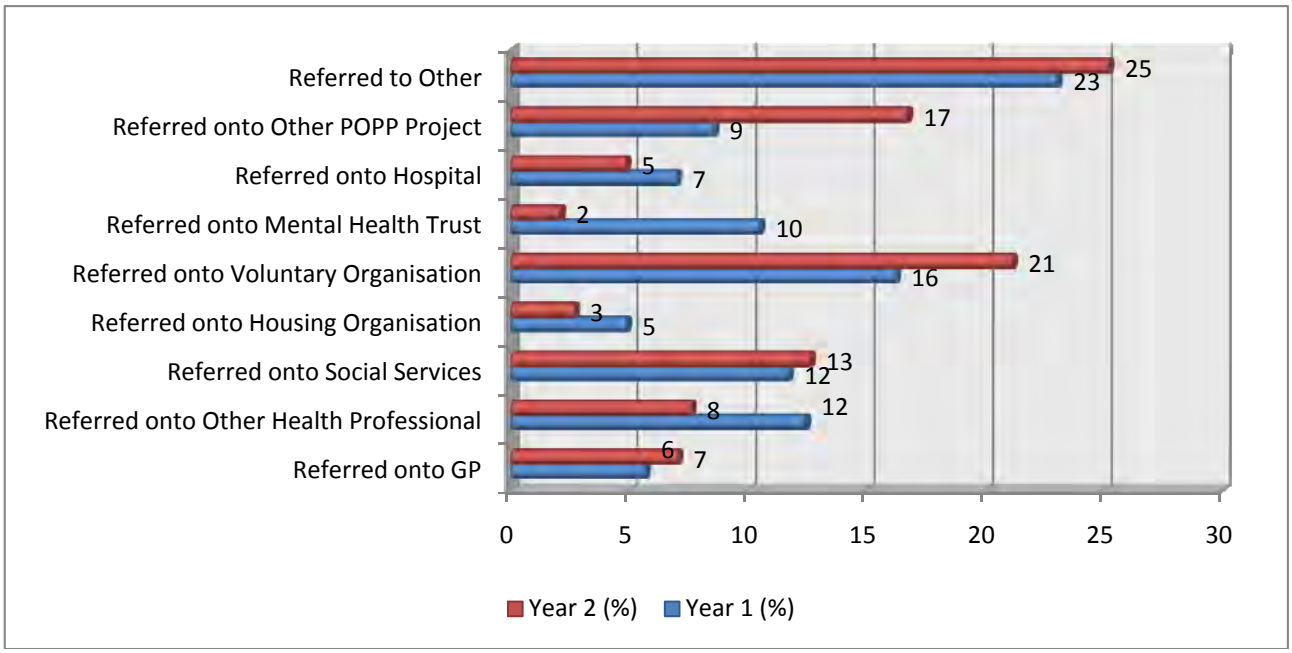
Second year of operation			
Pilot site 'round'	**Total number of users**	**Total number of users 'referred on'**	**Total % of user x referral**
Round 1	91166	21427	24
Round 2	33489	8455	25

The services to which users are referred on will obviously depend on their physical, emotional or social need. The referral pattern across the two years remained relatively stable (see Table 44 and Figure 40), with variation found in only two areas: referral to other voluntary organisations and to a further POPP project within the local programme.

Table 44. Referral on by service

	Rounds 1 & 2	
'Service' referred on to	**Year 1 (%)**	**Year 2 (%)**
Referred on to GP	6	7
Referred on to other health professional	12	8
Referred on to social services	12	13
Referred on to housing organisation	5	3
Referred on to voluntary organisation	16	21
Referred on to mental health trust	10	2
Referred on to hospital	7	5
Referred on to other POPP project	9	17
Referred on to other	23	25

Figure 40. 'Referral on' by service



That almost a fifth of users (17%) were referred to another POPP project in the second year of operation seems to be an indicator that, as the pilot sites moved from project planning, recruitment and 'bedding-in' their projects, they were able to look outwards to bring the discrete projects together into an overall programme of work:

> *'What we at [Local Pilot Site] have done, is we've got some very different projects that really in the last year they've only started to inter-refer and work out how they fit with each other. The first year was very focused on the individual services and trying to get up and running and I think maybe that was one of the things we recognised as a lesson learnt, that we didn't start that kind of partnership and inter-networking work sooner.'* (Participant 074)

5 Characteristics of respondents to the standardised questionnaire

Key points

- The average (mean) age of service users was 75, with a range of 40 – 101. The age reported by the highest number (mode) of respondents was 79.
- Half the sample (51%) were aged 75 and over with a fifth (21%) aged 85 and over. The sample that completed the standardised questionnaire was slightly younger than the overall POPP population.
- The age at which respondents use particular POPP services differs with levels of deprivation. Individuals in the most deprived areas (quartile 4, Lower Super Output Area) are three to four years younger than their counterparts in the least deprived areas (quartiles 2 & 3, Lower Super Output Areas).
- There were indications that POPP project users in the most deprived areas (quartile 4, LSOA) were eighteen years younger than their counterparts in the most affluent areas (quartile 1, LSOA).
- The extent of service use is affected by levels of deprivation: People in areas of highest deprivation reported higher use of secondary care services.
- When exploring the 'take-up' of services between men and women, fewer men (1:3) are using services that address the lower level needs than those focused toward specialist support (1:1). Whether this pattern arises from differences in equity of access, suitability of services, individual choices or attitudes to support services – all leading men to enter services later than women – is unclear.
- Roughly one-third was married (33%), with the remainder widowed, separated, divorced or single.
- The great majority (81%) lived in their own homes (or that of a relative), but almost a fifth (19%) lived in sheltered housing, residential or nursing care homes.
- Almost three-quarters (72%) of the respondents reported an income of less than £249 per week - £100 less than the median weekly income for couples under 75. Those individuals who lived alone reported lower levels of income, with over half reporting an income of less than £149 per week.

5.1 Introduction

This section sets out data on the characteristics of the respondents to the POPP standardised questionnaire, with particular attention to their age, gender, marital status, living arrangements, income and ethnicity. The questionnaire was administered to people across 62 projects in 25 of the POPP pilot sites at two time points; prior to their contact with the particularly project and following such contact. The background and structure of this questionnaire (pilot sites, variance, difficulties and range) are discussed in the Section 2 and such considerations are repeated here only if they assist in understanding key results.

In addition to describing the characteristics of the whole population as an overview, differences are noted across four different categorisations, which become important to the subsequent analysis of outcomes and cost-effectiveness (See sections 6 and 7). The findings from the final section of the standardised questionnaire, the Client Services Receipt Inventory (Beecham & Knapp 1992), are explored in Section 7.5 (impact on the wider health and social care economy).

Within these two sections, findings are presented in four 'tranches'. First, the results from the full sample are set out. As previously discussed, marked differences in the range of the projects, along with internal variance within and across the projects and the need to unpack what 'works', necessitated developing specific analytical sub-groups: the specific focus of projects (project typologies), the needs levels to which they were addressed and the assignment of whether each project is Community facing or Hospital Facing. These categories are set out in full in section 3 and are summarised here for convenience.

5.2 Age range: overarching sample

5.2.1 Introduction

Data on the ages and age ranges of service users are drawn from the administration of the questionnaire prior to the project. Any change in age from the first to the second questionnaire would be negligible, given that the time-frame of administration ranged between seven weeks and six months (see Table 45).

Table 45. Time-frame of administration of questionnaire

Administration time-frame	N	%
6 months (between T1 & T2)	858	56.1
4 months (between T1 & T2)	41	2.7
3 months (between T1 & T2)	372	24.3
2 months (between T1 & T2)	203	13.3
10 weeks (between T1 & T2)	7	0.7
7 weeks (between T1 & T2)	10	2.5
6 weeks (between T1 & T2)	38	0.5

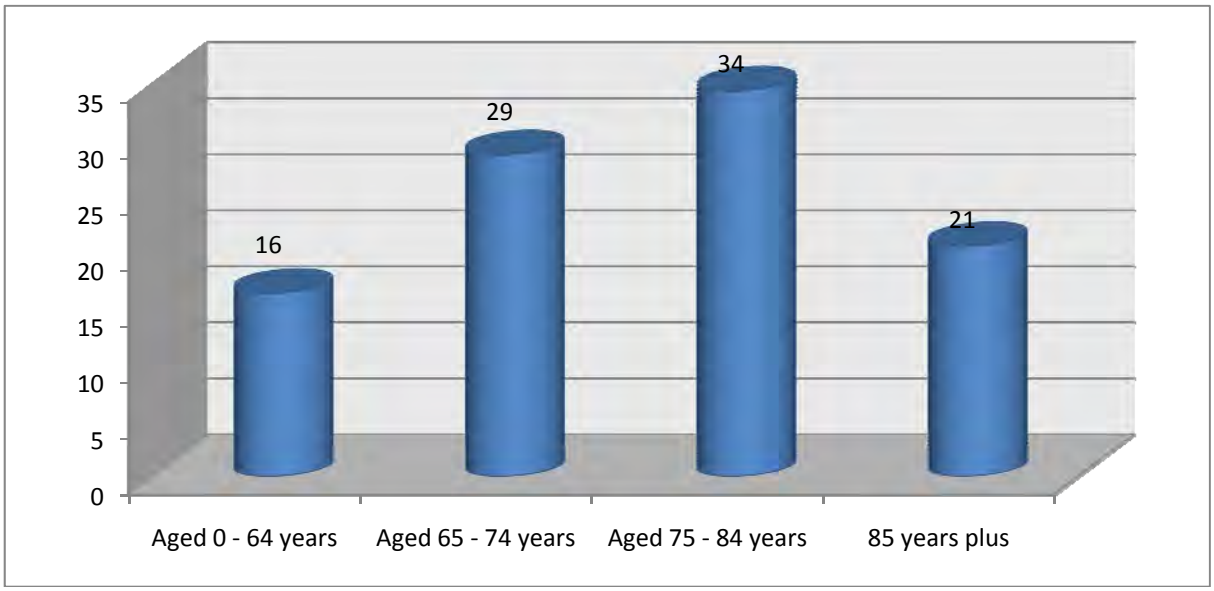
5.2.2 Findings

The mean age of participants was 75 years of age (sd 10 years), the median (mid-point) was 76, and the mode (the age reported by the highest number of participants) was 79. The reported range of ages was between 40 and 101 (61 years).

Table 46. Age range of sample

Age range	%
Aged 0 - 64 years	16
Aged 65 - 74 years	29
Aged 75 - 84 years	34
85 years plus	21
Totals	100

Figure 41. Age range of sample



Over half the sample, (51%), was aged 75 and over, and almost a third (29%) aged 65 to 74. Comparing participants' age across the period of the POPP programme, in the first year, 56% of users were aged 75 and over, whilst in the second year this had risen to 63% (see Section 4). The sample that completed the standardised questionnaire is somewhat younger than the overall sample, perhaps not surprisingly as by necessity the most common administration method was self-completion (see Table 47).

Table 47. Method of completing standardised questionnaire, pre-intervention

Method of completing the standardised questionnaire	Time 1 (pre-intervention)
Questionnaire is being completed by myself	56
Questionnaire is being completed with help from family/friend	19
Questionnaire is being completed as part of a telephone interview	2
Questionnaire is being completed as part of an interview	21
Questionnaire is being completed with one of local service team	3

As previously argued (see Section 2), it is not possible to extrapolate the findings across the full programme, given the type of sampling, the small numbers within projects and demographic spread. Indeed, differences in these comparison data (standardised questionnaire and overall activity) emphasise the necessity to be cautious about any wider interpretation.

5.3 Age ranges within the sub-group of project categories

5.3.1 Introduction

As noted above, because of the very different range and focus of projects, merely presenting outcomes from the overarching sample cannot provide an appropriate indication of the impact of the POPP programme. Projects were therefore grouped according to their specific focus. From Table 48 it can be seen that 11 categories were developed.

Table 48. Focus of projects

Category number	Project focus	Number of projects	Number of 'matched' responses
1	Well-Being - Practical	9	119
2	Well-Being - Emotional/Social Isolation	16	244
3	Well-Being – Physical Health	4	53
4	Well-Being - Geographical	6	188
5	Information, Sign-posting and Access	5	91
6	Proactive Case Co-ordination	8	444
7	Long-term Conditions – Complex Care	4	154
8	Long-Term Conditions – Hospital Discharge	2	37
9	Specialist Falls	5	94
10	Involving Older People	2	55
11	Supporting Carers	1	22
	Totals	**62**	**1501**

The first four categories encompass lower-level, 'upstream' initiatives focused on improving well-being, either through providing a direct service (e.g. handyman scheme) or through employing outreach workers to work with local communities to identify, implement and develop locally based support services. Well-being itself is a multi-factorial concept and is therefore further broken down into four sub-areas. ***Well-Being-Practical*** consists of 10 projects that include small housing repairs, gardening, limited assistive technology and shopping. ***Well-Being – Emotional/Social,*** incorporates lunch-clubs, 'hobby' or 'educational based' classes (e.g. photography or computer classes), specific BME-focused social centres and those services providing lower level 'talking therapies'. ***Well-Being – Physical*** **Health'**, involves time-limited (e.g. eight to ten weeks) exercise classes, focused either toward improving overall health or with a rehabilitation focus (e.g. stroke association classes). ***Well-Being – Geographical*** comprises a mixture of projects: direct interventions to specific localities as well as projects that set up neighbourhood schemes, strengthening and taking forward inclusive communities. The fifth category, ***Information and Signposting,*** includes four projects that range from a single access point for information on social care and health to peripatetic information workers carrying out face-to-face home-based contacts with users, exploring their needs and building action plans users could then put in place. Within the three categories ***Proactive Case Co-ordination, Complex Care and Hospital Discharge***, the 14 projects are all focused on those users with higher level needs. Projects range from the identification of those at risk of admission/re-admission (PARR tool); clinical nursing staff supporting and treating users within their own home; on-going home based (residential and private) medication reviews; supported hospital discharge arrangements; and integrated social, health and voluntary care teams. Those projects within the POPP programme providing rehabilitative interventions within ***Specialist Falls*** prevention programmes were grouped together. So, too, were those ***Involving Older People,*** with a primary

focus on the training of older people to participate in statutory service planning and design, influence key policy and strategy, or provide community peer support. The final category was projects focused on ***Supporting Carers***, either through time-limited support of the individual cared for, or by the provision of specific courses, working with carers to enable more effective coping strategies.

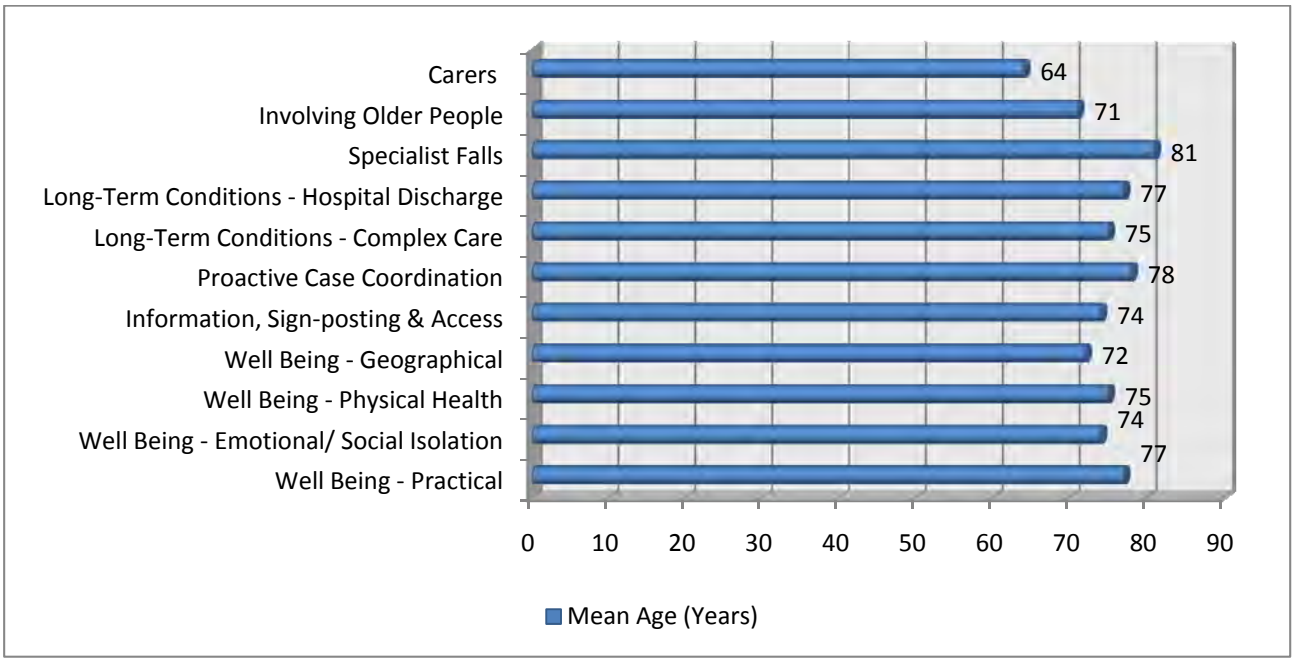
5.3.2 Findings

The mean ages of participants varied with the focus of the service in which they were involved (see Table 49 and Figure 42). Perhaps not surprisingly, the lowest mean age of participants was found among Carers (mean age of 64), whilst the highest was the category of Specialist Falls. In looking at the 'upstream' initiatives, it can be seen that these were not solely targeted at or provided to the younger age groups, with a spread across the age range. Such findings support the recognition that low-level services are not necessarily being provided to those with low-level needs. The range of ages also demonstrates the variance within and across projects. For example, in the category of Well-being social/emotional', the participants were aged between 40 and 101 years – a 61 year range. Similarly, within the category of Information and Signposting, there is a 50 year range. Given such ranges, the changes in HRQoL and overall QoL are likely to be affected by differences in individual characteristics, making it difficult to propose which type of service user benefited most from the pilot project.

Table 49. Age range of participants by focus of project

Project category	Mean age (years)	Range (years)	Standard deviation (years)
Well Being - Practical	77	50 -91 (41)	9
Well Being - Emotional/Social Isolation	74	40 -101 (61)	13
Well Being - Physical Health	75	56 - 94 (38)	10
Well Being - Geographical	72	55 - 90 (35)	9
Information, Sign-posting & Access	74	42 - 92 (50)	10
Proactive Case Co-ordination	78	48 - 99 (51)	9
Long-Term Conditions - Complex Care	75	41 - 97 (56)	12
Long-Term Conditions - Hospital Discharge	77	52 - 89 (37)	10
Specialist Falls	81	60 - 96 (36)	8
Involving Older People	71	52 - 93 (41)	9
Carers	64	45 - 81 (36)	8

Figure 42. Age range of participants by focus of project



Some differences in the mean ages were found to be statistically significant, when compared across categories (F-test and post-hoc Scheffe). For example, those individuals identified as receiving services in the category of Well-being-emotional were 12 years older than those receiving Carers Services (p=0.000, CI 3.11, 22.29). Similarly, users within the category of Well-being-emotional/social isolation were four years younger than those using services within Proactive Case Co-ordination (p=0.001 CI -7.66, -1.01) and 10 years older than those using Carers Services (p=0.013 CI .97 – 19.35).

5.4 Age ranges within the needs levels

5.4.1 Introduction

A further categorisation of projects addressed variations in the needs levels at which they were targeted (see Table 50 and discussion in Section 3).

Table 50. Description of levels of need

Level of need	Description
Universal services: level 1	• Low-level, up-stream community orientated interventions • Universal services available to all older people within the locality of the POPP programme • Examples include: gardening/handyperson schemes, crime prevention, learning (e.g. computers or photography), leisure, signposting services
Additional support level 2	• Higher level of services to support older people who are 'at risk' of admission • Examples include: medicines management, follow-up falls services, holistic assessments, mentoring, falls prevention
Specialist support level 3	• Those services targeted to support older people at serious risk of imminent hospital admission • Examples include: community rapid response teams, hospital at home/intensive support teams, case management

The number of projects and users within each category can be seen in Table 51. It can be noted that there was only a very small sample within those projects categorised as Specialist Support, necessarily affecting findings of statistical significance. This becomes more important when the key outcomes of health-related quality of life and self-reported quality of life are explored (see Section 6).

Table 51. Levels of need by focus of projects and number of users

Level of need	Number of projects	Number of users
Universal services: level 1	36	813
Additional support: level 2	22	668
Specialist support: level 3	4	48
Totals	**62**	**1529**

5.4.2 Findings

In examining the mean ages across the different needs levels (see Table 52), it can be seen that the differences are far smaller than those found in the when projects are categorised by typology. The mean age of users within Universal Services is 74, compared with 78 within Additional Support Services and 76 in Specialist Support. It is perhaps counter-intuitive that those in the last group, with the highest level of need, are younger than those 'at risk' of admission. The age differences were found to be statistically significant between Universal Services and Additional Support (F-Test & post hoc Scheffe, p=0.000, CI -4.86, -2.29), although no statistically significant differences were found between the ages of Specialist Support and the other categories.

Table 52. Levels of need by age range of users

	Mean age (years)	Range between ages (total range)	Standard deviation (years)
Universal services: level 1	74	40 - 101 (61)	10
Additional support: level 2	78	41 - 99 (58)	10
Specialist support: level 3	76	52 - 91 (39)	10

Such patterns have been found in prior research (e.g. see Marmot & Wilkinson 1999), where it is psycho-social determinants (income, health-related behaviours, social exclusion etc), that affect service use throughout the life course, if there is no mitigation of such effects. One way of exploring the impact of overarching deprivation is through the Index of Multiple Deprivation (IMD). Scores represent the overall measure of deprivation in any local authority area and are calculated using the following criteria:

- income deprivation
- employment deprivation
- health deprivation and disability
- education, skills and training deprivation
- barriers to housing and services
- living environment deprivation and crime.

A lower average score demonstrates low levels of deprivation, whilst a higher score demonstrates higher levels of deprivation. Within the standardised questionnaire, the IMD scores were calculated at the lower super output area (LSOA) level (ODPM 2004). There are 34,378 LSOAs in England and in this case, the ranks are reversed. The most deprived SOA is given a rank of 1 and the least deprived a rank of 32,482 (Noble et al 2008)

In exploring the impact of age on receipt of services, it can be seen from Table 53 that those individuals within the most deprived quartile of the LSOA (see 6.11 below) are three (2.817) to four years (3.797) younger than their counterparts in the two higher quartiles (p=<0.05).

Table 53. Impact of age on receipt of services

Age (Scheffe)				
(I) IMD ranks by quartiles	**(J) IMD ranks by quartiles**	**Mean difference (I-J)**	**Std. error**	**Sig.**
1st quartile	2	-1.349	.674	.261
	3	-2.817*	.730	.002
	4	-3.797*	.939	.001

When examining the ages of those service users living within the most deprived LSOA and receiving services within level 3, there were indications that users were far younger (18 years) than their counterparts in the most 'affluent' areas (Level 4). Care needs to be taken in interpreting this finding, as it is not statistically significant (p=0.08).

5.5 Age ranges and community & hospital facing projects

5.5.1 Introduction

The final categorisation used to explore projects is a simple dichotomy. The projects were coded as either primarily Hospital Facing, focused on and located within acute or predominantly health care services, or Community Facing, involved with improving community engagement and developing community-based services. It can be seen from Table 54 that less than a fifth of the projects were Hospital Facing (18% or 11). Similarly, almost three-quarters of the respondents to the standardised questionnaire received services from those projects designated as Community Facing (73%, 113).

Table 54. Project type by number of projects and users

Project type	**Projects, number (%)**	**Users, number (%)**
Community facing	51 (82)	1113 (73)
Hospital facing	11 (18)	416 (27)
Totals	**62**	**1529**

5.5.2 Findings

The age differences across these two categories are pronounced. Table 55 shows that the mean age for those individuals in Community facing projects was 75 years, compared with 78 years for those in Hospital Facing projects.

Table 55. Project type by age range of users

	Mean age (years)	Range between ages (total range)	Standard deviation (years)
Community facing	75	40 – 100 (61)	10
Hospital facing	78	41 – 99 (58)	10

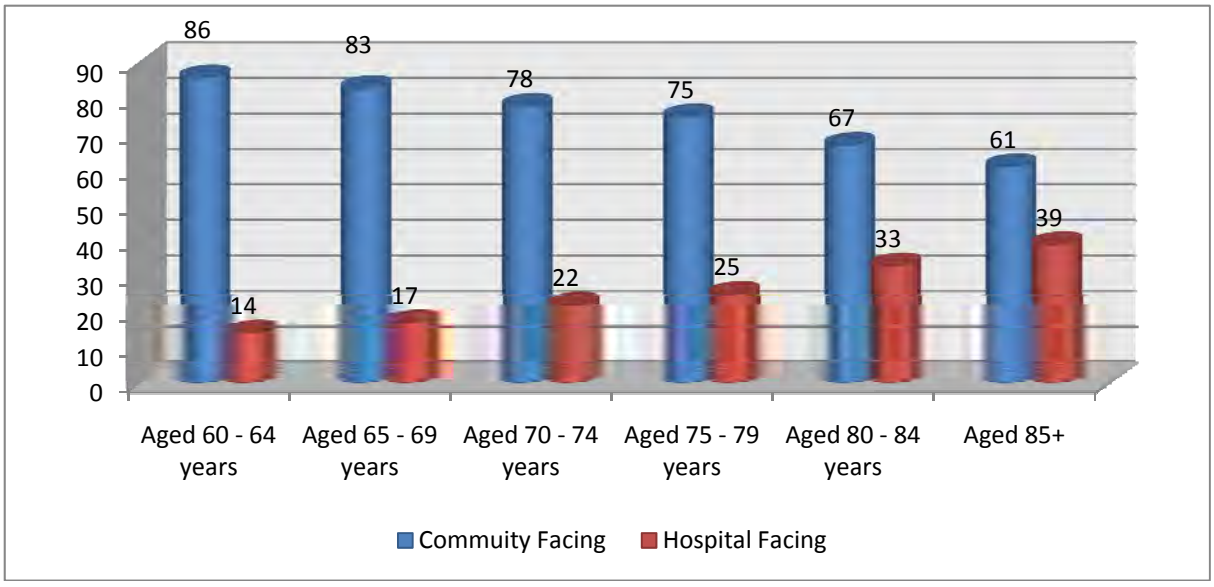
t(df=1491)=-5.47, p=.000 (p<.001)

These findings are not particularly surprising. As known from prior research, hospital admissions increase significantly as patients age (e.g. see Cove et al 2006, Downing & Wilson 2005, Bentley & Meyer 2004, Richardson 1992) and a greater number of older users within Hospital Facing projects should be expected, where the focus is reduction of admission, either to hospital or to residential care. As can be seen from Table 56 and Figure 43, the number of participants involved with Hospital Facing projects rose incrementally with age.

Table 56. Focus of projects by age range of users

Age range	Community facing (number of users, % of users within category)	Hospital facing (number of users, % of users within category)
Aged 60 - 64 years	101 (86%)	16 (14%)
Aged 65 - 69 years	160 (83%)	34 (17%)
Aged 70 - 74 years	191 (78%)	55 (22%)
Aged 75 - 79 years	194 (75%)	66 (25%)
Aged 80 - 84 years	177 (67%)	87 (33%)
Aged 85+	194 (61%)	122 (39%)
Totals	1017	380

Figure 43. Focus of projects by age range of users



5.6 Sex of users

Among the full set of users completing the standardised questionnaire, approximately two-thirds (70%) were women and one-third (30%) were men. Such findings mirror general service use for older people (e.g. see Glendinning et al 2008).

Table 57. Participants by gender

Sex of participants	Number	%
Male	450	30
Female	1062	70
Total	**1512**	**100**

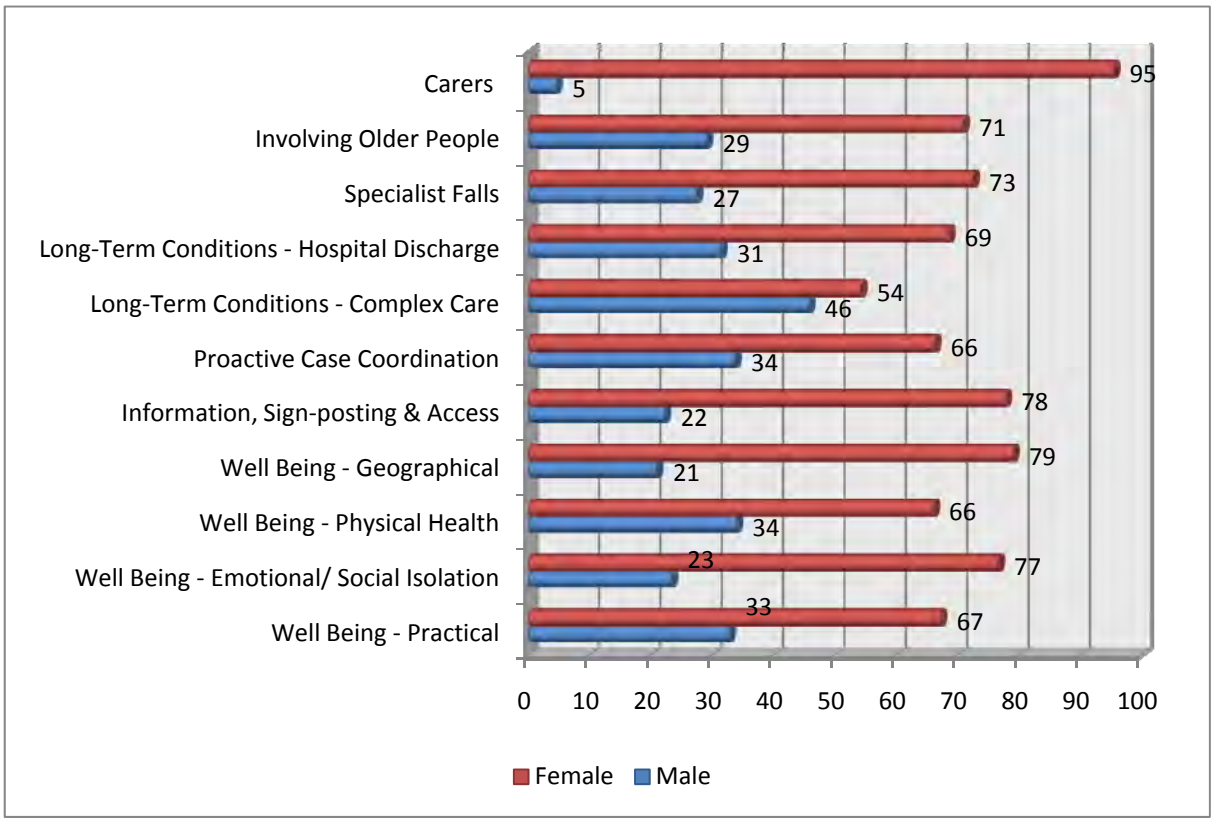
This division changes, however, when the project focus categories are examined (see Table 58 and Figure 44). It can be seen that the broad two-thirds-one third division holds only for two categories of Well-being: practical and physical health, and Proactive Case Co-ordination and Hospital Discharge. In other projects, the split varies, so that men make up only one-fifth of the sample of users of Well-being emotional/social isolation, Well-being-Community and Information Signposting and Access. The explanation for such findings may lie in the well-known gender bias in activities concerned to extend social or community contacts. Women are far more likely to join hobby and lunch clubs, and their social networks within any community are slightly higher than those of men. Similarly, given the gender division in caring responsibilities and roles, women may have a greater need for information and advice.

Table 58. Typology of project by gender

Project typology	Male n (%)	Female n(%)	Totals
Well Being - Practical	39 (33%)	80 (67%)	119 (100%)
Well Being - Emotional/Social Isolation	57 (23%)	187 (77%)	244 (100%)
Well Being - Physical Health	18 (34%)	35 (66%)	53 (100%)
Well Being - Geographical	39 (21%)	147 (79%)	186 (100%)
Information, Sign-posting & Access	20 (22%)	70 (78%)	90 (100%)
Proactive Case Co-ordination	147 (34%)	289 (66%)	436 (100%)
Long-Term Conditions - Complex Care	70 (46%)	83 (54%)	153 (100%)
Long-Term Conditions - Hospital Discharge	11 (31%)	24 (69%)	35 (100%)
Specialist Falls	25 (27%)	66 (73%)	91 (100%)
Involving Older People	16 (29%)	39 (71%)	55 (100%)
Carers	1 (5%)	21 (95%)	22 (100%)

$X^2 = 43.945$, d$f = 10$, p =0.000

Figure 44. Category of project by gender

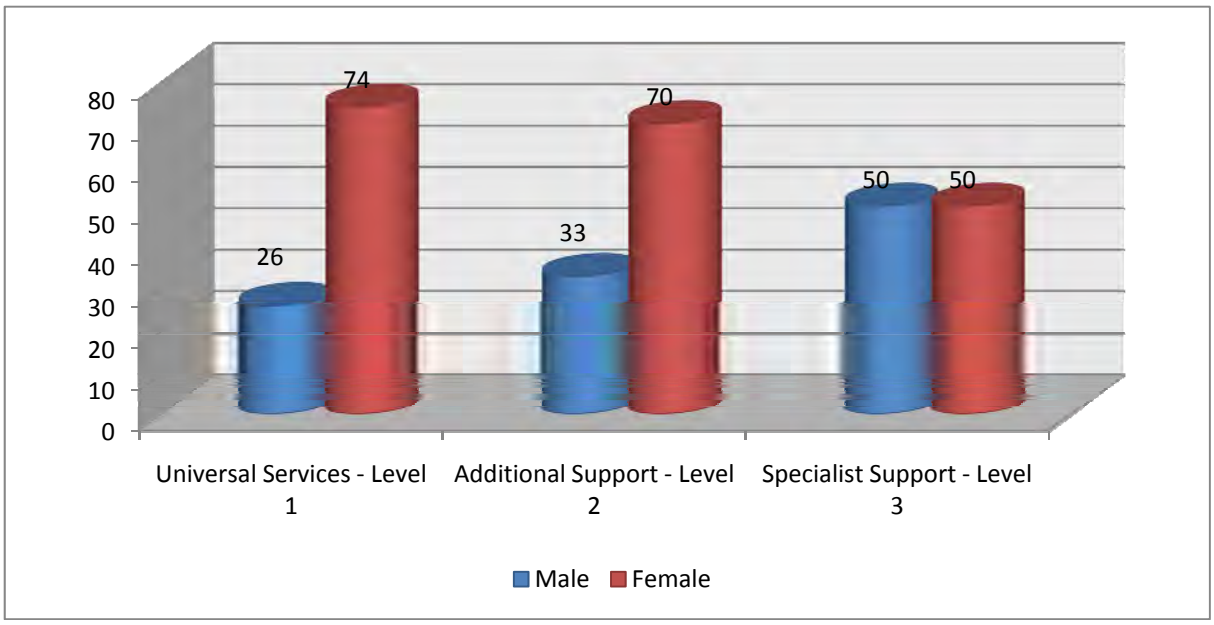


A further rationale is suggested when the gender division is examined across needs levels (see Table 59 and Figure 45). As services become more focused toward admission avoidance (Additional support, Specialist support), the gender ratio becomes increasingly balanced.

Table 59. Level of need by gender

Needs levels'	Male n (%)	Female n (%)	Totals n, (%)
Universal services - level 1	209 (26%)	598 (74%)	813 (100%)
Additional support - level 2	218 (33%)	441 (70%)	668 (100%)
Specialist support - level 3	23 (50%)	23 (50%)	46 (100%)

Figure 45. Level of need by gender



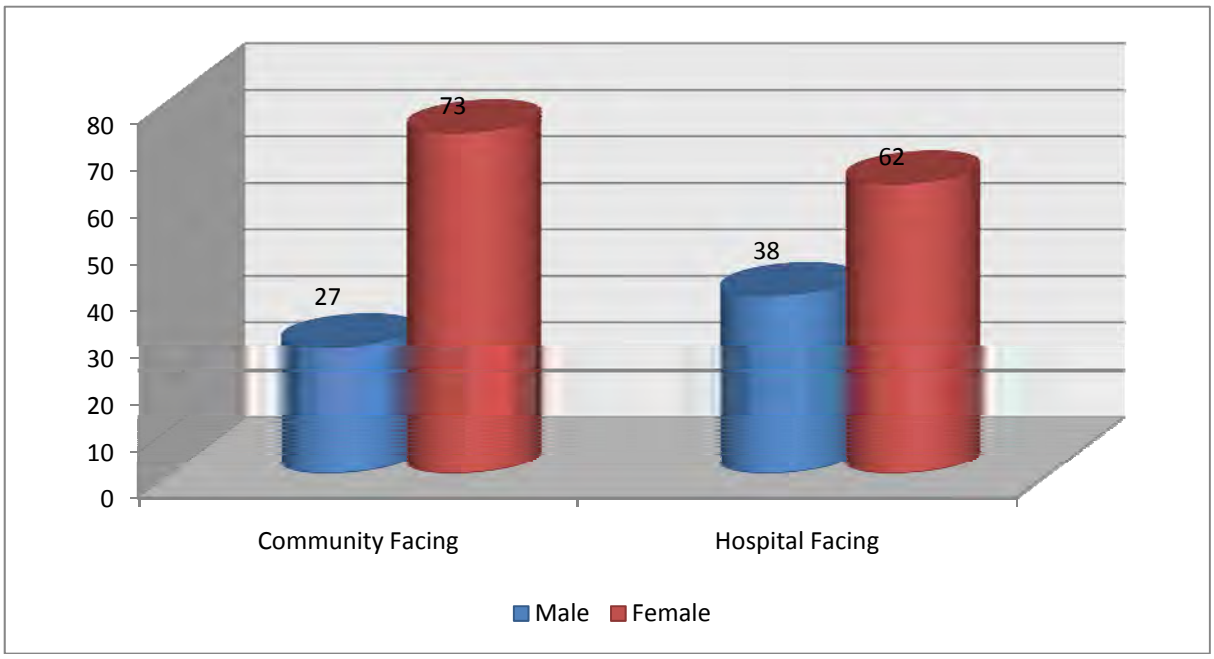
The above findings are partially reinforced through an examination of Community-Facing and Hospital-Facing projects (Table 60 and Figure 46). Here, we move from almost three-quarters of female users (73%) within Community Facing projects to under two-thirds (62%) within Hospital Facing projects.

Table 60. Focus of project by gender

Project focus	Male n (%)	Female n(%)	Totals n, (%)
Community facing	294 (27%)	811 (73%)	1105 (100%)
Hospital facing	156 (38%)	251 (62%)	407 (100%)

Fisher's Exact, p = 0.000

Figure 46. Focus of project by gender



Such sex differences in service use could be argued to be a simple reflection of the population skew: that is, women have a slightly higher life expectancy at age 65 than men, 18.9 years compared with 15.8 (Wanless 2003). Yet when age is analysed against gender, there are indications of a two-thirds/one-third split in the higher age ranges (75 and upwards) compared to the three-quarters/one quarter division in the lower age ranges (see Table 61).

Table 61. Age range by gender

Age range	Males n, (%)	Females (n, %)	Totals
Aged 60 - 64 years	25 (21%)	93 (79%)	118 (100%)
Aged 65 - 74 years	128 (29%)	311 (71%)	439 (100%)
Aged 75 - 84 years	175 (33%)	351 (67%)	526 (100%)
Aged 85 and over	96 (31%)	218 (69%)	314 (100%)

X^2 = 7.112, d*f* = 3, p = 0.06, n.s.

From this analysis, it would seem that fewer men are utilising services that address lower level needs. Whether this pattern arises from differences in equity of access, suitability of services, individual choice or attitudes to support services – all leading men to enter services later than women – is unclear. Such detailed data could not be collected nationally.

5.7 Marital status and bereavement

5.7.1 Introduction

Being within a close and intimate marriage is known to have health and social benefits (Phillipson et al 2001), although *'marriage is generally considered to benefit men rather than women'* (Askham et al 2007). Conversely, bereavement of a spouse can lead to reduced health and psycho-social outcomes and is, not surprisingly, the single most important precursor to loneliness and aloneness

(Victor et al 2002). The marital status of the sample is therefore important to any further analyses of outcomes, such as changes in quality of life. This section sets out the overarching data on marital status/bereavement and explores whether different patterns are seen across the sub groups.

5.7.2 Marital status & bereavement: sample and sub-groups

Within the overall sample, just over one third of individuals were married (35%), with two thirds (64%) being single, widowed, divorced or separated (see Table 62).

Table 62. Marital status

Marital status	%
Single	8
Married	35
Cohabiting	1
Widowed	45
Divorced/Separated	11
Totals	**100**

Of the full sample (1529), 619 individuals had been widowed (45%). Given their age, such a result is not surprising. Three quarters of the sample had been widowed five years or more prior to any POPP intervention (see Table 63).

Table 63. Time since bereavement

Bereavement time-frame	Base-line
Less than six months ago	17 (3%)
Six months, less than a year	18 (3%)
1 year, less than 3 years	62 (10%)
3 years, less than 5 years	60 (10%)
Five years or more	462 (75%)

An analysis of different sub-groups (project typology, needs levels and Community/Hospital Facing) suggests that marital status has an impact on service use. For example, higher numbers of widows/widowers use projects within the categories of Well-being practical, Proactive Case Co-ordination and Hospital Discharge. But this relationship is somewhat spurious: the key factor here is that such widows and widowers live alone.

5.8 Living alone

Previous research has demonstrated that the combination of ageing and living alone heightens risk factors, leading to likely higher service use. For example, patients who live alone and use an A&E service are more likely to be admitted to secondary care, independent of diagnoses, and have a longer length of stay (Cove et al 2006). In the overall POPP sample, of the 1026 individuals who responded to this question, 581, over half the sample (57%), indicated that they lived alone.

Table 64. Participants living alone

Participant reports living alone	Number (%)
Lives alone	581 (57%)
Lives with other(s)	445 (43%)
Totals	**1026 (100%)**

Such living arrangements seemingly affect service use and take up, with those who live alone having a higher service use of Well-Being Practical, Proactive Case Co-ordination, Complex care, Long-term Conditions - Hospital discharge, Involving older people and Specialist Falls.

Table 65. Living arrangements by focus of project

Project category[7]	Lives alone	Lives with others
Well Being - Practical	68 (63%)	40 (37%)
Well Being - Emotional/Social Isolation	63 (46%)	73 (54%)
Well Being - Physical Health	14 (38%)	23 (62%)
Well Being - Geographical	73 (46%)	87 (54%)
Information, Sign-posting & Access	33 (50%)	33 (50%)
Proactive Case Co-ordination	218 (59%)	153 (41%)
Long-Term Conditions - Complex Care	25 (56%)	20 (44%)
Long-Term Conditions - Hospital Discharge	28 (85%)	5 (15%)
Specialist Falls	39 (52%)	36 (48%)
Involving Older People	28 (56%)	22 (44%)

$X^2 = 31.775$, d$f = 9$, p = 0.000

It would seem that those individuals who live alone do, in the main, have a higher take up of higher-level services, compared to those who live with a spouse/friend or family member. When the projects are grouped into the triadic needs levels (see Table 66 and Figure 47), there is some indication of difference: the use of services moves from an equal division within Universal Services (Level 1), to an almost two-thirds (62%)-one third split within those services offering support to those individuals at immediate risk of hospital or residential care admission (Specialist Support – Level 3).

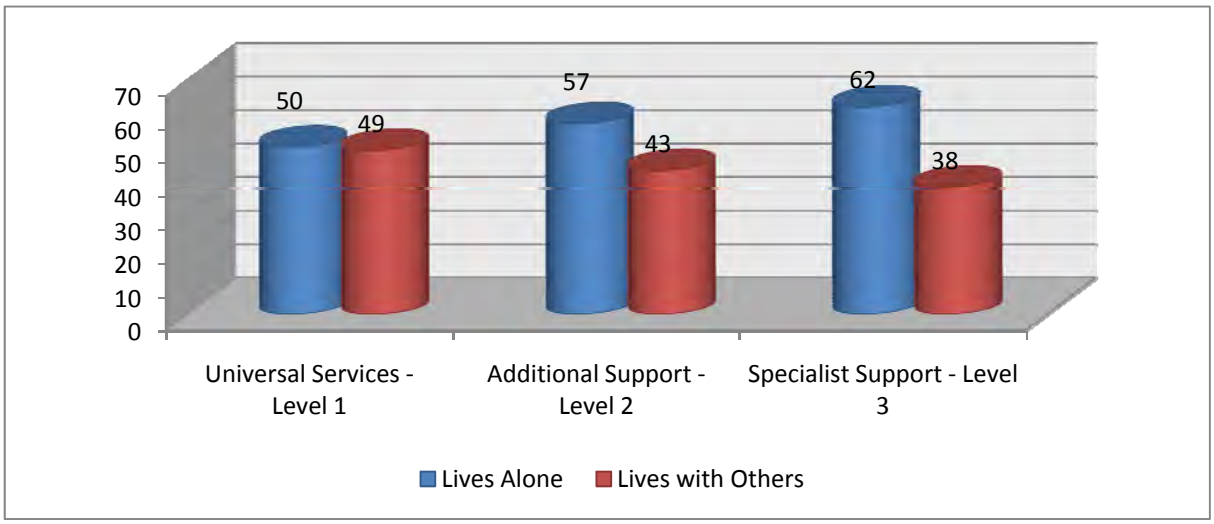
Table 66. Living arrangements by level of need

Needs levels	Lives alone	Lives with others
Universal services - level 1	316 (50%)	307 (49%)
Additional support - level 2	265 (57%)	198 (43%)
Specialist support - level 3	24 (62%)	15 (38%)

$X^2 = 5.512$, d$f = 29$, p = 0.063, n.s.

[7] Carers Services have been excluded from the analysis to ensure that the dichotomy (11% lives alone to 89% lives with others) was not skewing the results.

Figure 47. Living arrangements by level of need



Such a simplistic analysis does not provide the full picture. It cannot simply be stated that 85% of users within any hospital discharge project will live alone. As noted above, the age of individuals affects their service use and living alone is often a result of a bereavement of a spouse or partner, which in itself is linked to the age of the participant (see above). In exploring the impact of age and living alone on service use, it was found that age had an additional impact on the take up of services or projects within the further categories of Well-Being - Geographical, Information and Signposting and Well-Being physical health. Individuals who live alone are more likely to access higher level services. However, not surprisingly, once a person is over 75, the likelihood of needing *any* service becomes higher.

5.9 Accommodation type

Whether living alone or with a spouse/partner/family or friend, over three-quarters of the sample lived in private or rented accommodation, with almost a fifth of the sample living in sheltered housing (14%), residential care homes (4%) or nursing homes (1%) (see Table 67).

Table 67. Accommodation type

Type of accommodation	Base-line n (%)
Domestic housing	1129 (81%)
Sheltered housing	194 (14%)
Residential housing	53 (4%)
Nursing housing	15 (1%)

Differences in service use were found among individuals living in different forms of accommodation. For example, fewer people living in sheltered housing received services within the category of Well-being - practical. Such differences are not surprising, given the type of projects within the sub-groups (i.e. gardening, housing repairs and shopping), as such home care tasks tend to be performed centrally.

Where such differences in service use could be expected is in the use of 'higher-level' services. Individuals within sheltered housing or residential/nursing care are likely to be frailer and older than those individuals still within their own home – and those individuals who completed the standardised questionnaire illustrated this relationship. As can be seen in Table 68, those aged 85 and over were more likely to be in sheltered housing and/or residential and nursing homes.

Table 68. Accommodation type by age range

Age range	Domestic housing	Sheltered housing	Residential home	Nursing home	Totals
Aged to 64 years	179 (85%)	25 (11%)	6(3%)	1 (1%)	211 (100%)
Aged 65 - 74 years	331 (81%)	65 (16%)	10 (2%)	3 (1%)	409 (100%)
Aged 75 - 84 years	399 (82%)	67 (13%)	17 (4%)	3 (1%)	486 (100%)
Aged 85 plus	220 (77%)	37 (13%)	20 (7%)	8 (3%)	285 (100%)
Totals	**1129 (81%**	**194 (14%**	**53 (4%)**	**15 (1%)**	**1391 (100%)**

$X^2 = 23.293$, d*f* = 9, p = 0.006

As previously discussed, higher age and frailty has an impact on service use, for example, in A&E visits, hospital admissions, hospital nights (Cove et al 2006, Victor 2002, Bentley & Meyer 2004), and the POPP sample (Table 69) follows such patterns at base-line (prior to the intervention).

Table 69. Mean number of nights in hospital by age range

Age Range	Mean number of hospital nights @ base-line
Aged 0 - 64 years	1.71
Aged 65 - 74 years	1.21
Aged 75 - 84 years	1.96
Aged 85 plus	2.41

However, when the nature of a person's accommodation was analysed against different needs levels, there was a seemingly counter-intuitive outcome, namely that those within sheltered housing and residential or nursing homes were no more likely to use higher level services than lower level services. Indeed, those living in residential or nursing homes were less likely to use those higher level services grouped into specialist support.

Table 70. Accommodation type by level of need

'Needs levels'	Domestic housing	Sheltered housing	Residential home	Nursing home	Totals
Universal Services - Level 1	625 (79%)	130 (16%)	28 (4%)	5 (1%)	788 (100%)
Additional Support - Level 2	466 (83%)	57 (10%)	25 (4%)	10 (2%)	558 (100%)
Specialist Support - Level 3	38 (84%)	7 (16%)	0 (0%)	0 (0%)	45 (100%)

$X^2 = 19.515$, d*f* = 6, p = 0.003

Perhaps such findings are not particularly surprising, as nursing homes have on-site clinical staff, while residential homes should have regular visits from key health staff, such as GPs and district nurses, although research has reported difficulties in obtaining such support in the latter (e.g. see

Goodman et al 2003). The lack of service use within the higher sub-groups for those living in sheltered housing and residential/nursing care continues when the category of Community or Hospital Facing projects is explored (see Table 71).

Table 71. Focus of project by accommodation type

Project sub-grouping	Domestic housing	Sheltered housing	Residential home	Nursing home	Totals
Community facing	863 (80%)	159 15%)	44 (4%)	15 (1%)	1081 (100%)
Hospital facing	266 (86%)	35 (11%)	9 (3%)	0 (0%)	310 (100%)

$X^2 = 8.24$, d*f* = 3, p = 0.041

Differences were seen within this sample, however, in the scoring of individuals' health-related and overarching quality of life. This is discussed in the next section.

5.10 Household income

From an analysis of the above variables, a picture emerges that the participants who completed the standardised questionnaire were older and frailer than might perhaps be expected for users of 'low-level' or upstream service use. In discussing the issue of age, a measure of deprivation was explored (LSOA), and the full findings are discussed below. A further measure of deprivation is income. Poverty in old age is highest among older women, particularly widows (Naegele & Walker 2007), and it is known that those who are *'worse off socio-economically have worse health*' (Shaw et al 1999: 211). If the differences in the HRQoL found in this study are to be explained, it is necessary first to outline levels of poverty measured through weekly income.

As discussed in section 2, it was initially intended that a question on total weekly income be included in the standardised questionnaire, but this proved to be a very sensitive issue. Of the 23 sites, only six felt that such a question was appropriate. To ensure cooperation with the research, compromises had to be made and, unfortunately, this was one question that became an 'opt-in' – rather than a core – question.

From the six sites that included this question, there is a total sample of 362 respondents, almost a fifth of the overall sample (24%, fs=1529). Of those six sites, only one had low levels of deprivation (seeTable 72), with the others in the first or second quartiles (highest level) of deprivation. Given such levels of deprivation, lower levels of income would be expected.

Table 72. Level of deprivation in six pilot sites

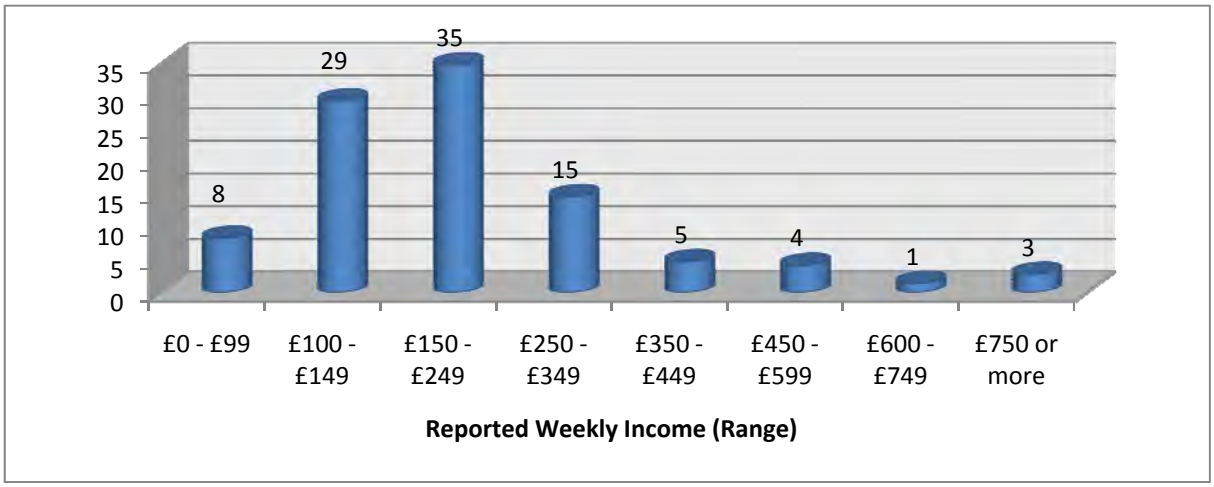
Pilot site	IMD score
Pilot site 4	28.4
Pilot site 10	32.9
Pilot site 15	48.9
Pilot site 22	33.7
Pilot site 47	14
Pilot site 88	25.4

Almost three-quarters of the sample (72%) reported an income of less than or equal to £249 per week (Table 73 and Figure 48). This is £100 less than the median weekly income for couples under 75 in 2006/7: £349 (Age Concern 2008).

Table 73. Reported weekly income

Weekly income	Income at base-line (n, %)
£0 - £99	30 (8%)
£100 - £149	106 (29%)
£150 - £249	126 (35%)
£250 - £349	53 (15%)
£350 - £449	17 (5%)
£450 - £599	15 (4%)
£600 - £749	5 (1%)
£750 or more	10 (3%)

Figure 48. Reported weekly income



In order to ensure that any findings were not being skewed, the least deprived pilot site (Pilot site 47) was removed from the analysis. However, little change was found, with only a 1% increase in the proportion of participants who reported weekly incomes of £249 or less (73% as opposed to 72%).

Not surprisingly, income is dependent on age and marital status, and Table 74 demonstrates how such variables affect income levels.

Table 74. National weekly income by marital status and age

Marital Status	National median weekly income 2006/7 (non-POPP)
Couples under 75	£349
Couples over 75	£287
Single under 75	£188
Single over 75	£179

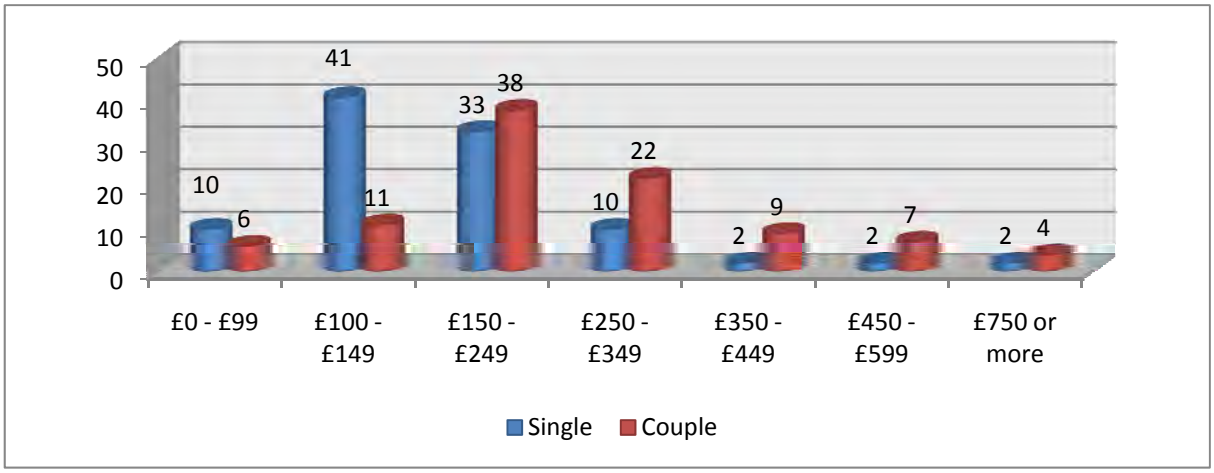
(Table drawn from Age Concern 2008: 13)

Within the POPP sample, it was found that those individuals who were married had a higher weekly income. Over a fifth of the married sample (22%) reported income between £250 and £349, compared to only 10% of individuals who were single, widowed, divorced or separated. Similarly, considering the cumulative percentage, well over three quarters of single individuals had an income less than £249 (84%), compared with only half of those married or cohabiting (54%) (see Table 75 and Figure 49).

Table 75. POPP sample weekly income by marital status

POPP sample weekly income	Single/widowed/ divorced/separated	Couple
£0 - £99	21 (10%)	8 (6%)
£100 - £149	90 (41%)	15 (11%)
£150 - £249	73 (33%)	53 (38%)
£250 - £349	21 (10%)	30 (22%)
£350 - £449	5 (2%)	12 (9%)
£450 - £599	4 (2%)	10 (7%)
£750 or more	4 (2%)	6 (4%)

Figure 49. POPP sample weekly income by marital status



Adding age to this analysis, it was found that single individuals over 75 reported a slightly lower weekly income than single individuals under 75, although within both samples half (50%) reported a weekly income of less than £150 per week. Couples under 75 reported higher weekly incomes, with almost half the sample (47%) reporting a weekly income over £250, compared with 15% of single individuals under 75 and 13% of single participants over 75. Compared with their single counterparts, couples over 75 did have slightly higher income. However, this was slightly lower than that of couples under the age of 75, with 41% of the sample reporting an income of over £250 per week (see Table 75, Table 76 and Figure 50).

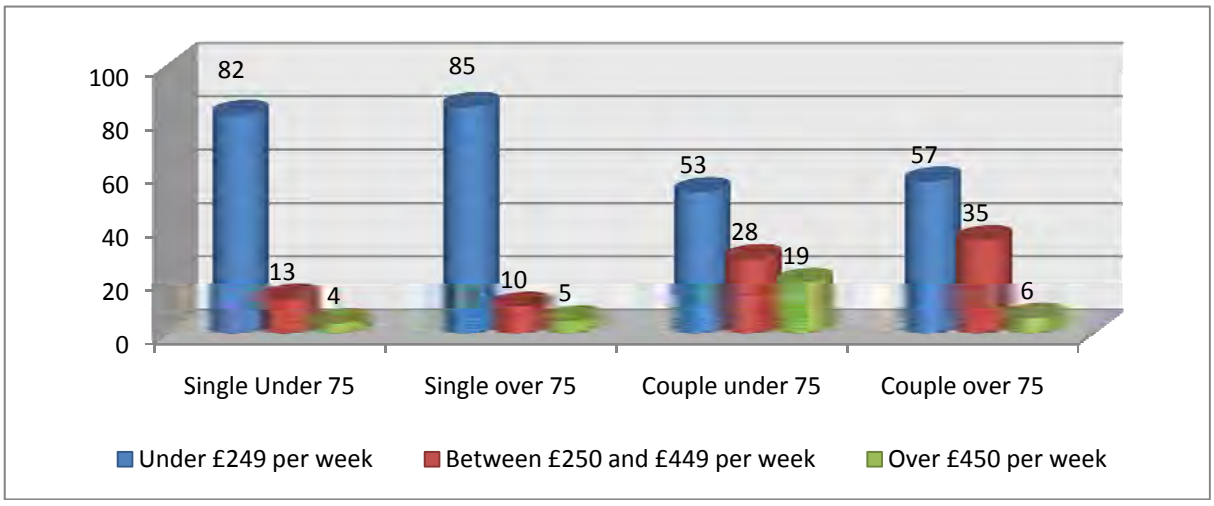
Table 76. POPP sample weekly income by marital status and age

	Single under 75	Single over 75	Couple under 75	Couple over 75
£0 - £99	14 (11%)	7 (8%)	6 (6%)	2 (5%)
£100 - £149	49 (39%)	39 (42%)	14 (14%)	1 (2%)
£150 - £249	40 (32%)	32 (35%)	33 (33%)	20 (53%)
£250 - £349	14 (11%)	7 (8%)	21 (21%)	9 (24%)
£350 - £449	3 (2%)	2 (2%)	8 (7%)	4 (11%)
£450 - £599	2 (2%)	3 (3%)	10 (10%)	0 (0%)
£600 - £749	0 (0%)	0 (0%)	4 (4%)	1 (3%)
£750 or more	2 (2%)	2 (2%)	5 (5%)	1 (3%)

Table 77. POPP sample weekly income by marital status and age

	Single under 75	Single over 75	Couple under 75	Couple over 75
Under £249 per week	82	85	53	57
Between £250 and £449 per week	13	10	28	35
Over £450 per week	4	5	19	6

Figure 50. POPP sample weekly income by marital status and age



It should be stressed that whether single or married, aged under or over 75, the level of income per week of the sample was low, compared with the national average weekly income of pensioner couples: £508 per week (ONS, www.statistics.gov.uk/cci/nugget.asp?id=2158).

5.11 Indicators of multiple deprivation (IMD)

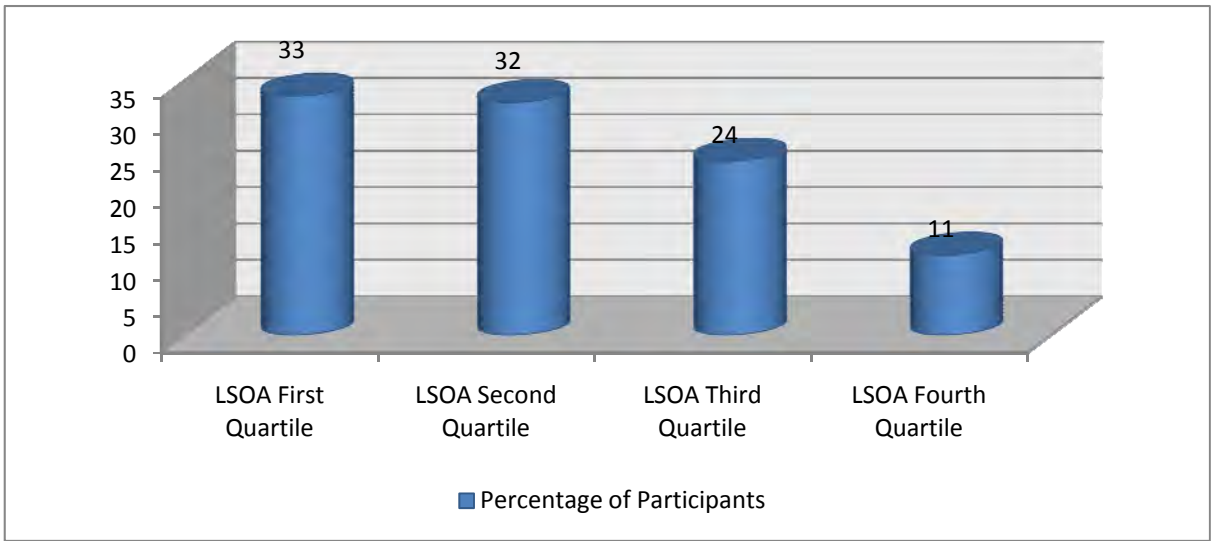
The general issue of deprivation was raised in the discussion of service use and age, as well as across weekly income levels. A measure of deprivation is crucial to any standardised questionnaire exploring changes in quality of life and service use. As already discussed, psycho-social determinants affect base-line levels of health and consequent service use (Marmot & Wilkinson 1999).

When the Lower Super Output Area (LSOA) is collapsed into quartiles, it can be seen (Table 78 and Figure 51) that almost two thirds (65%) of the sample were in deprived groupings, with one third of participants coming from the most deprived areas (first quartile is most deprived).

Table 78. Lower Super Output Area (LSOA) by number of participants

	Number of participants	Percentage of participants
LSOA first quartile	444	33
LSOA second quartile	432	32
LSOA third quartile	323	24
LSOA fourth quartile	149	11
Totals	**1348**	**100**

Figure 51. Lower Super Output Area (LSOA) by number of participants



If the scores of the pilot sites are themselves examined, such a weight toward the most deprived areas is not found (see Table 79).

Table 79. Level of deprivation (IMD average score) by pilot site

Pilot site	IMD average score
Pilot site 03	25.9
Pilot site 04	28.4
Pilot site 06	17.3
Pilot site 10	32.9
Pilot site 11	46.6
Pilot site 13	14.3
Pilot site 15	48.9
Pilot site 19	34.7
Pilot site 22	33.7
Pilot site 25	17.9
Pilot site 29	29.8
Pilot site 38	11.9
Pilot site 41	21.9
Pilot site 47	14
Pilot site 51	16
Pilot site 56	15.8
Pilot site 63	29.3
Pilot site 79	17.4
Pilot site 82	13.5
Pilot site 88	25.4
Pilot site 93	19.8
Pilot site 95	14.1
Pilot site 98	21.2

As discussed in section 2, one fifth of the overall sample (207 or 19%) was drawn from one particular pilot site, and the IMD score of this local authority was in the lowest quartile (high levels of deprivation). Nevertheless, despite this finding, the further 43% within quartiles one and two were drawn from across the other pilot sites and yet were still within the lower levels of deprivation, despite the local authorities as a whole scoring higher. Such a finding supports the recommended targeting of pilot projects within the sites; the need to reduce health inequalities within their areas *'targeted in the first instance the most deprived areas in the Borough'* (Pilot Site 11).

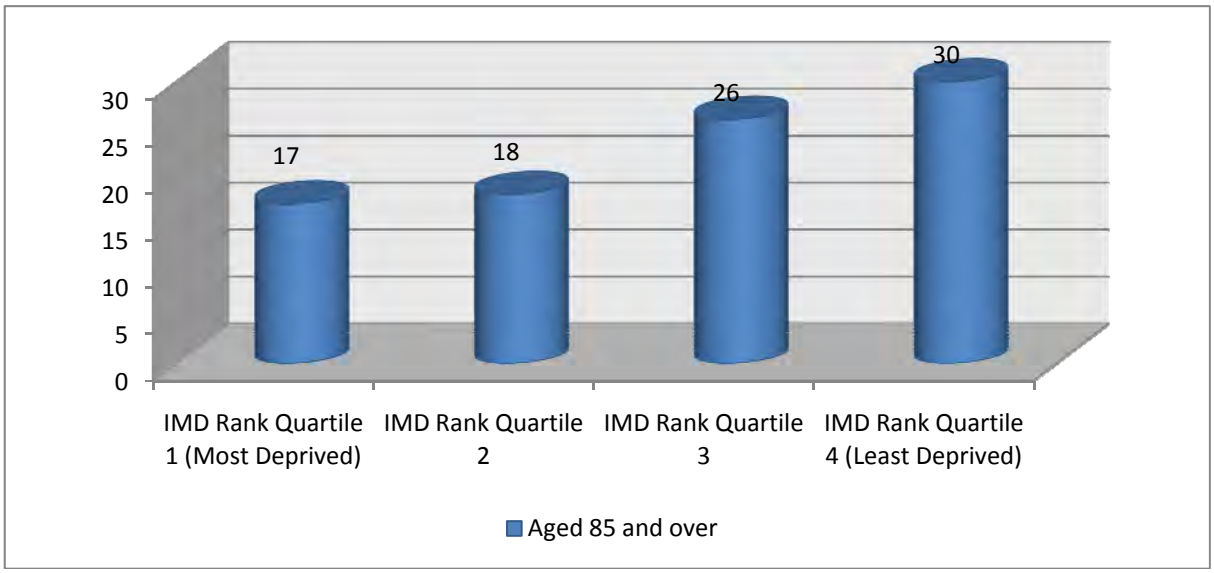
That the level of deprivation faced by participants affects their health-related and overall QOL will be discussed in the next section. But levels of deprivation also have an impact on base-line service use, although different patterns are seen, owing to the secondary impact of participants' age. That is, as previously noted, those individuals within the most deprived areas were far younger than those in the least deprived. As can be seen from Table 80, 17% of users in quartile 1 were aged 85 and over, compared with almost a third of the sample (30%) in Quartile 4 – a difference of almost 50% (see Figure 52).

Table 80. Level of deprivation (IMD average score) by age range

	IMD rank quartile 1 (most deprived)	IMD rank quartile 2	IMD rank quartile 3	IMD rank quartile 4 (least deprived)
Aged to 64 years	90 (20%)	55 (13%)	46 (14%)	17 (11%)
Aged 65 - 74 years	136 (31%)	148 (34%)	76 (24%)	32 (21%)
Aged 75 - 84 years	143 (32%)	151 (35%)	117 (36%)	56 (38%)
Aged 85 and over	75 (17%)	78 (18%)	84 (26%)	44 (30%)
Totals	**444 (100%)**	**432 (100%)**	**323 (100%)**	**149 (100%)**

$X^2 = 37.210$, d*f* = 9, p = 0.000

Figure 52. Level of deprivation (IMD average score) by age range



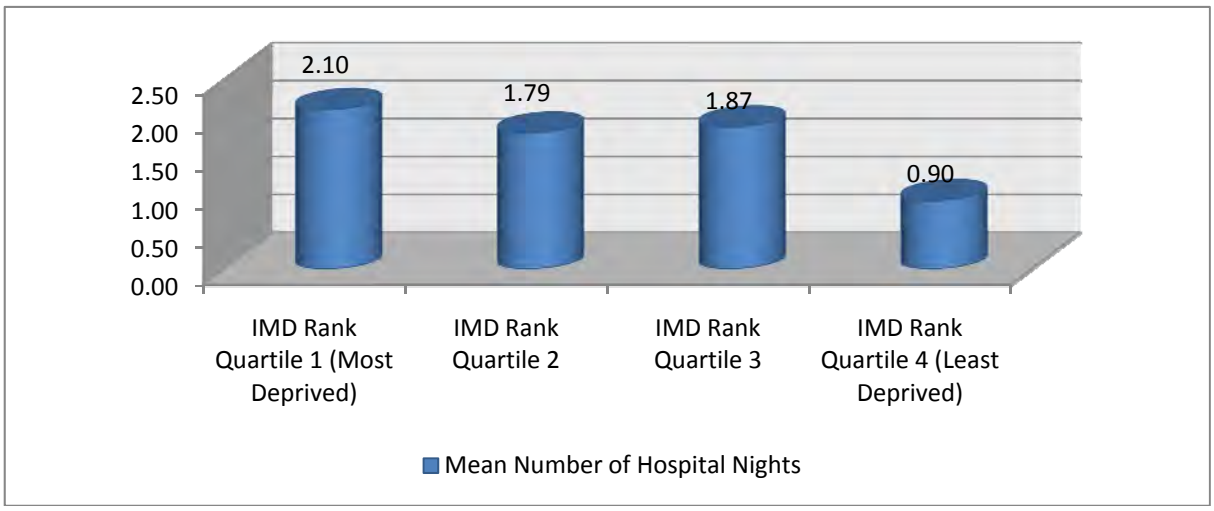
In exploring health service use, statistically significant differences in the number of hospital nights were found (see Table 81 and Figure 53).

Table 81. Level of deprivation (IMD average score) by number of nights in hospital

IMD rank (LSOA)	Mean number of hospital nights
IMD rank quartile 1 (most deprived)	2.10
IMD rank quartile 2	1.79
IMD rank quartile 3	1.87
IMD rank quartile 4 (least deprived)	0.90

t = 51.197, p = 0.000

Figure 53. Level of deprivation (IMD average score) by number of nights in hospital



The pattern of use of other health services was not as clear, given the impact of age. However, when use of community services was assessed, those in the most deprived quartile, perhaps not surprisingly, reported prior and greater use of bus passes, day/drop in or resource centres, lunch-clubs and community centres.

5.12 Ethnicity

The pilot sites were located across England and as such, had a spread of black and minority ethnic (BME) communities. The following table indicates the total percentage of BME communities within the pilot sites and responses within the standardised questionnaire.

Table 82. BME communities by pilot site

Pilot site	% BME communities within the locality*	% BME communities responding to the standardised questionnaire
Pilot site 03	39.3	35
Pilot site 04	3.5	7
Pilot site 06	1.1	0
Pilot site 10	8	19
Pilot site 11	0.8	4
Pilot site 13	0.9	0
Pilot site 15	8.8	48
Pilot site 19	12.9	33
Pilot site 22	4.1	4.4
Pilot site 25	0.7	0
Pilot site 29	2.6	3
Pilot site 38	1.5	5
Pilot site 41	0.5	0
Pilot site 47	0.4	0
Pilot site 51	1.4	1.2
Pilot site 56	0.7	1.1
Pilot site 63	0.6	0
Pilot site 79	0.6	0
Pilot site 82	1.5	0
Pilot site 88	2.3	0
Pilot site 93	16.2	9
Pilot site 95	0.7	3
Pilot site 98	1	0

* Office of National Statistics, Estimates (Mid 2004), Table EE3

It can be seen that there were considerable variations across the sites, in part dictated by the sample on which the local teams and their evaluators focused (see section 2). Similarly, some sites took up the further monies to administer the questionnaire through translators. There was clear over-sampling of BME communities in five sites, one site (pilot site 15) having almost half of their sample (48%) from BME respondents. In comparison, eight sites had no BME representation, although the population itself was small.

In contrast to the other variables above, it is not appropriate to explore ethnicity in relation to specific project categories. There are statistically significant findings that a higher proportion of individuals from BME communities access certain categories of projects: e.g. Well-being-emotional and social isolation and Well-Being - physical health. Nevertheless, this does not take into account the fact that some projects were directed solely toward supporting specific BME communities. For example, within Well-Being Emotional and social isolation, of the 16 projects, one quarter (4) were specific BME projects, whilst of the 244 responses, 114 (47%) were drawn from different BME communities, including Chinese, Indian and Somali groups.

Care should be taken in using these data to demonstrate the accessibility of specific projects across sites. Instead, it is necessary to take into account the context of the projects, the relatively high level

of difficulty of the questionnaire, the sample selected by local evaluators and the administration parameters of single projects within pilot sites (rather than overall site administration), all of which may have had an impact on responses.

6 The Impact of POPP on Quality of Life Outcomes and Benefit Receipt

Key points

The evaluation addressed the programme's impact in two ways. A standardised questionnaire, administered before and three months after the POPP intervention, i) measured the health-related quality of life of a sample of 1,529 older people, and ii) recorded their perception of any changes in their overall quality of life, using a single rating question. A sample drawn the British Household Panel Survey was used as a comparison.

Assessing the impact of projects on these users' quality of life is difficult, because many were very old and frail and likely to experience deteriorating well-being in any case. Moreover, a number of services, although providing valuable help to people, were unlikely to have a striking impact on overall quality of life, as other factors, such as poverty, illness or bereavement, were more likely to be critical here.

Overall changes in health-related quality of life (HRQoL)

- These varied with the type of project, but improvements were found in 9 of the 11 types, compared to the control sample.

- Those receiving practical help ('that little bit of help') reported a notable improvement (12% increase), as simple aids or services could affect well-being, such as a grab-rail making washing easier or minor repairs reducing anxiety.

- An equivalent improvement (12% increase) was also noted following interventions providing exercise, presumably due to increased strength and flexibility and a positive effect on mood.

- Smaller improvements (4%) were found in those involved with projects offering community support, proactive case co-ordination and specialist falls programmes (3-4%).

- A very slight deterioration was found in people involved in projects offering hospital discharge and complex care (lower than 2% decline), but these individuals still fared better than the comparative sample. Moreover, further analysis found that some types of intervention 'bucked the trend'; if an intervention was multi-disciplinary, better outcomes were recorded.

- People using 'community-facing' services experienced improved HRQoL compared to the control sample. Those using tertiary services had an improved HRQoL of 25% and even those involved with low-level preventive projects experiencing a 2% improvement.

- All these findings must be treated with caution, as the variance in the data make it impossible to attribute statistical significance across the wider groupings. But when individual services were examined as representatives of the whole, changes in HRQoL were found to be significant.

Overall changes in Quality of Life (QoL)

Individual self-ratings of their overall quality of life, based on a single rating question (ranging from 'my life is so bad, it could not be worse', through to 'my life is so good, it could not be better'). This was necessarily affected by individual interpretations according to their own circumstances, preferences and beliefs.

- Overall, people reported a small deterioration in their quality of life following the POPP intervention, with some variation according to the nature of the area in which they lived and their age. Fewer people in the most deprived areas reported that their quality of life had remained the same, whilst the younger old people reported the greatest deterioration (but their level of disability was likely to be high, given their involvement with services).

Changes in Benefit receipt

- Older people further benefited from the POPP programme through a reported increase in the receipt of state benefits. More people were receiving attendance allowance following the programme than before, with information and advice services increasing benefits by £23,000 per annum. The overall increase was £53,768 per year.

6.1 Introduction

The previous section set out demographic data on the participants from the standardised quality of life tool. Building on this demographic information, this section examines the impact of the projects on service users' health related quality of life (HRQoL) and overarching quality of life following the POPP intervention.

6.2 EQ-5D tool and analytical frameworks

To explore the impact of the projects on users' reported changes in health related quality of life (HRQoL), the key tool is the EQ-5D (http://www.euroqol.org/). This measure has three parts. The first assesses five key 'domains': mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Individuals are asked to indicate their level of difficulty in carrying out these tasks within each domain: 'no problem', 'some problems', or 'great problem'. For example, within the domain of pain/discomfort, users are asked to state:

- I have no pain or discomfort, OR
- I have moderate pain and discomfort OR
- I have extreme pain and discomfort.

Users' responses are then scored and the changes between pre- and post-intervention assessed. Full information on the Tool scoring systems for the different domains can be found in Appendix T.

The second part of the EQ-5D asks users to indicate how they feel that their 'general level' of health has changed: whether it has got better, stayed much the same, or got worse. Finally, users are asked to indicate how good or bad their heath state is on a 'thermometer' that runs from 0 (worst imaginable health state) to 100 (best imaginable health state).

In this section, we first set out base-line EQ-5D data on POPP service users taken as a whole, compared to the 'normal population' (where possible). This allows an exploration of the differences in initial scores within each grouping and an assessment of where the POPP population is situated with respect to their HRQoL.

Changes between base-line (pre-intervention) data and post-intervention data are then reported across four frameworks of analysis. First, the different elements of the EQ-5D are presented for all responses (n=1529), to see whether users report that their HRQoL has improved or deteriorated. Second, we report outcomes by the 62 projects in which users were involved, according to their focus (e.g. Well-Being-Practical, Information and Signposting and so forth) to examine whether some groups of projects demonstrate a larger positive (or indeed negative) change in health-related quality of life compared to others. Third, variations according to the Needs Levels of users are examined and, finally, variations are considered across Community Facing and Hospital Facing projects. The development and the structure of these categories are set out in previous chapters, but brief explanations are provided here to assist understanding.

6.3 Note on the EQ-5D 'scores'

6.3.1 BHPS quasi-control sample and standardisation to one year

In presenting changes in EQ-5D scores before and after involvement in a POPP project, we are reporting two specific figures. First, the actual figures reported by users are given, but second, the information is standardised to a year (i.e. an estimate is made of how the data would appear if based on a full year). This was undertaken to provide an appropriate comparison between our data and that of a quasi-comparison sample.

The need for a control sample needs some explanation. If we simply looked at the EQ-5D raw figures, we could write only of the effect of particular projects on the HRQoL of our particular sample. We would not know what changes might have occurred in the absence of involvement in the POPP programme. To be able to provide such information, a 'control' group is needed. Ideally, there would have been a randomised control trial (RCT) involving two groups: those receiving a POPP service and those receiving 'usual care'. We could then have measured changes in HRQoL of both groups to assess whether it was the POPP services that were responsible for any reported changes or if such changes were due to other confounding variables.

It was not possible to set up a randomised control trial, given the breadth and depth of projects, as all had differing structures, processes and proposed outcomes (see Section 3). We therefore needed a 'proxy' comparison group or benchmark for our results. From existing surveys, the most appropriate proxy control group appeared to be a sample from the British Household Panel Survey (BHPS). The BHPS is the most complete available survey in the UK and, more importantly, enables individuals to be tracked across different time points. This allows any changes in health to be observed across time, for individuals not using POPP services. As the BHPS is administered every 12 months, it was necessary to standardise the scores from our particular sample to ensure comparison of like with like.

To standardise the EQ-5D score to 12 months, a simple compute was carried out. For example, if a participant indicated that their score was 0.508 at six months, the score was simply multiplied by two (0.508 x 2 – 1.016). Such multiplication is carried out across the different timeframes of administration. Further work was carried out on standardising the scores, for example, limits being placed at 1.00 and 0.00, representing perfect health and death. Many of our sample indicated that their HRQoL to be 'worse than death' (minus score) and such limits on the data were therefore misleading and not implemented. Negative EQ-5D scores are found often in the literature and are considered an imperfection of the tool. Additional computations (not reported) were made from a standardisation using a double sigmoid function that 'tails off' at either end. These results were virtually identical to the ones that are reported below.

In using this standardisation, care must be taken in interpreting the results, as there are strong assumptions underlying such statistical changes – in particular, that any changes (whether positive or negative) experienced by a service user will continue throughout the given period (in this case, one year). As we know from other research evidence on older people, neither improvement nor deterioration is linear. Instead, individuals may experience a particular change and then 'plateau' for a period of time. But given the lack of any other form of control group, this was the only way we could provide an approximate (proxy) control group to provide some comparative data to assess the likely impact of the POPP projects.

6.4 Overarching quality of life

In exploring the self-reported quality of life, the key question was developed by Professor Ann Bowling (Bowling et al 1995). Figure 54 shows how participants were asked to rate their quality of life.

Figure 54. Self-reported quality of life question

Thinking about the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole?
(Please tick the box next to the answer that best describes the quality of your life:)

(1)	So good, it could not be better	☐
(2)	Very good	☐
(3)	Good	☐
(4)	Alright	☐
(5)	Bad	☐
(6)	Very bad	☐
(7)	So bad, it could not be worse	☐

Mirroring the reporting of the HRQoL, the findings are given by the different project sub-categories.

6.5 Caveat: on statistical significance within the HRQoL

Within any statistical analyses, it is usual to give only those findings where there is a certain level of confidence in the data. Within this type of analysis, data are usually only presented if there is a less than 5% chance of the findings occurring by chance alone ($p=<0.05$). However, necessary compromises around the sample frame, inclusion of questions and externally dictated parameters regarding follow-ups and reminders had to be made (see Section 2). The wide variation in the type of projects has led to variance within the data. In order for this variance to be eliminated or minimised, it would have been necessary to run either a full randomised control trial (RCT) of specific projects or some form of case control. As noted above, such an approach was not possible owing to the structure of POPP and the requirements of the National Evaluation. Alternatively, a far greater sample size would have been necessary, again not possible within the parameters of the evaluation.

It must therefore be emphasised that no single finding within the data on changes in EQ-5D is statistically significant. Nevertheless, the findings are presented as an indication of direction of travel. Due care must be given to any interpretation.

6.6 EQ-5D base-line differences against 'normal population'

6.6.1 Overall sample

In comparing the POPP sample against population norms, it was found that those within the POPP sample reported substantially lower HRQoL compared to the overall 'normal' population. Comparator data were drawn from the MVH National Survey Data (Kind et al 1999).

The average scores from the overarching sample (n = 1529) by age ranges are given in Table 83.

Table 83. 'Normal' population EQ-5D scores compared with the POPP sample

Age range of participant	Overall population	POPP sample
Aged 55 - 64	0.80	0.54
Aged 65 - 74	0.78	0.58
Aged 75+	0.73	0.54

It can be seen from Table 83 that the HRQoL for a 'normal' population ranged from 0.80 (80% of perfect health) for those aged 55-64, to 0.73 (73% of perfect health) at age 75 and over. In contrast, the POPP sample reported between one fifth (20%) and over a quarter (26%) of perfect health, with lower HRQoL. Those aged 55-64 who used POPP services, reported 54% of perfect health (0.54), the same as those aged 75 and over, whilst those aged 65-74 reported 58% of perfect health. It is not surprising that the younger age group reported lower levels of HRQoL, as people in contact with health or social care services are likely to have some form of long-term or chronic illness. As discussed in the previous section, the mean age of those using Specialist Services (tertiary prevention) was, at 76, younger than those using Additional Support Services (secondary prevention).

The level of HRQoL reported by the POPP sample was low. Within the 'normal population', such levels would only be reached among those aged 75 or over and smoking more than 20 cigarettes per day: 54% of perfect health or 0.54 (Kind et al 1999). This finding suggests two propositions regarding the POPP programme. First, simply maintaining levels of HRQoL would be a successful outcome for projects, given that individual levels of health were low at base-line and very likely to decline. Indeed, improving HRQoL would be a greater outcome than could reasonably be expected. Secondly, the low scores must be placed against the perception of POPP services as solely low-level preventive projects. There is a need to perceive prevention not as merely something carried out via low-level services run by voluntary organisations, but as a continuum, including low to high needs and ranging from prevention of early deterioration (e.g. exercise classes) to prevention of admission to secondary or residential care.

6.7 EQ-5D changes: The whole sample (n=1529)

6.7.1 EQ-5D domains

The majority of the sample population reported a level of difficulty across all domains. Almost three-quarters of the sample reported some problems in walking (71%), well over a third (40%) indicated difficulties with self-care, almost two-thirds (64%) stated they had problems with performing their usual activities, three-quarters (76%) that they suffered from on-going pain and discomfort, whilst over 40% reported increased levels of anxiety and depression.

Table 84. Overarching sample: all EQ-5D dimensions (% change)

EQ-5D dimension		Pre-intervention (Time 1)%	Post-intervention (Time 2)%
Mobility	I have no problems in walking about	29.05	28.62
	I have some problems in walking about	69.03	69.39
	I am confined to bed	1.92	1.99
Total		100	100
Self Care*	I have no problems with self-care	62.59	60.44
	I have some problems washing and dressing myself	33.71	33.68
	I am unable to wash or dress myself	3.69	5.88
Total		100	100
Usual Activities	I have no problems with performing my usual activities	36.89	35.55
	I have some problems with performing my usual activities	51.30	50.85
	I am unable to perform my usual activities	11.81	13.61
Total		100	100
Pain/ Discomfort	I have no pain or discomfort	23.60	24.24
	I have moderate pain or discomfort	60.40	60.66
	I have extreme pain or discomfort	16.00	15.10
Total		100	100
Anxiety/ Depression	I am not anxious or depressed	54.34	55.63
	I am moderately anxious or depressed	39.09	37.71
	I am extremely anxious or depressed	6.57	6.66
Total		**100**	**100**

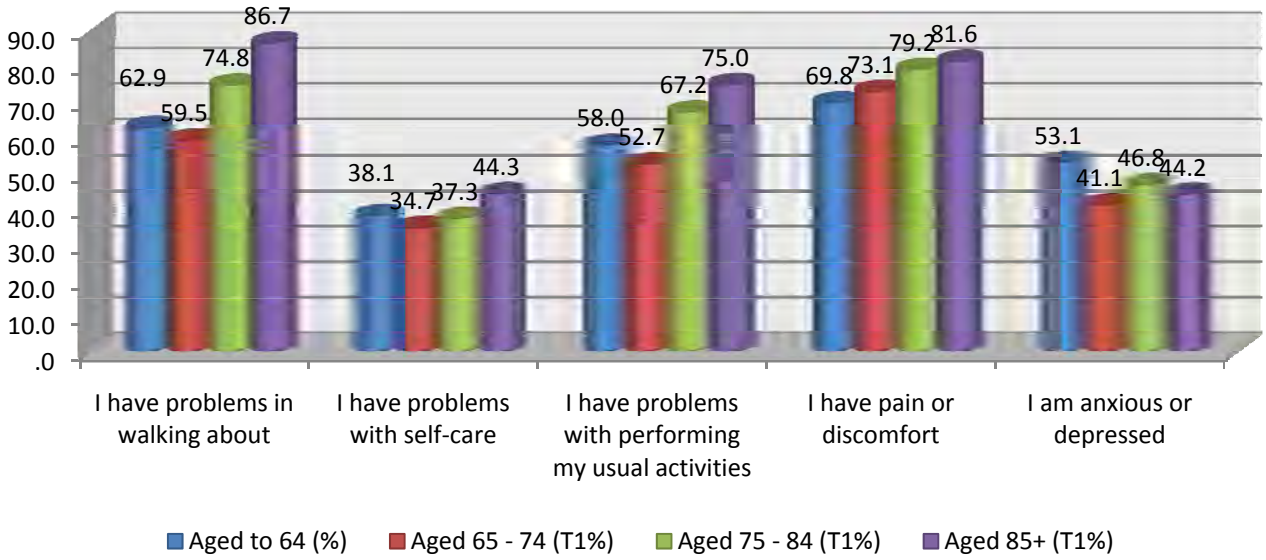
* p = 0.008

Age, not surprisingly, affected the reported outcomes n the domains of mobility, self-care, usual activities and pain/discomfort (see Table 85 and Figure 55). It is only within the dimension of anxiety/depression that higher levels of anxiety are seen in the younger population.

Table 85. Reported problems at T1 (pre-intervention) by age (%).

EQ-5D dimension		Aged to 64 (%)	Aged 65 - 74 (T1%)	Aged 75 - 84 (T1%)	Aged 85+ (T1%)
Mobility	I have problems in walking about	62.9	59.5	74.8	86.7
Self Care	I have problems with self-care	38.1	34.7	37.3	44.3
Usual Activities	I have problems with performing my usual activities	58.0	52.7	67.2	75.0
Pain/ Discomfort	I have pain or discomfort	69.8	73.1	79.2	81.6
Anxiety/ Depression	I am anxious or depressed	53.1	41.1	46.8	44.2

Figure 55. Reported problems at T1 (pre-intervention) by age (%)



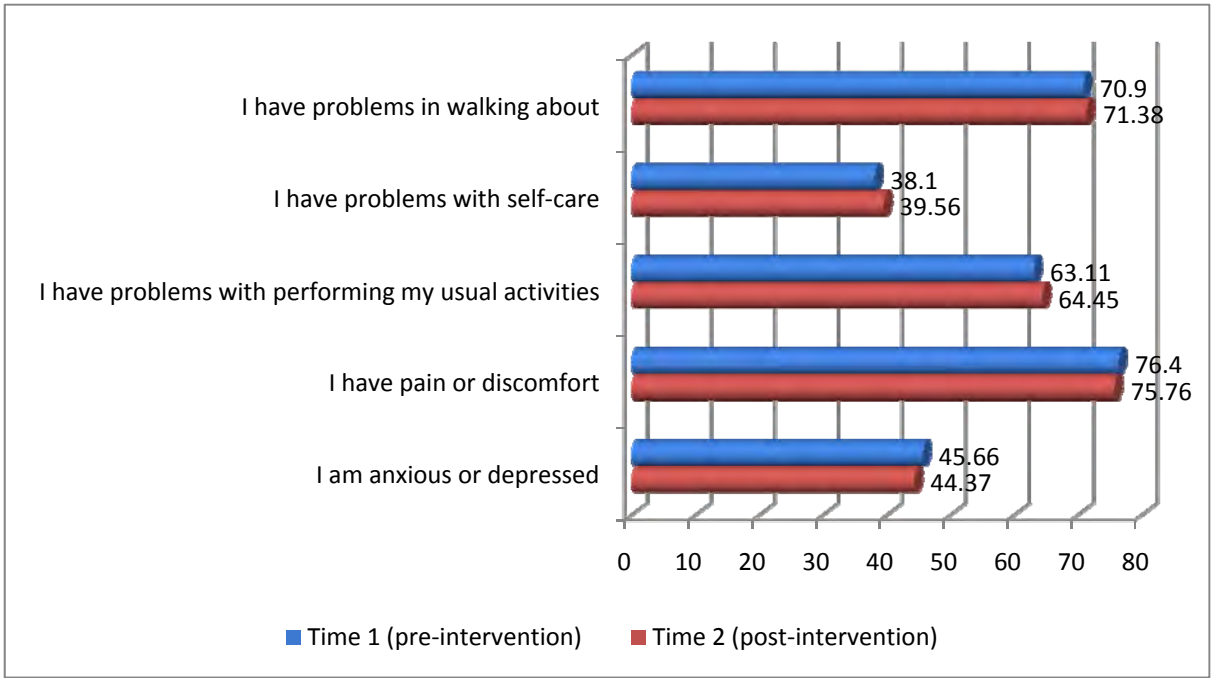
As we have argued, the levels of disability are high when placed against the perception of POPP services as solely low-level preventive projects. This data again emphasises the need to perceive prevention as a continuum, inclusive of low to high needs.

In exploring reported changes before and after taking part in POPP services, it can be seen from Table 86 that individuals reported a slight deterioration in mobility, self-care and usual activities. Such changes were very small and statistically non-significant. A slight improvement was reported in the domains of pain/discomfort and anxiety/depression, although again such changes were not statistically significant.

Table 86. Overarching sample: EQ-5D domains (dichotomised) pre- and post POPP intervention (%)

EQ-5D dimension		**Time 1 (pre-intervention)**	**Time 2 (post-intervention)**
Mobility	I have no problems in walking about	29.10	28.62
	I have problems in walking about	70.90	71.38
Total		100	100
Self care	I have no problems with self-care	61.90	60.44
	I have problems with self-care	38.10	39.56
Total		100	100
Usual activities	I have no problems with performing my usual activities	36.89	35.55
	I have problems with performing my usual activities	63.11	64.45
Total		100	100
Pain/ discomfort	I have no pain or discomfort	23.60	24.24
	I have pain or discomfort	76.40	75.76
Total		100	100
Anxiety/ depression	I am not anxious or depressed	54.34	55.63
	I am anxious or depressed	45.66	44.37
Total		**100**	**100**

Figure 56. Percentage of reported problem across all domains by Time 1 and Time 2



6.7.2 'Health today'

In this section of the EQ-5D, users are asked to indicate their general level of health on the day they complete the questionnaire (see Figure 57).

Figure 57. Self-reported general level of health question

Compared with my general level of health over the past 12 months, my health state today is:

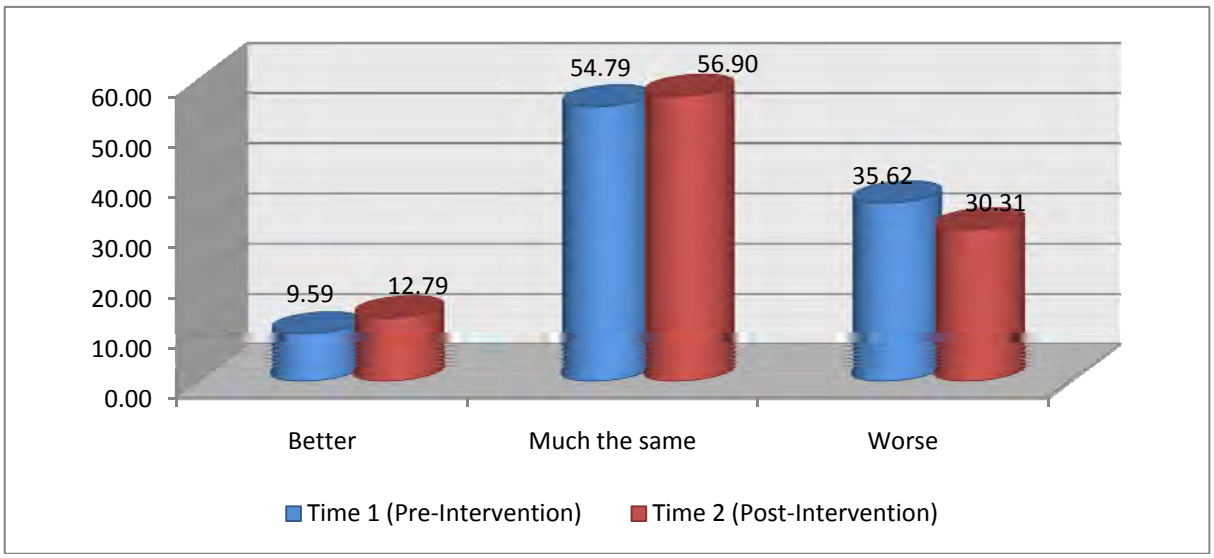
Better	❑	PLEASE TICK
Much the same	❑	ONE
Worse	❑	BOX

Table 87 and Figure 58 show the improvement or deterioration in reported general health state before and after the intervention.

Table 87. Reported 'Health State' pre- and post-intervention (%)

Health State Today	Time 1 (pre-intervention %)	Time 2 (post-intervention %)
Better	9.59	12.79
Much the same	54.79	56.90
Worse	35.62	30.31

Figure 58. Chart of reported 'Health State' pre- and post-intervention (%)



Such changes were found to be statistically significant and relate to individual reporting prior to and after the intervention (see Table 88). For example, if we look at the number of people who said their health today was 'better' following the intervention (n=187), it can be seen that of those reporting lower 'health today' (much the same and worse), a total of 79 people (10%) 'moved' from 'much the same' to 'better', while 45 (7%) who had indicated that their health had been worse also reported a temporally better health state. In short, people perceived that their health was better following the POPP service.

Table 88. Changes in reported levels of 'Health Today' pre- and post-intervention

		Health Today (post-intervention)			
Health Today (pre-intervention)		**Better**	**Much the same**	**Worse**	**Total**
Better	(n)	63	59	18	140
	(%)	45.0%	42.1%	12.9%	100.0%
Much the same	(n)	79	566	144	789
	(%)	10.0%	71.7%	18.3%	100.0%
Worse	(n)	45	203	277	525
	(%)	8.6%	38.7%	52.8%	100.0%
Total	(n)	187	828	439	1454
	(%)	12.9%	56.9%	30.2%	100.0%

p=0.000 (MHT)

6.7.3 Visual analogue scale

The third part of the EQ-5D tool is a visual analogue scale. Represented as a thermometer and ranging from 0 (worst imaginable health state) to 100 (best imaginable health state), participants were asked to indicate on the scale how good or bad they perceived their 'health state' to be on the

day they completed the questionnaire. It was found that there was a very slight increase in subjective health state of 0.7.

Table 89. Response to visual analogue scale (VAS) pre- and post-intervention

'Scores'	Response to VAS pre-intervention	Response to VAS post-intervention
Mean	59.27226	60.00519
Change in mean		0.732938
Total number of respondents		**1348**

R^2 = 0.608, p=0.000

6.7.4 EQ-5D changes: raw figures

From Table 90, it can be seen that the EQ-5D scores of the overall sample (aged 60 and over) indicated a small, non-significant, reduction in health related quality of life. Prior to receiving any of the POPP interventions, the users reported a score of 0.558, which can be interpreted as having 55% of perfect health. Following the intervention, users reported their health-related quality of life had deteriorated, giving a mean score of 0.552.

Table 90. EQ-5D 'scores' pre- and post-intervention

	Overarching sample EQ-5D
Pre-intervention	0.558
Post-intervention	0.552
Absolute variation	-0.006
% variation	-1.048
N. observations	**1320**

p=0.7 (Friedman)

This reduction gives an absolute variation of -0.006, a percentage variation of -1.05%. Such a reduction is so small that it would normally be argued that the HRQoL of POPP service users was maintained. As discussed above, the EQ-5D is a health measure and it would be reasonable to expect a decline in the health of a population of this age over time. That is, even if their general health remained stable, they would be likely to become frailer as time passes. That the scores in the overall sample (where there was huge variation across the different project types) were arguably 'maintained', indicates that the interventions would seem to be addressing improvements in HRQoL.

6.7.5 EQ-5D changes: comparison with quasi-control sample

In reporting such a slight deterioration (-0.006) in the HRQoL score, we do not know if such changes would have occurred anyway without the input of the POPP projects. As noted above, it would have been expensive and difficult to set up a randomised controlled trial and we therefore developed a proxy group to benchmark the results on the impact of the POPP projects. This group was extracted from the British Household Panel Survey (BHPS). Further details on the selection of this group can be found in Section 2.

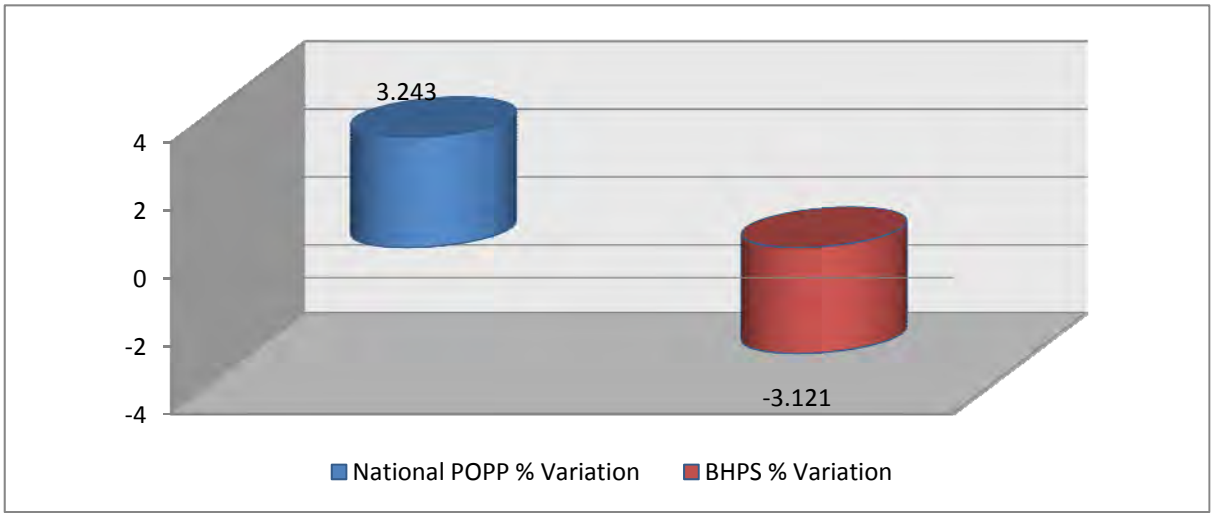
Standardising the changes to a 12 month period (see above), Table 91 and Figure 59 provide the changes in HRQoL across the national POPP programme and those seen in the population of the BHPS.

Table 91. Changes in HRQoL: POPP sample compared to BHPS

	National POPP (standardised)	BHPS
Pre-intervention	0.55317	0.55531
Post-intervention	0.57111	0.53798
Absolute variation	**0.01794**	**-0.01733**
% variation	**+3.243**	**-3.121**
Number of observations	**1215**	**494**

p=0.7 (Friedman)

Figure 59. Changes in HRQoL: POPP sample compared to BHPS



Users participating in POPP projects reported a greater improvement, compared to individuals drawn from the BHPS who had not received any POPP intervention, with a difference of 6% between the samples. This result supports the argument that for those projects where users completed the QoL, it is the POPP intervention (rather than any confounding variable), that brought about an improvement.

6.8 EQ-5D & project categories

6.8.1 Introduction

Across the national POPP programme, service users in 62 projects in 23 of the POPP pilot sites completed the standardised questionnaire. The range and focus of these projects were very different, and merely presenting the outcomes from the overall sample cannot provide an indication of the likely impact of the POPP programme on HRQoL. Projects were therefore grouped according to their specific focus. As described in the previous section, 11 categories were developed, set out in Table 92.

Table 92. 'Matched' responses by project focus

Category number	Project focus	Number of projects	Number of 'matched' responses
1	Well-Being - practical	9	119
2	Well-Being - emotional/social Isolation	16	244
3	Well-Being - physical health	4	53
4	Well-Being - geographical	6	188
5	Information, Sign-posting and Access	5	91
6	Proactive Case Co-ordination	8	444
7	Long-term Conditions – Complex Care	4	154
8	Long-Term Conditions – Hospital Discharge	2	37
9	Specialist Falls	5	94
10	Involving Older People	2	55
11	Supporting Carers	1	22
	Totals	**62**	**1501**

It can be seen from Table 92 that there is considerable variation across the number of 'matched' responses. As previously discussed, the variance and numbers within any grouping affects the extent to which we can indicate whether such findings are statistically significant.

6.8.2 Summary charts

Figure 60. Percentage of 'actual' change by project categories (T1 & T2)

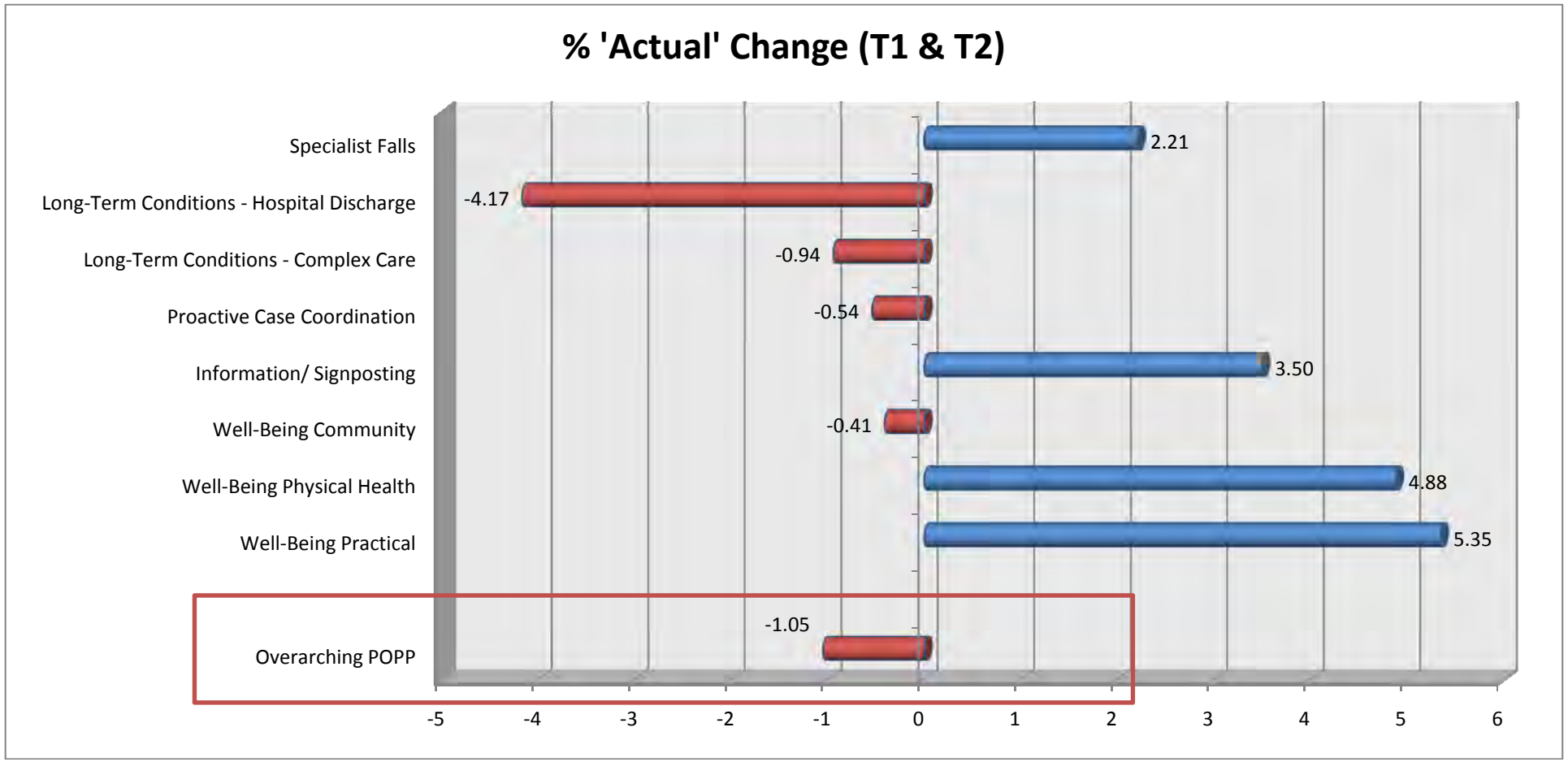


Figure 61. Percentage of standardised change by project categories (T1 & T2)

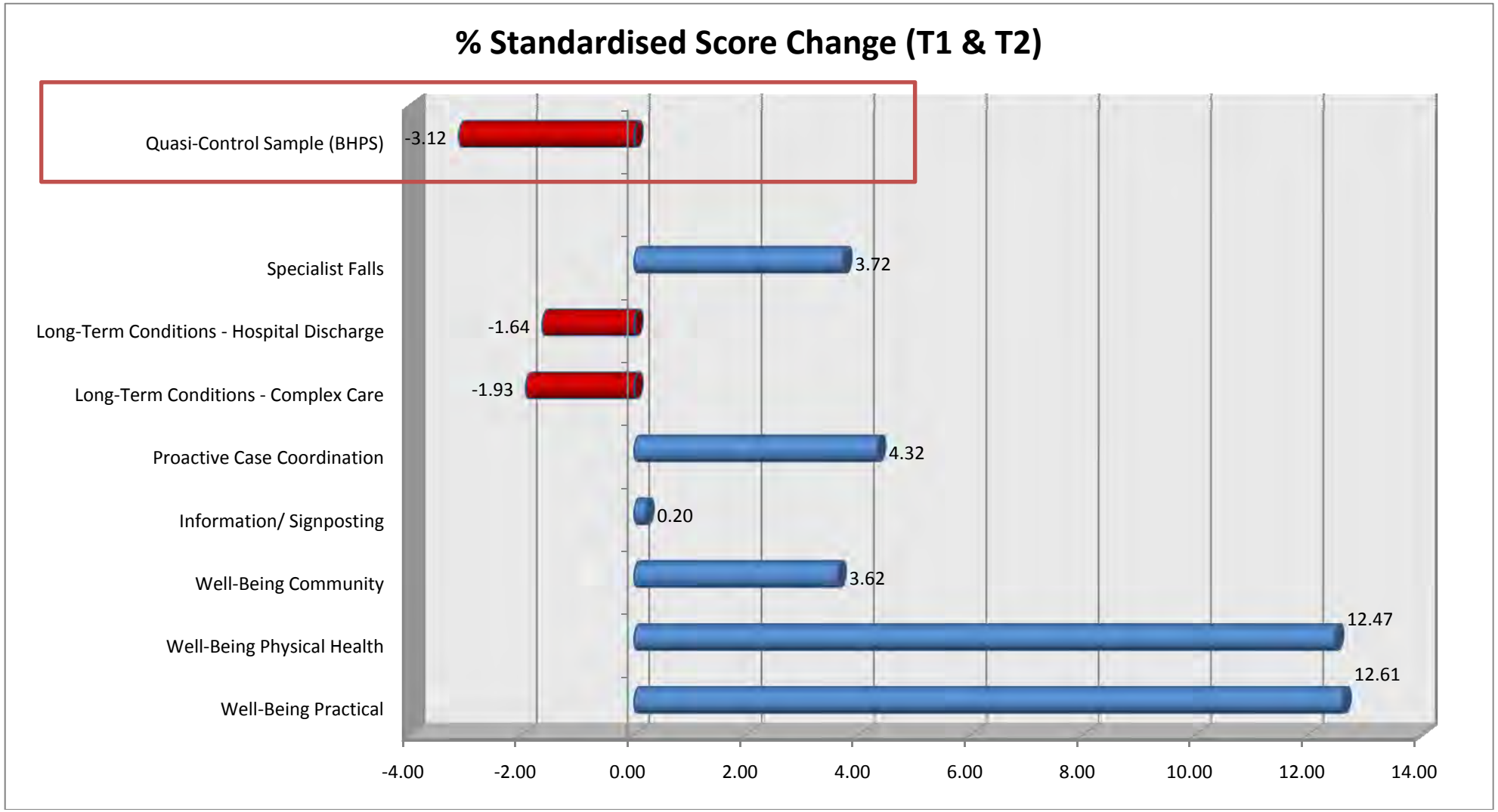


Figure 62. Percentage of 'actual' change in EQ-5D scores across needs levels (T1 & T2)

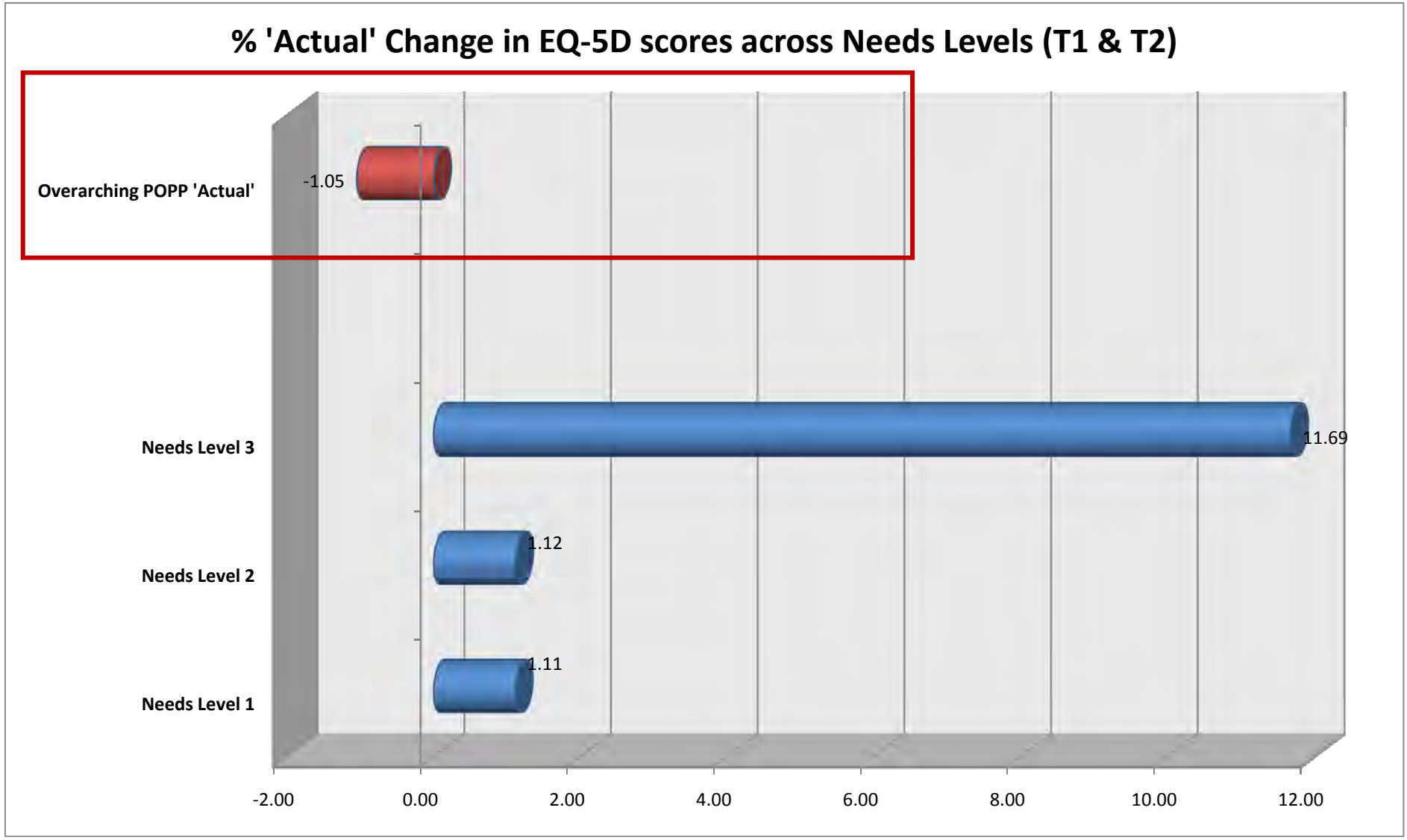


Figure 63. Percentage of standardised score change in eq-5d across needs Levels (T1 & T2)

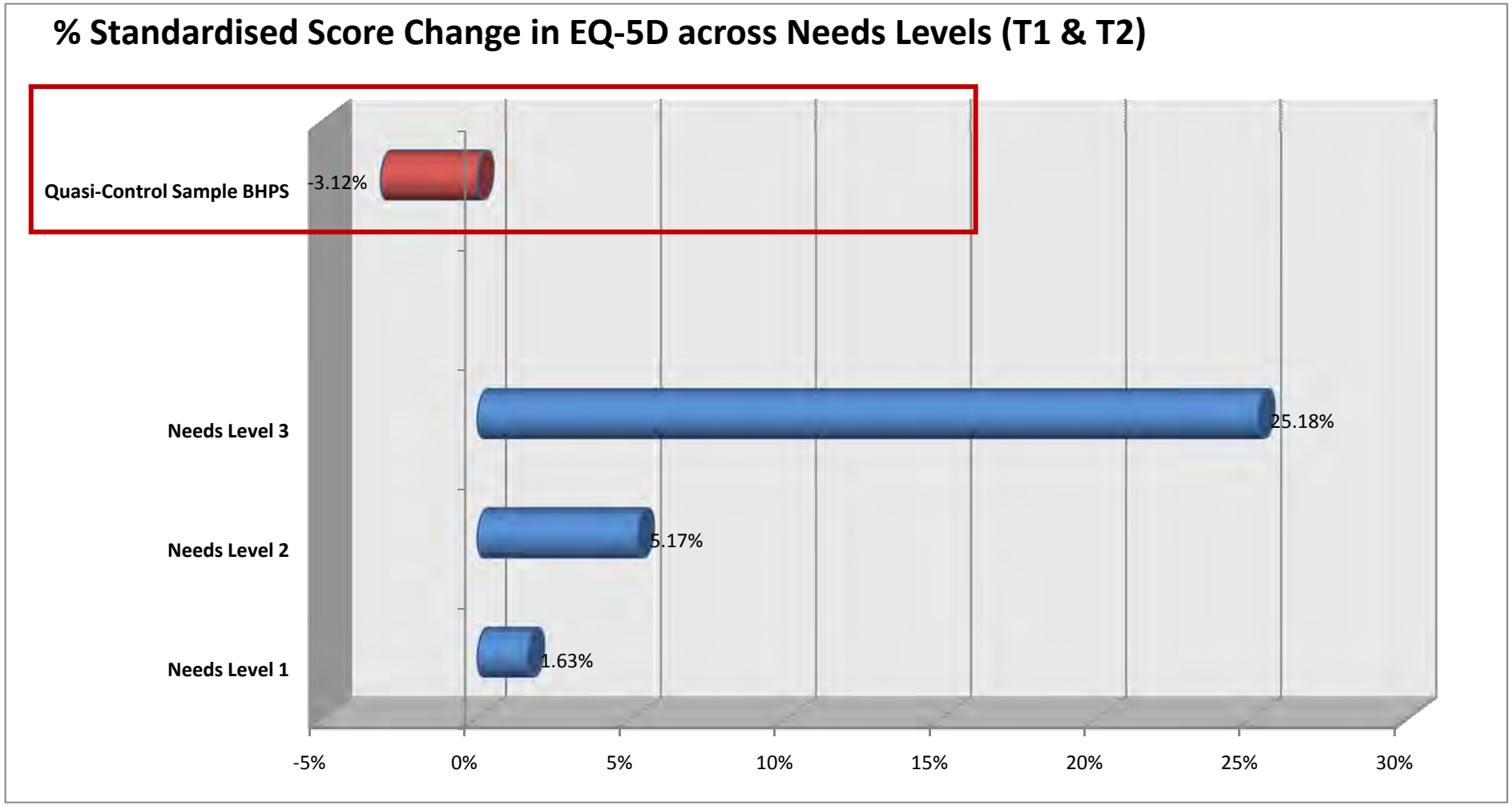


Figure 64. Percentage of 'actual' change: community and hospital facing (T1 & T2)

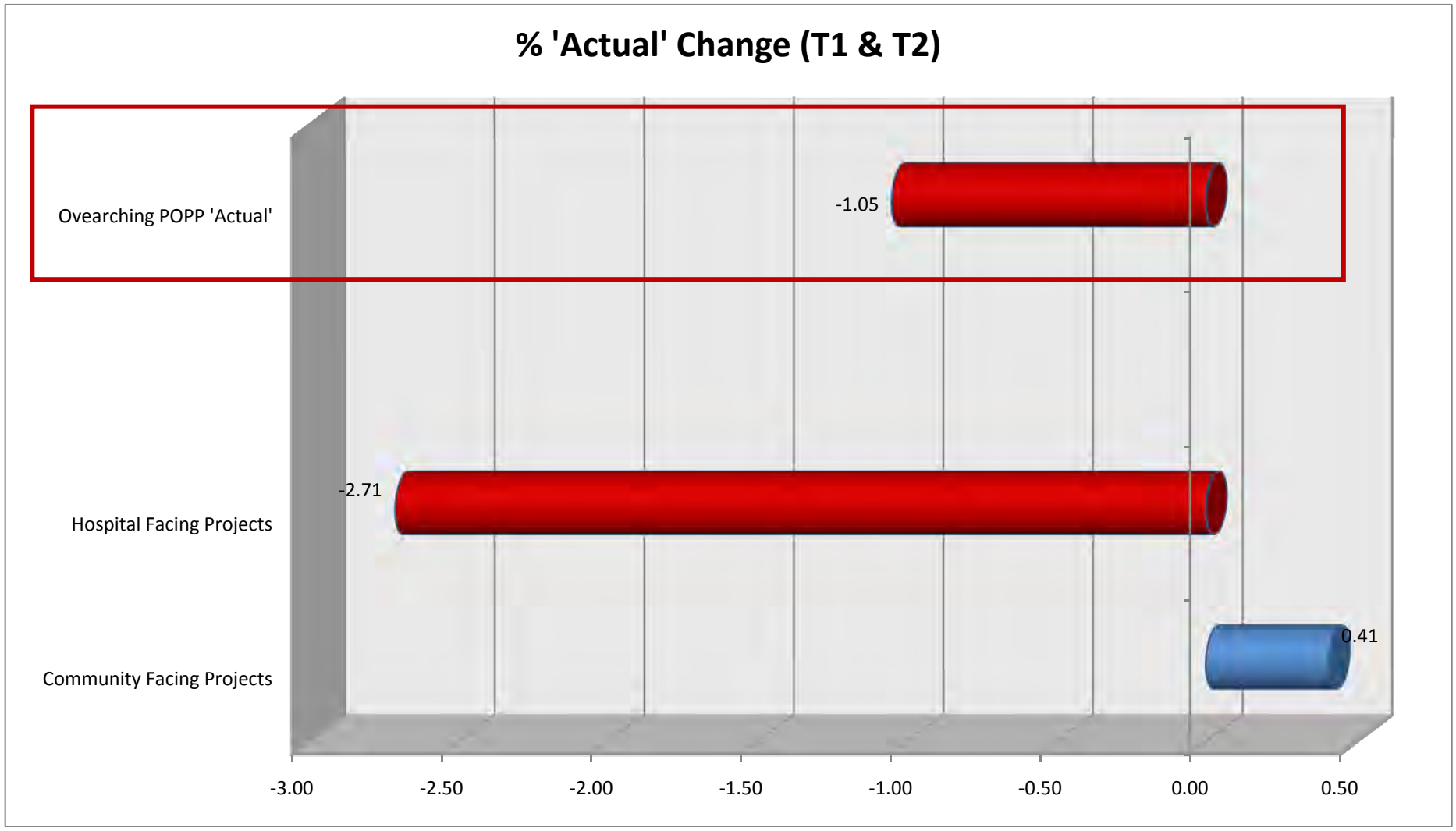
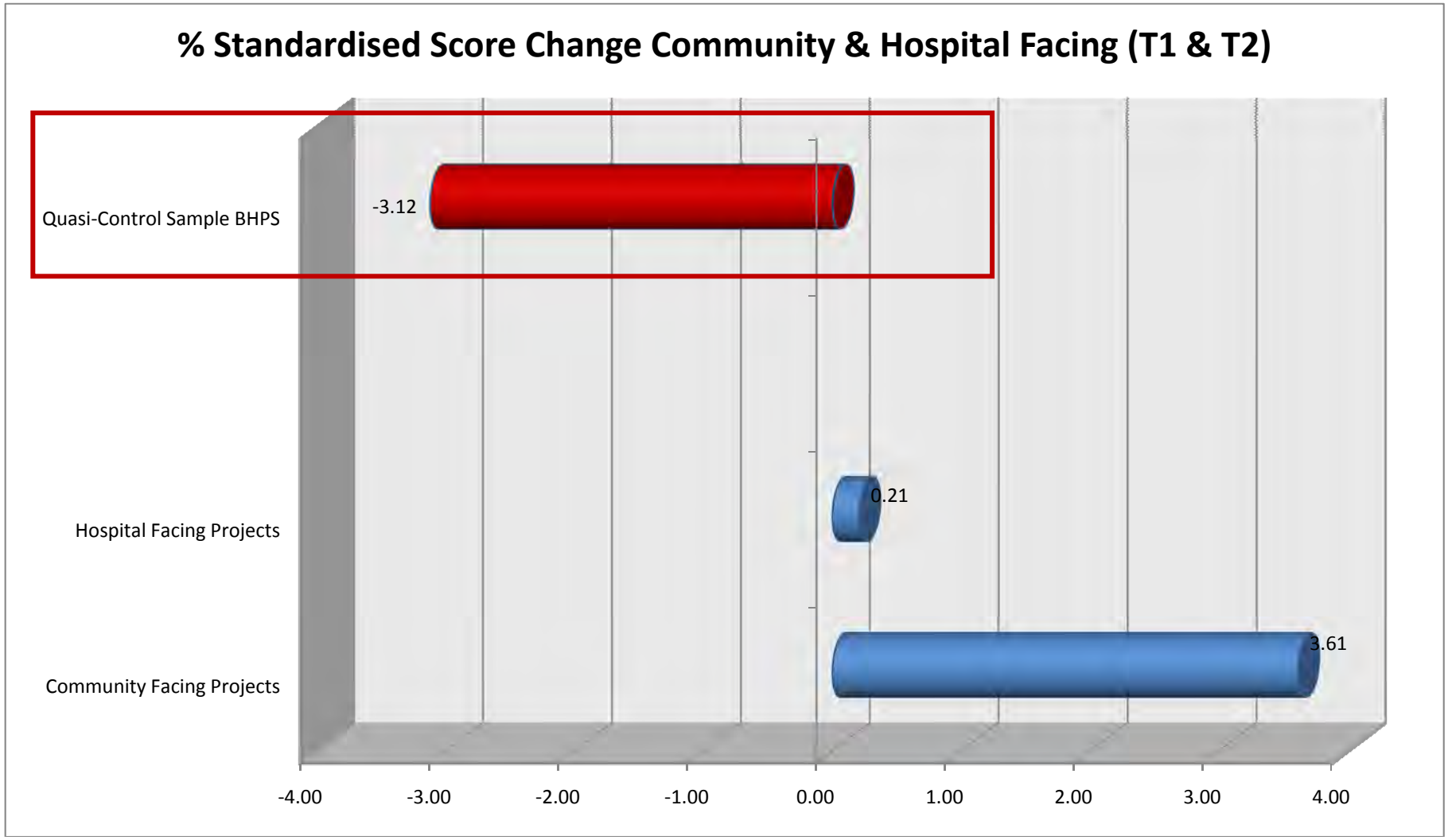


Figure 65. Percentage of standardised score change: community and hospital facing (T1 & T2)



6.8.3 Detailed findings EQ-5D changes: actual scores

The following tables and figures detail the changes in the HRQoL of those users within projects depending on their focus.

6.8.4 Lower level – 'upstream' groupings

Well-being-practical

Users of the projects providing that 'little bit of help' reported a far higher change in their HRQoL than might be expected from such simple focused services. It could be argued that those services that provide simple aids and adaptations can change the ease of self-care. A grab-rail attached to a lavatory, bath or shower can make washing easier. Similarly, providing gardening services or making simple repairs can reduce user anxiety. Such projects appeared to have a notable impact on users' HRQoL, with their change in this respect 6% greater than that of the overall sample and 16% greater than that of the quasi-control group.

Table 93. EQ-5D changes: 'actual scores' pre- and post-intervention: well-being - practical

	Actual change	Standardised change	BHPS quasi-control
EQ5D 'score' pre-intervention (T1)*	0.549943925	0.549943925	0.55531
EQ5D 'score' post-intervention (T2)*	0.579365385	0.619266562	0.53798
Absolute variation	0.029421459	0.069322636	-0.01733
% variation	**5.349901696**	**12.60540088**	**-3.12077**
% difference between overarching % variation and WB-P	**6.397901696**		
% diff between standardised and BHPS quasi-control	**15.72640088**		

*p=0.07 (Friedman)

Figure 66. EQ-5D changes: 'actual scores' pre- and post-intervention: well-being-practical

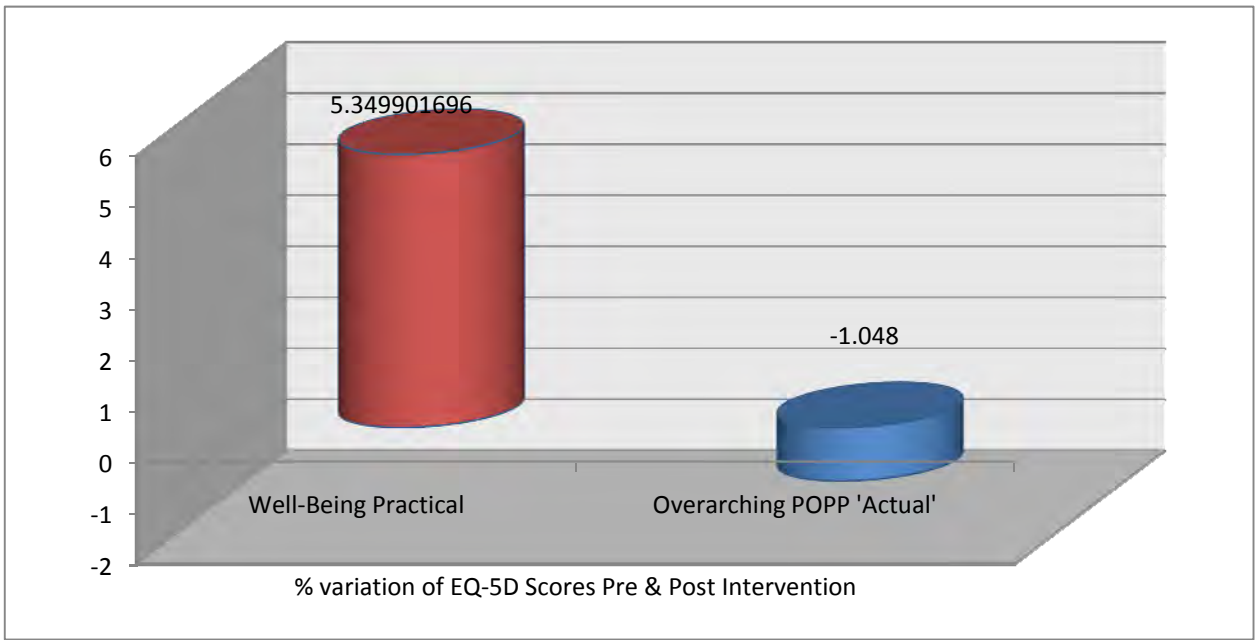
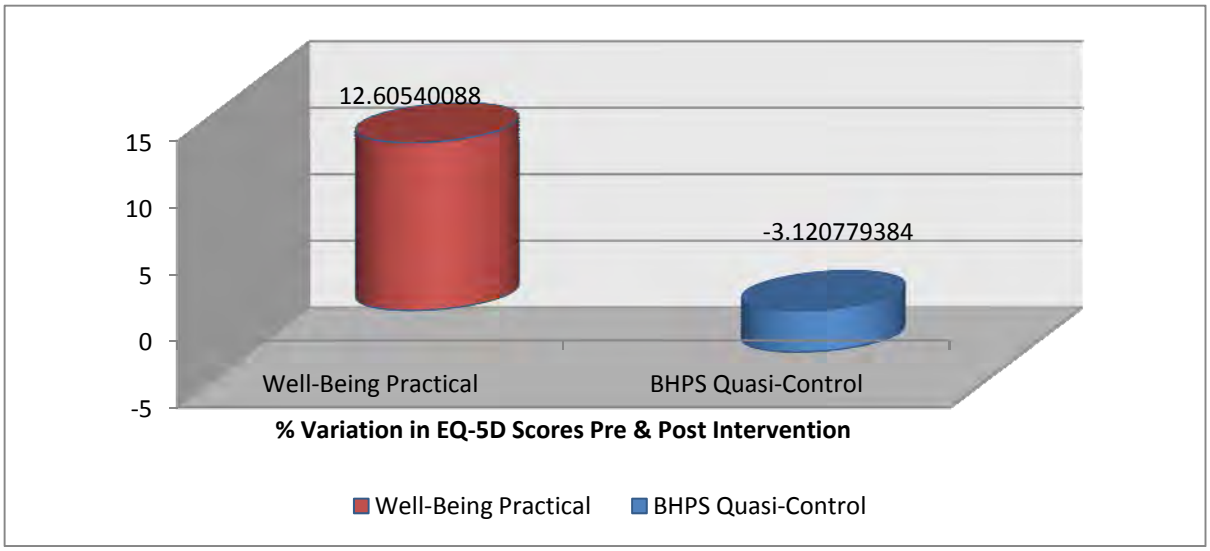


Figure 67. Well Being – Practical - Percentage of standardised variation in EQ-5D scores pre- and post-intervention, compared to BHPS quasi-comparison group.



Well-being - emotional/social/isolation

For users of those projects focused toward psycho-social outcomes, their HRQoL deteriorated quite markedly over the short time-frame of the intervention. Compared with all other projects within the overall sample (number of projects=62), there was a 3% further drop in users' reported HRQoL. Similarly, against the BHPS sample there was a further 0.5% deterioration.

Table 94. EQ-5D changes: 'actual scores' pre- and post-intervention: well-being - emotional

	Actual change	standardised change	BHPS quasi-control
EQ5D 'score' pre-intervention (T2)	0.64188	0.64188	0.55531
EQ5D2 'score' post-intervention (T2)	0.61588	0.62522	0.53798
Absolute variation	**-0.02600**	**-0.01667**	**-0.01733**
% variation	**-4.05105**	**-2.59628**	**-3.12078**
% difference between overarching % variation and WB-E/S	**-3.00300**		
% diff between standardised and BHPS quasi-control	**-0.52450**		

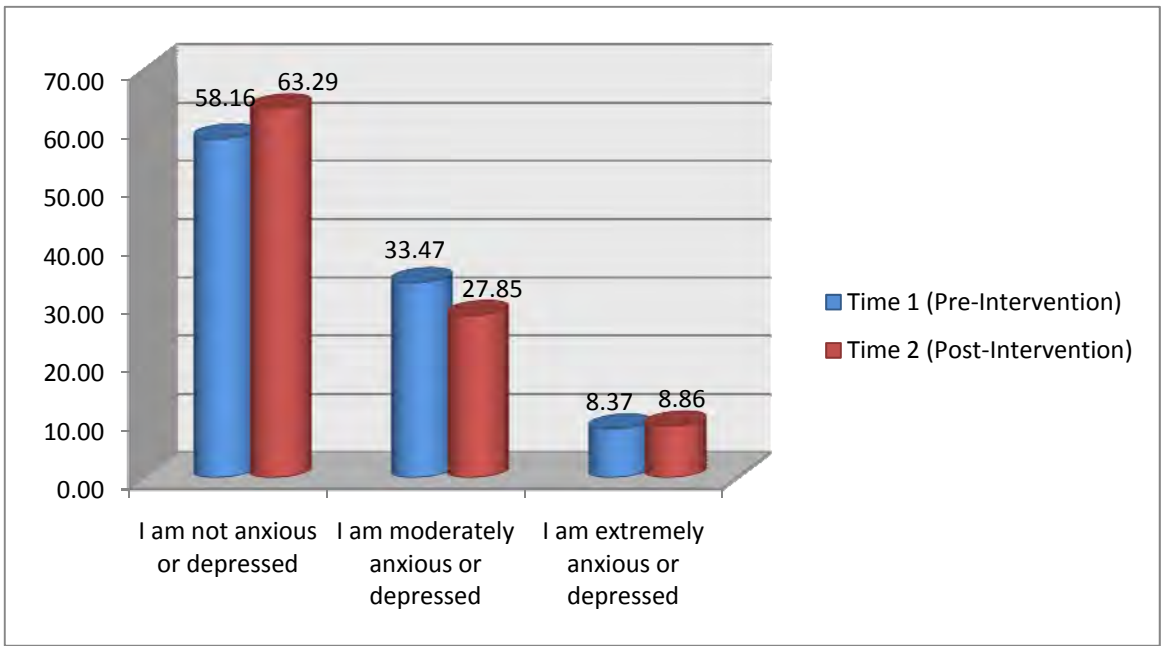
p=0.15 (Friedman)

It is within this category that the limitations of using HRQoL for psycho-social focused projects become most clear. It would not reasonably be expected that projects designed to provide social support (through lunch clubs or outings) or emotional support would necessarily affect mobility, self-care, usual activities or pain/discomfort. In contrast, however, it could reasonably be expected that the provision of some social event or a specific low-level mental health intervention might have an impact on anxiety and depression – and this seems to be the case. From Table 95 and Figure 68, it would seem that following the intervention, fewer users reported feeling anxious or depressed: 58% pre-intervention and 63% post-intervention.

Table 95. EQ-5D domain: anxiety/depression

EQ-5D domain – anxiety/depression	Time 1 (pre-intervention)	Time 2 (post-intervention)
I am not anxious or depressed	58.16	63.29
I am moderately anxious or depressed	33.47	27.85
I am extremely anxious or depressed	8.37	8.86

Figure 68. Change in EQ-5D domain: anxiety/depression



When movements in the views of users following the intervention are analysed across this domain, there is indeed a positive change (see Table 96). For example, of the 20 people who reported 'I am extremely anxious or depressed' at Time 1, 12 (60%) reported improvement following the intervention.

Table 96. Change in EQ-5D domain: anxiety and depression (T1 & T2)

		Post-intervention (T2)			Total
		I am not anxious or depressed	I am moderately anxious or depressed	I am extremely anxious or depressed	
Pre-intervention (T1)	I am not anxious or depressed	119 (87%)	17 (12%)	1 (0.7%)	137 (100%)
	I am moderately anxious or depressed	23 (30%)	41 (54%)	12 (16%)	76 (100%)
	I am extremely anxious or depressed	6(30%)	6 (30%)	8(40%)	20 (100%
	Totals	**148 (63%)**	**64 (28%)**	**21 (9%)**	**233 (100%**

It can be argued that the EQ-5D is not a suitable measure within this specific grouping of projects, focused toward improving emotional well-being and reducing social isolation. However, change can

be measured across overall quality of life and the outcomes from this measure are reported below in 6.11.

Well-being-physical health

In contrast, it is appropriate to use the EQ-5D to measure changes resulting from participation in efforts to improve physical health, for instance through exercise classes. Exercise by older people builds balance, strength and flexibility and increases bone density (a major factor in falls) (Verhagan 2004, Gardner 2000). In addition, exercise has a positive effect on mood. Following such interventions, users of these POPP projects reported an increase in their HRQoL.

Table 97. Change in EQ-5D domain: Well-being - physical health (T1 & T2)

	Actual change	Standardised change (12 months)	BHPS quasi-control
EQ5D 'score' pre-intervention (T2)	0.505893617	0.505893617	0.55531
EQ5D2 'score' post-intervention (T2)	0.530595745	0.568995598	0.53798
Absolute variation	**0.024702128**	**0.063101981**	**-0.01733**
% variation	**4.88287**	**12.47336968**	**-3.12078**
% difference between overarching % variation and WB-PH	**5.931**		
% diff between standardised and BHPS quasi-control	**8.003**		

*n = 47, Friedman, p = 0.14

These projects had a 6% per cent greater impact on HRQoL compared with the overall POPP findings, and an 8% difference compared to the quasi-control group.

Figure 69. Change in EQ-5D domain: Well-being - physical health, POPP sample

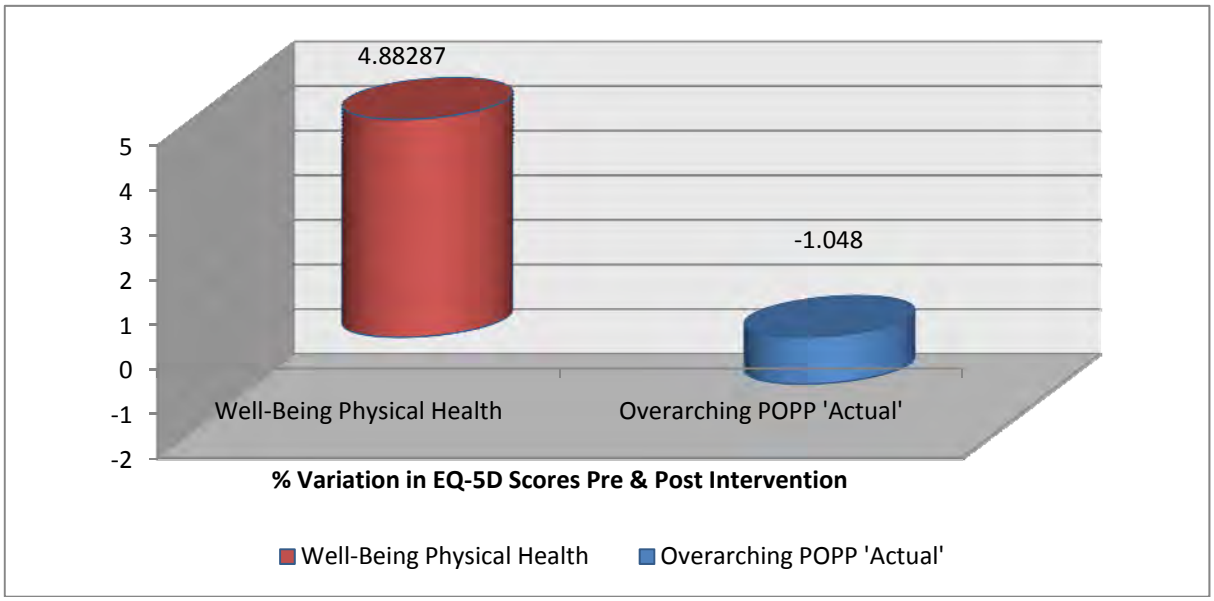
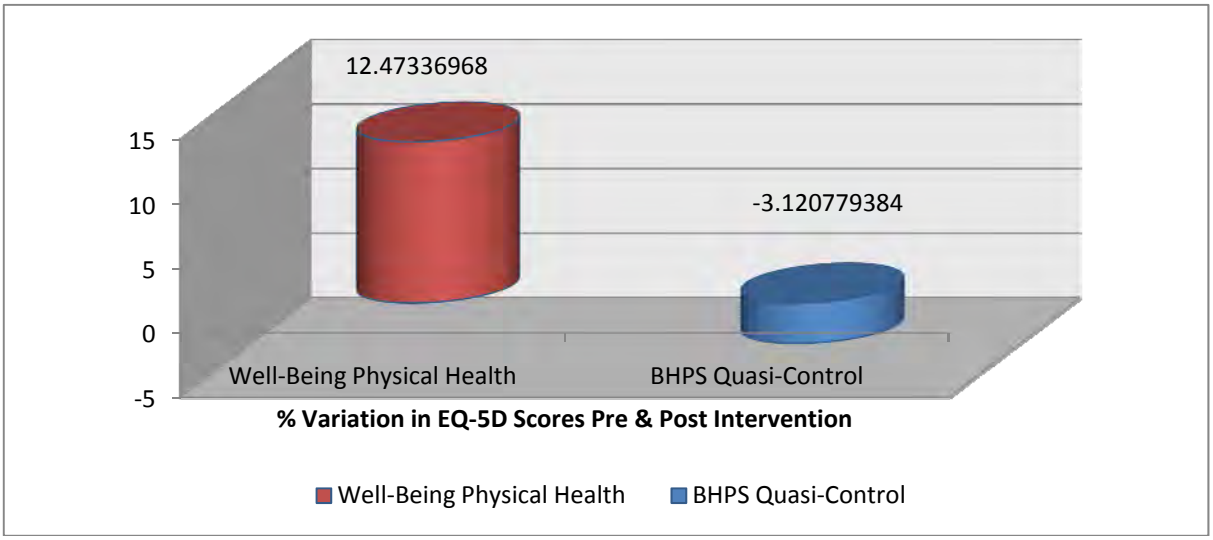


Figure 70. Change in EQ-5D domain: Well-being - physical health, compared to BHPS



Well-being - community

Projects in this category include neighbourhood schemes and community development, as well as direct interventions developed by older individuals living within the locality. Projects ranged across social recreation and learning opportunities, volunteering, healthy-living activities and others. Given such foci, it was not expected that there would be strong differences in individual HRQoL before and after any intervention. Where change might be expected was in overall quality of life, through increased social inclusion and reduction in isolation. That there was a slight decrease in the HRQoL of people taking part in such projects (see Table 98) is not surprising. Nevertheless, when compared with the findings from the overarching POPP and proxy samples, there was a clear increase. Such findings appear somewhat suspicious (or spurious) and are therefore worth examining more closely.

Table 98. Change in EQ-5D domain: Well-being -community (T1 & T2)

	Actual change*	**Standardised change***	**BHPS quasi-control**
EQ5D 'score' pre-intervention (T2)	0.717660377	0.717660377	0.55531
EQ5D2 'score' post-intervention (T2)	0.714714286	0.743627089	0.53798
Absolute variation	**-0.002946092**	**0.025966711**	**-0.01733**
% variation	**-0.410513348**	**3.618245097**	**-3.12078**
% difference between overarching % variation and WB-Community	**-0.637**		
% difference between standardised and BHPS quasi-control	**6.738**		

* Friedman, p = 0.17

It can be noted from the above table that individuals using these services reported good health (0.72) equivalent to 72%. We would not expect to find an increase their HRQoL as this is already very high and a proportion of the population would be expected to deteriorate over the period of the interventions. In consequence, it is not surprising that their HRQoL was reduced although, as has been noted, when such changes are standardised, there is an overall increase in the EQ-5D, i.e. an improvement. To assess whether such a change could reasonably be attributed to the projects, each of the domains (mobility, self-care, usual activities, pain/discomfort and anxiety) was analysed. It was found that the change in EQ-5D was due solely to reported changes in levels of pain/discomfort (see Table 99)

Table 99. The domain of pain/discomfort (collapsed) pre and post intervention

		Post-intervention (T2)		
		No problems with pain	**Problems with pain**	**Totals**
Pre-intervention (T1)	No problems with pain	37 (75%)	12 (25%)	49 (100%)
	Problems with pain	26 (23%)	86 (77%)	112 (100%)
Totals		**63 (39%)**	**98 (61%)**	**161 (100%)**

* McNemar, p = 0.03

The domains were then examined across each of the seven projects and it was found that not only was the change due to this single domain, but the impact was skewed by the outcomes reported by one project in this category.

Table 100. The domain of pain/discomfort (collapsed) pre and post intervention explored within a single project (Site 88, Project 83)

		Post-intervention (T2)		
		No problems with pain	**Problems with pain**	**Total**
Pre-intervention (T1)	No problems with pain	3(100%)	0 (100%)	3 (100%)
	Problems with pain	5(29%)	12 (71%)	17 (100%)
Totals		**8(40%)**	**12 (60%)**	**20 (100%)**

* McNemar, p = 006

Through a study of the annual reports and the local evaluation report for this particular project (coded 88, 83), it would seem unlikely that there was specific health advice or direct signposting. Rather, it seemed to concentrate on social engagement:

> *'The [project] was considered to be especially successful in encouraging older people to get out and socialise, and older people made friendships with people they would not otherwise have met which continued outside of the activities'.* Local Evaluation Report: p29 (Site 88)

Such changes reported in pain/discomfort are likely to be coincidental – and not part of the impact of the project. However, our findings might be valid if such pain was psychosomatic, owing to social isolation. But as we cannot know, care needs to be taken in interpreting these findings, particularly as the overarching categorical change is not statistically significant.

Information and Signposting

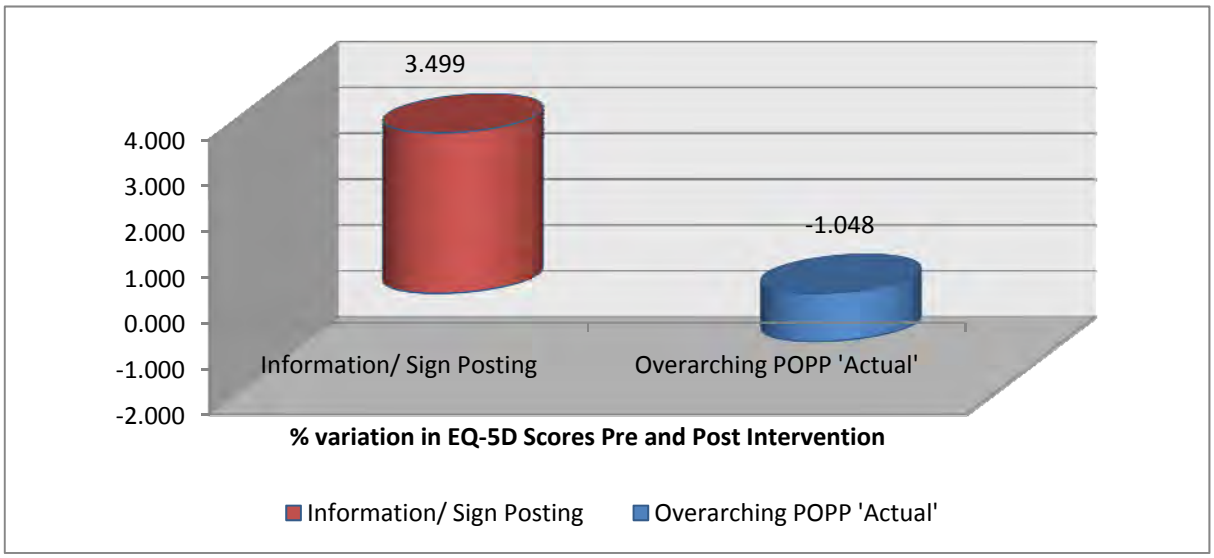
Any change in users' HRQoL is likely to be an indirect outcome from information and signposting services. That is, if individuals are signposted correctly or, through information, become aware of previously unknown services, their subsequent access may affect their scores following involvement in the project. From Table 101 and Figure 71, it can be seen that a positive change was found.

Table 101. Change in EQ-5D domain: information & signposting (T1 & T2)

	Actual change	Standardised change	BHPS quasi-control
EQ5D 'score' pre-intervention (T2)	0.583220779	0.583220779	0.55531
EQ5D2 'score' post-intervention (T2)	0.603626667	0.584365127	0.53798
Absolute variation	**0.020405887**	**0.001144348**	**-0.01733**
% variation	**3.498827232**	**0.196211813**	**-3.12078**
% difference between overarching % variation and Information/Signposting	**4.547**		
% diff between standardised and BHPS quasi-control	**3.316211813**		

* Friedman, p = 0.11

Figure 71. Change in EQ-5D domain: information & signposting (T1 & T2) compared with overarching POPP sample



It should be noted that this finding was not statistically significant. Indeed, when the change is standardised to 12 months, a reduced effect is seen. This is due to the effect of 'extremes'. For some people within this sample, the information and advice service did not stop any deterioration: when we standardise the scores, any negative effects become magnified. Such techniques enable an assessment of the balance between those who improved and those who deteriorated. Within this grouping it would seem that more individuals report deterioration than those who report improvements. The difficulties of the variance within and between projects have been discussed above.

Carers services

Data for both time 1 and time 2 were available for only one Carers project (Site 22), but it is nevertheless, important to identify the impact of this service. The project was an 'Expert Carers Programme: Looking After Me' course, aimed to increase carers' skills and coping strategies. Given this focus, rather than on practical respite and or sitting services, it is unlikely that the overall HRQoL of users would change and, indeed, the positive change of 0.005 is negligible. Moreover, the impact from the course would seem to be time-limited. When the scores are standardised to 12 months, there is an increased deterioration in HRQoL (-0.04, -6%), with users having a lower level of HRQoL compared to the quasi-control sample (see Table 102 and the figures that follow).

Table 102. Change in EQ-5D domain: Carers services (T1 & T2)

	Actual change	Standardised change	BHPS quasi-control
EQ5D 'score' pre-intervention (T2)	0.681076923	0.681076923	0.55531
EQ5D2 'score' post-intervention (T2)	0.6864375	0.640521245	0.53798
Absolute variation	**0.005360577**	**-0.040555678**	-0.01733
% variation	**0.787073639**	**-5.954639875**	-3.12078
% difference between overarching % variation and Carers Services	**1.835**		
% diff between standardised and BHPS quasi-control	**-2.835**		

n=13, p=0.70

Figure 72. Change in EQ-5D domain: Carers Services (T1 & T2) compared with overarching POPP sample

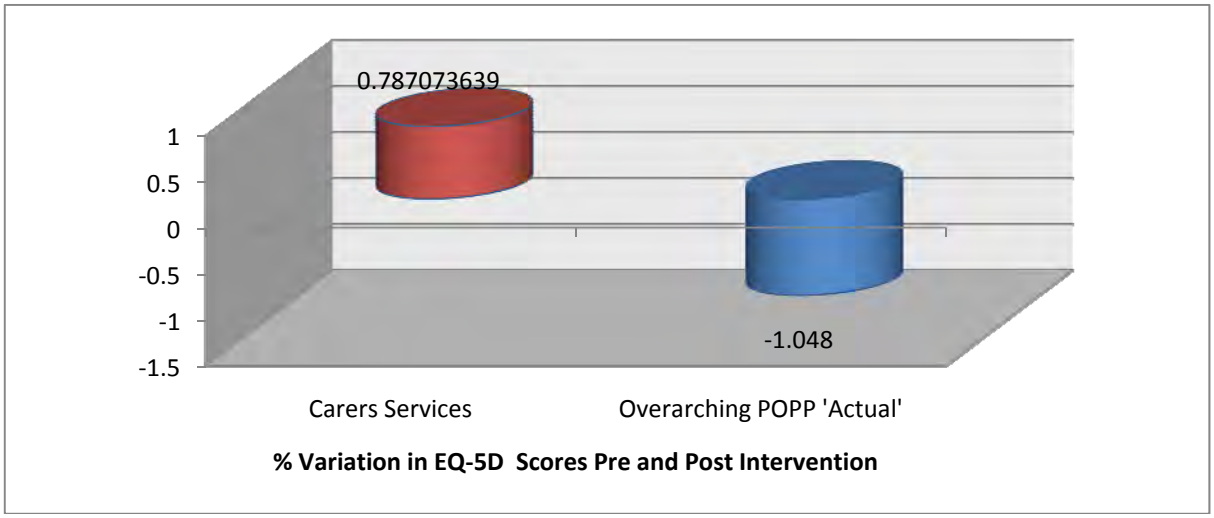
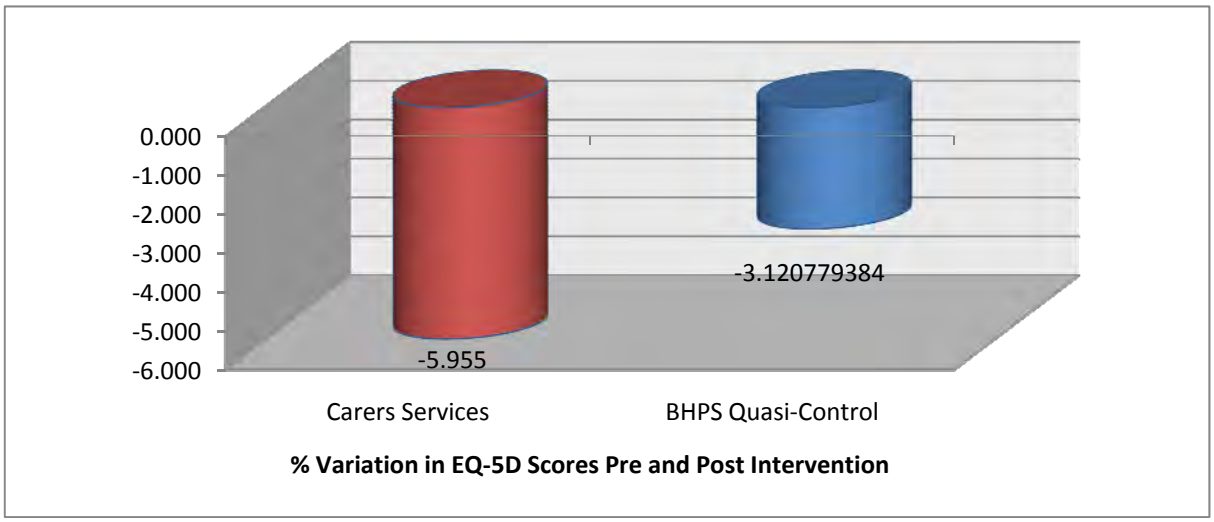


Figure 73. Change in EQ-5D domain: Carers Services (T1 & T2) compared with BHPS quasi-control sample



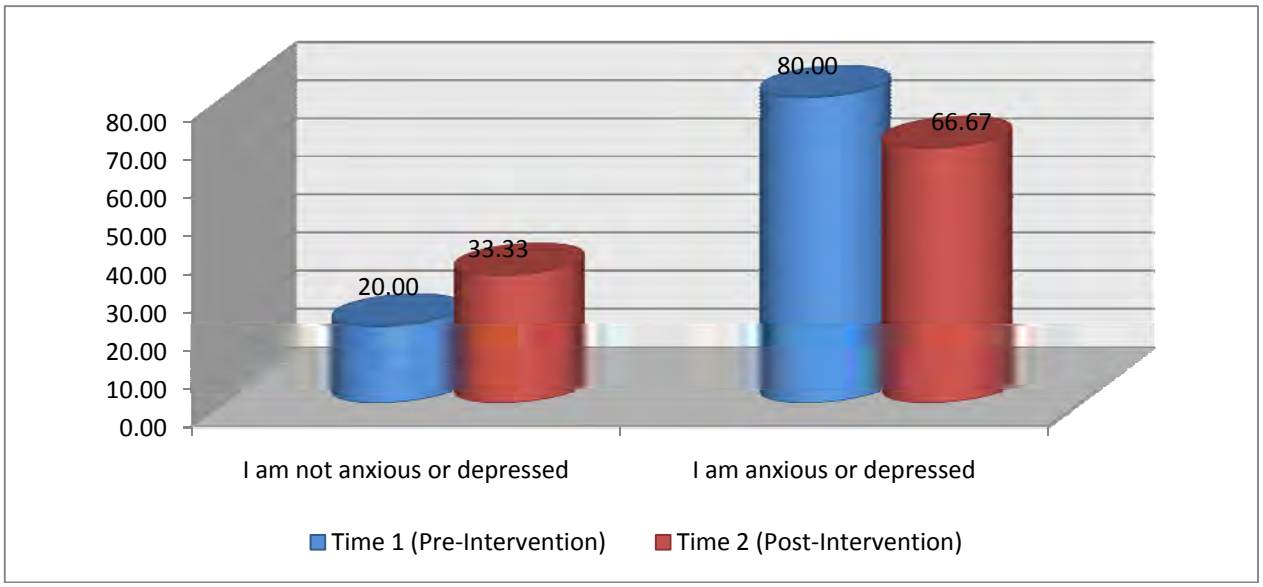
It could be argued that using the EQ-5D measure to assess effectiveness in this type of project is inappropriate. The project is focused on improving psycho-social outcomes rather than health, and any overall mental-health related measure (e.g. GHQ12) would tell us more about changes in self-efficacy than any health measure. As part of the 'Expert Carers Programme', users should start to feel more in control of their situation or know better where to go to obtain appropriate support. The

domains of 'usual activities' and 'anxiety/depression' should provide a better picture of changes before and after the intervention. From Table 103 and Figure 74, it can be seen that for the 14 individuals who reported being moderately anxious or depressed (a level at which such a course might be effective), one fifth stated that they were no longer anxious or depressed following such use, whilst only one user reported a deterioration in symptoms.

Table 103. Change in EQ-5D domain: anxiety and depression: Carers services (T1 & T2)

		Post -intervention (T2)			
		I am not anxious or depressed	**I am moderately anxious or depressed**	**I am extremely anxious or depressed**	**Totals**
Pre-intervention (T1)	I am not anxious or depressed	3 (75%)	1 (25%)	0 (0%)	4 (100%)
	I am moderately anxious or depressed	4 (27%)	9 (64%)	1 (7%)	14 (100%)
	I am extremely anxious or depressed	0 (0%)	0 (0%)	2 (100)	2 (100%)
	Totals	**7 (35%)**	**10 (50%)**	**3 (15%)**	**20 (100%)**

Figure 74. Change in EQ-5D domain: anxiety and depression (collapsed): Carers Services (T1 & T2)



Within the domain of 'usual activities' (including work, study, housework, family or leisure activities), there was also a reported improvement. Of those who reported some problems with performing usual activities, over one third no longer reported such difficulties after the course (see Table 104). Such findings provide some support for the proposition that individuals were coping better, perhaps having learned from the course and then accessed respite services or asked for help from family and friends.

Table 104. Change in EQ-5D domain: performing usual activities: Carers services (T1 & T2)

		Post-intervention (T2)		
		I have no problems with performing my usual activities	**I have some problems with performing my usual activities**	**Totals**
Pre-intervention (T1)	I have no problems with performing my usual activities	12 (92%)	1 (8%)	13 (100%)
	I have some problems with performing my usual activities	3 (38%)	5 (62%)	8 (100%)
Total		**15 (71%)**	**6 (29%)**	**21 (100%)**

Despite improvements in these domains, if carers are to be appropriately supported and an impact seen in their overall HRQoL, some direct form of support, such as respite or sitting services, will need to be available. From interviews with carers, it would seem that although they welcomed the service, there was still a huge need for respite and sitting services.

Involving older people

The two projects in this particular category were completely different from one another. The first focused on training older people to participate in the local POPP programme as decision-makers: to be involved in the governance, operational service delivery, the evaluation steering group or to assist in obtaining patients' or users' opinions on services. The second built up community integration and support through a 'good neighbour' scheme. Given that neither of these projects had an improvement in HRQoL as its primary or even secondary focus, using the EQ-5D as a measure is arguably inappropriate, with any findings likely to be spurious. In fact, there was a slight decrease in the overall HRQoL of users of projects in this group, increasing over time. Such a relationship is not statistically significant (Table 105 and Figure 75).

Table 105. Change in EQ-5D: Involving older people (T1 & T2)

	Actual change	**Standardised change**	**BHPS quasi-control**
EQ5D 'score' pre-intervention (T2)	0.764	0.764	0.55531
EQ5D2 'score' post-intervention (T2)	0.759	0.763	0.53798
Absolute variation	**-0.006**	**-0.001**	-0.01733
% variation	**-0.746**	**-0.182**	-3.12078
% difference between overarching % variation and Involving Older People	**-0.301**		
% diff between standardised and BHPS quasi-control	**-2.938**		

n = 45, p=0.68

Where a change might be seen is in overall quality of life, given that involvement in volunteering benefits volunteers along with recipients. It may also provide meaningful roles for older people promoting 'citizenship participation and the social economy' (Narushima 2005: 567). The data on overall quality of life can be found below (6.11).

Figure 75. Change in EQ-5D: involving older people compared with overarching POPP sample

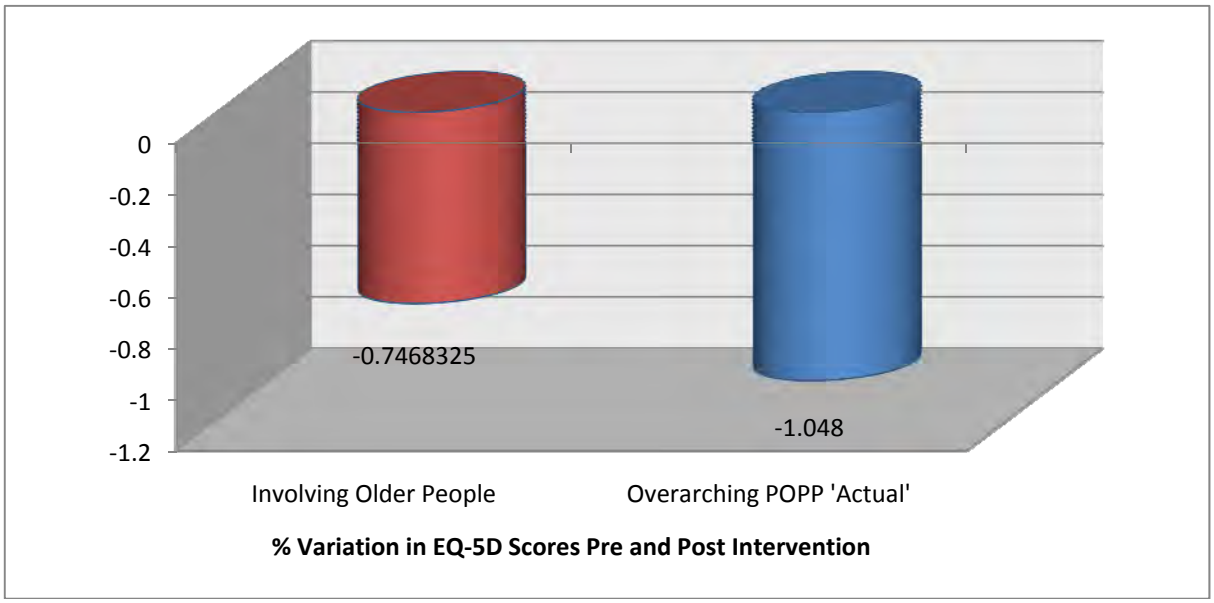
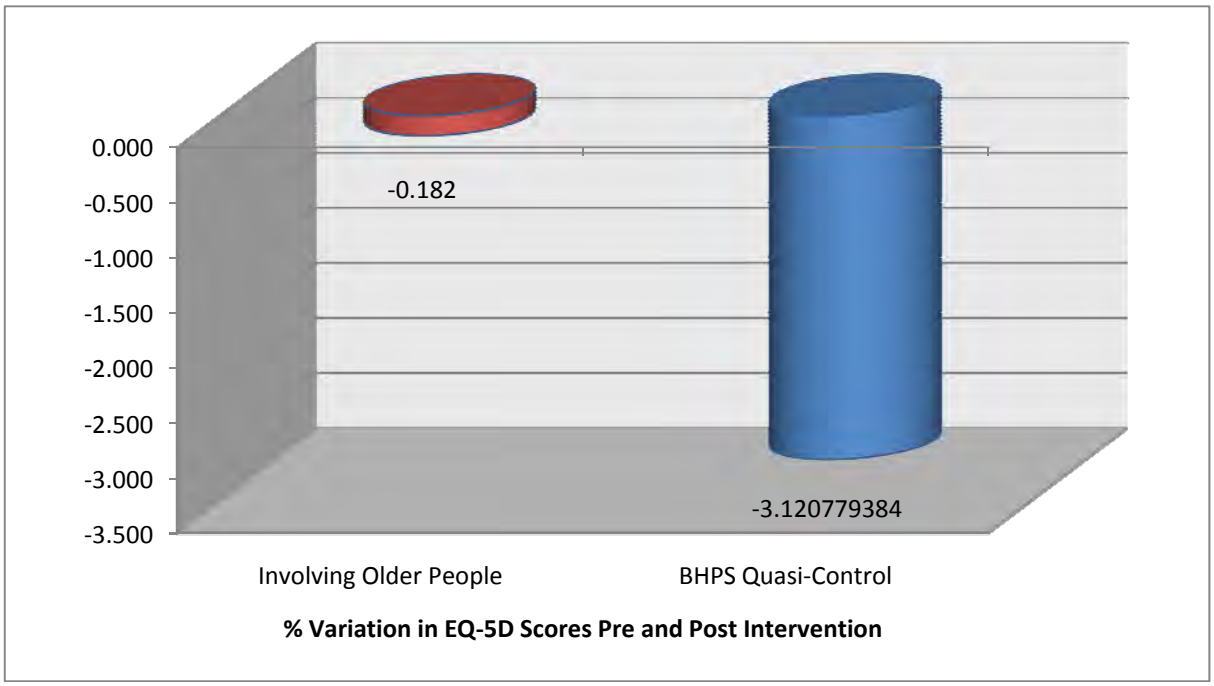


Figure 76: Change in EQ-5D: involving older people, as compared with BHPS sample



6.8.5 Higher needs levels groupings

Proactive Case Co-ordination

In contrast to the previous category, use of the EQ-5D to assess outcomes from Proactive Case Co-ordination could be argued to be eminently appropriate. Proactive case finding is usually a service for individuals with complex needs and/or at risk of hospital admission and is primarily focused toward providing appropriate health and community care services. Because the projects within this category had a wide range of foci, it is almost impossible to compare like with like. For example, one project identified individuals who were at risk of hospital admission, so that a multi-disciplinary team could work with them to ensure more appropriate service provision, preventing admissions to secondary

care. In contrast, a second project had no particular admission criteria, obtaining referrals across the whole population and working with individuals with a range of needs to reduce social isolation, falls and anxiety or depression. In presenting the findings from this grouping, therefore, it is necessary to examine overarching changes and then 'drill down' to explore the particular outcomes for individuals with different needs.

From Table 106 and Figure 77, it can be seen that there was a very slight drop in HRQoL scores of participants pre- and post the interventions (-0.002, or -0.5%). It could be argued that such projects maintained overall quality of life: when the standardised scores are explored, an improvement is demonstrated (0.02 or 4%), and both the actual and 'standardised' scores are higher than the overall POPP HRQoL and that of the BHPS comparison group.

Table 106. Change in EQ-5D: Proactive case co-ordination (T1 & T2)

	Actual change	**Standardised change**	**BHPS quasi-control**
EQ5D 'score' pre-intervention (T2)	0.458058974	0.458058974	0.55531
EQ5D2 'score' post-intervention (T2)	0.455585013	0.477855528	0.53798
Absolute variation	**-0.002473961**	**0.019796554**	-0.01733
% variation	**-0.540096708**	**4.321835162**	-3.12078
% difference between overarching % variation and Proactive case co-ordination	**-0.508**		
% diff between standardised and BHPS quasi-control	**2.580**		

n = 30, p=0.9

Figure 77. Change in EQ-5D: Proactive case co-ordination compared with POPP actual (T1 & T2)

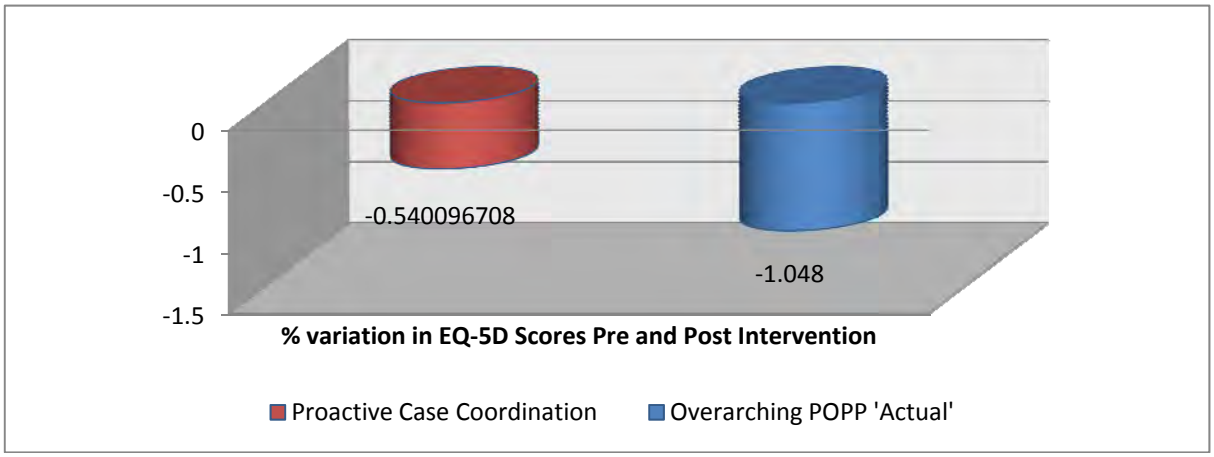
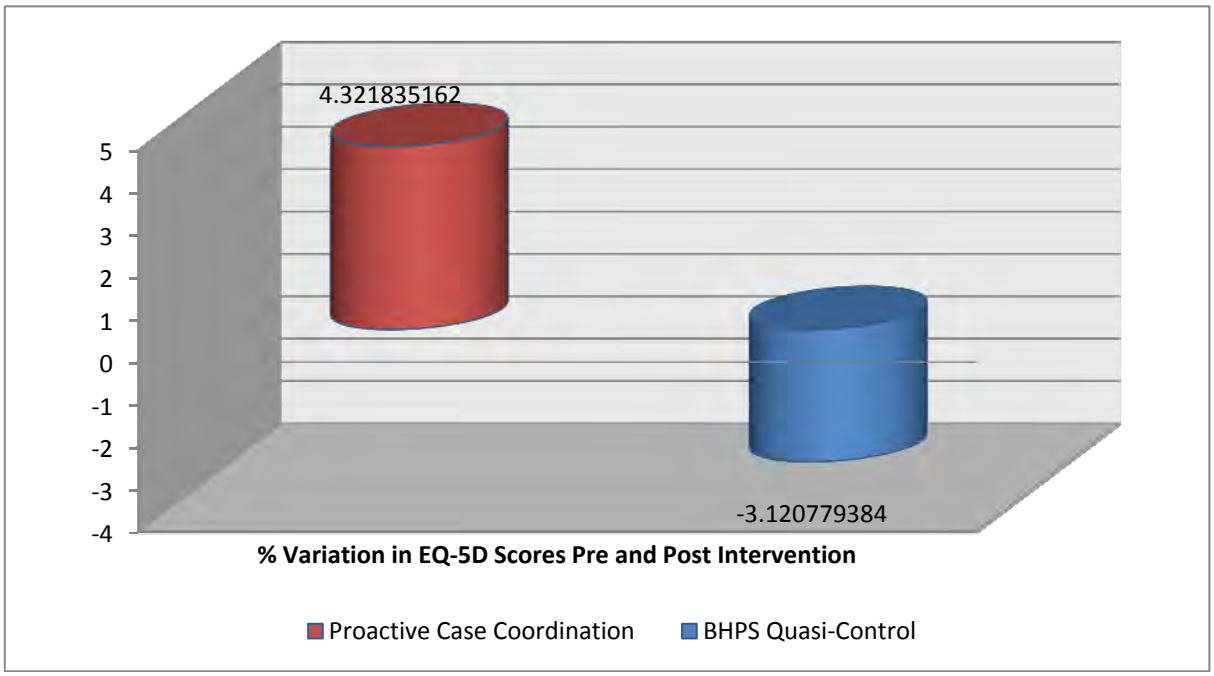


Figure 78. Change in EQ-5D: proactive case co-ordination compared with BHPS: (T1 & T2)



It could be expected that such a category, with its focus on identifying those at risk and preventing further deterioration, should provide a more positive change in HRQoL. To understand the issues better, we analysed projects according to the different Levels of Need of their users. From Table 107, it can be seen that if those projects aimed at people with designated Level 2 needs (those at risk of hospital admission) are examined, there is a far greater actual and standardised percentage change.

Table 107. Change in EQ-5D: Proactive case co-ordination within Level 2 Needs (T1 & T2)

	Actual change	**Standardised change**	**BHPS quasi-control**
EQ5D 'score' pre-intervention (T1)	.42694	.42694	0.55531
EQ5D2 'score' post-intervention (T2)	.43188	.47	0.53798
Absolute variation	**0.0049**	**0.046**	-0.01733
% variation	**1.1583**	**10.69**	-3.12
% difference between overarching % variation and Proactive case co-ordination	**2.206**		
% diff between standardised and BHPS quasi-control	**13.817**		

Figure 79.Change in EQ-5D: Proactive case co-ordination (Level 2 Needs) compared with POPP actual

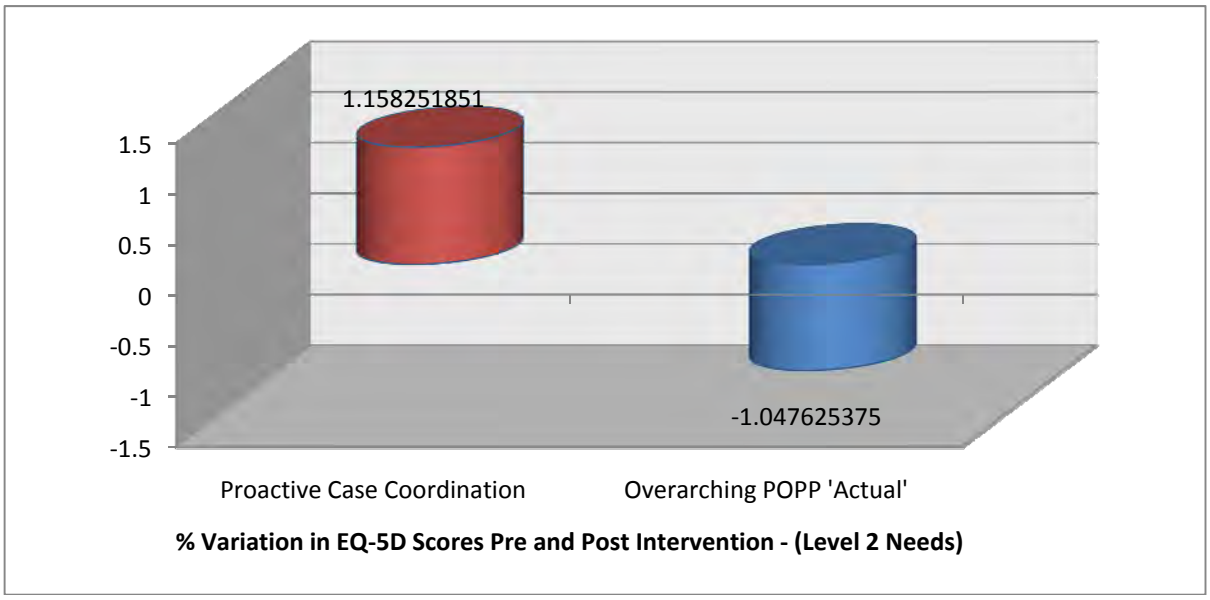
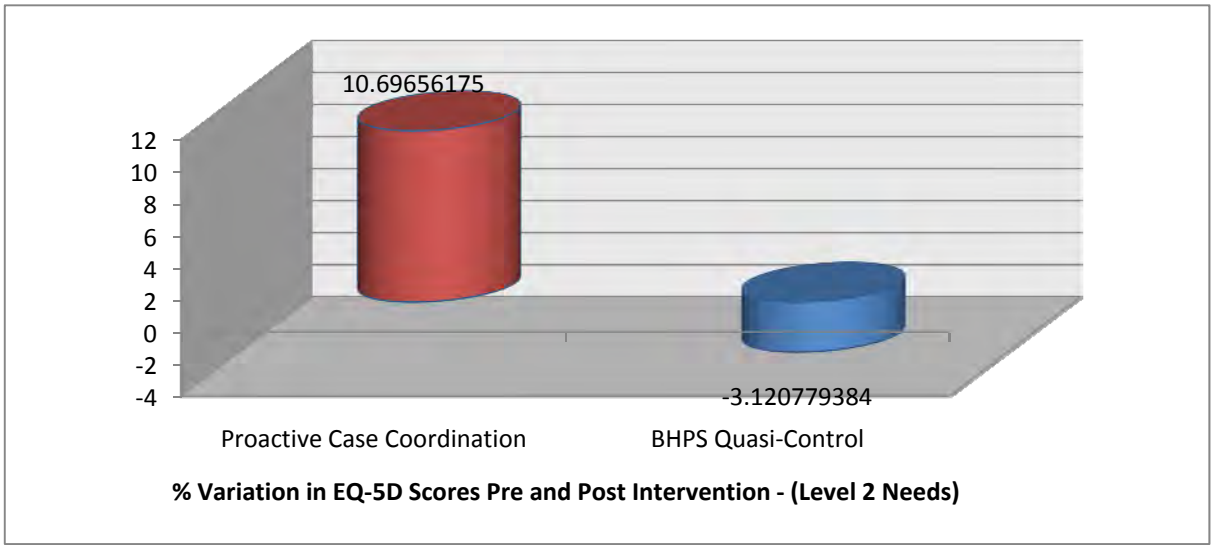


Figure 80. Change in EQ-5D: Proactive case co-ordination (Level 2 Needs) compared with BHPS



In contrast, when projects aimed at Level 3 needs are explored, we found a large drop in the scores of EQ-5D for participants before and after the intervention.

Table 108. Change in EQ-5D, Proactive case co-ordination, Needs level 3 (T1 & T2)

	Actual change	Standardised change	BHPS quasi-control
EQ5D 'score' pre-intervention (T1)	.34233	.34233	0.55531
EQ5D2 'score' post-intervention (T2)	.29207	.19	0.53798
Absolute variation	**-0.0503**	**-0.1542**	**-0.01733**
% variation	**-14.6822**	**-45.03976873**	**-3.12078**
% difference between overarching % variation and Proactive case co-ordination (Needs Level 3)	**-15.730**		
% diff between standardised and BHPS quasi-control	**-48.160**		

From Table 108, it can be seen that the initial HRQoL scores were very low, with individuals reporting only 34% of perfect health. Following the intervention, there was a 14% drop in HRQoL.

Figure 81. Change in EQ-5D, Proactive case co-ordination, Needs level 3 (T1 & T2), compared with POPP actual

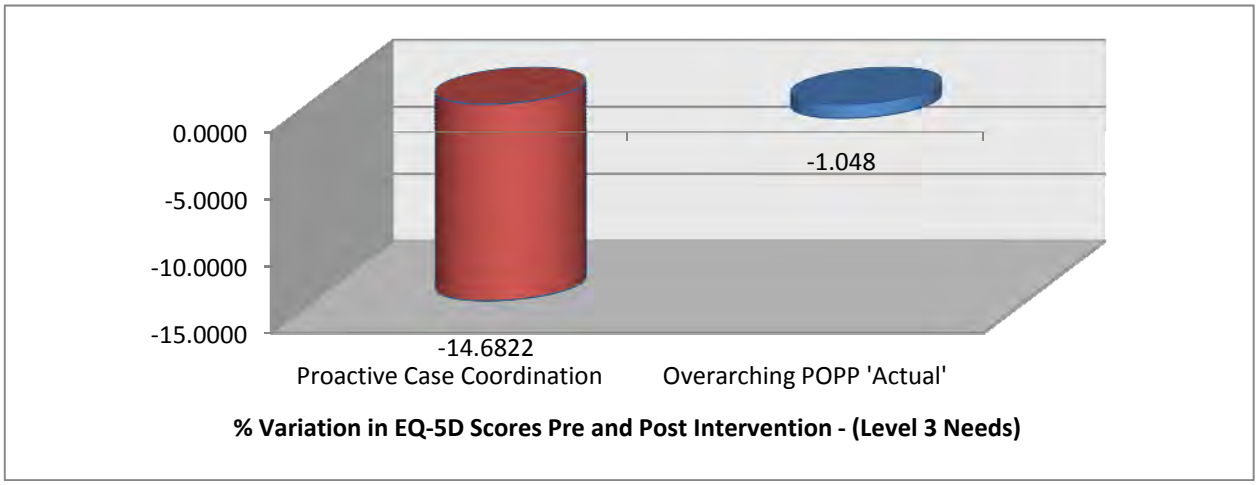
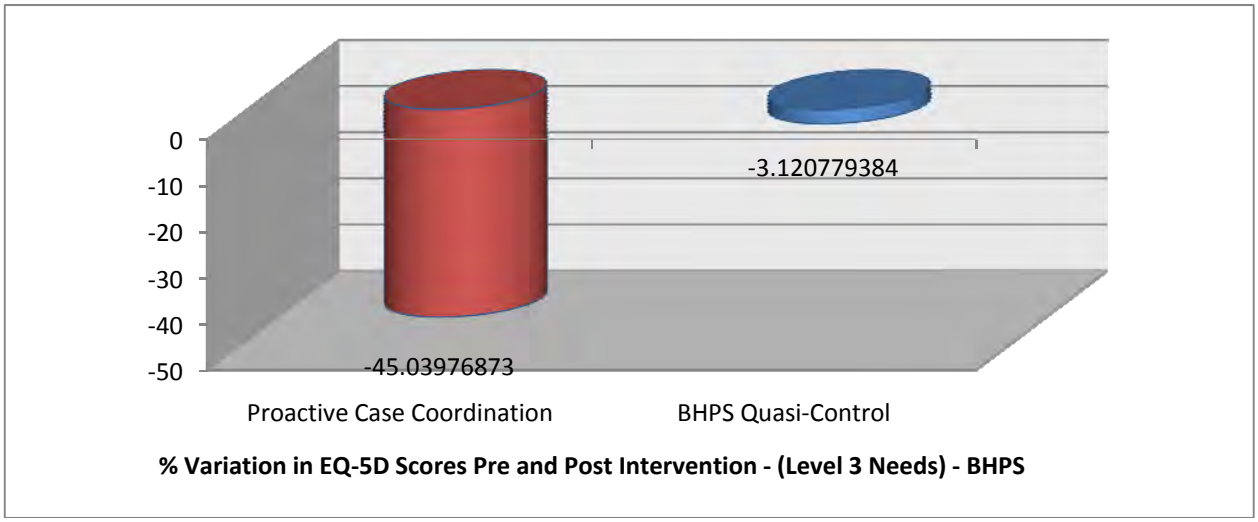
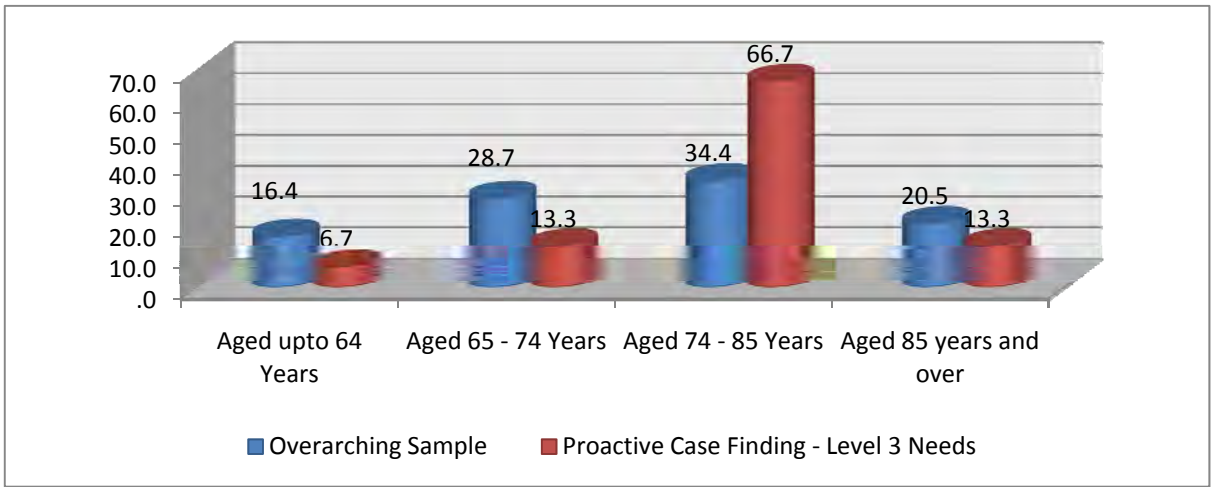


Figure 82. Change in EQ-5D, Proactive case co-ordination, Needs level 3 (T1 & T2), compared with BHPS



Such a drop could be expected, given that those people in these two specific projects were not only frail but within the older old age group. Within the overall sample, those aged 75 and over comprised 55% of the population, whilst those within this sub-category comprised 80% of the overall population. However, such findings do affect the overall mean.

Figure 83. Age range of users: overarching sample, proactive case finding – Level 3 Needs



Long-term conditions – complex needs

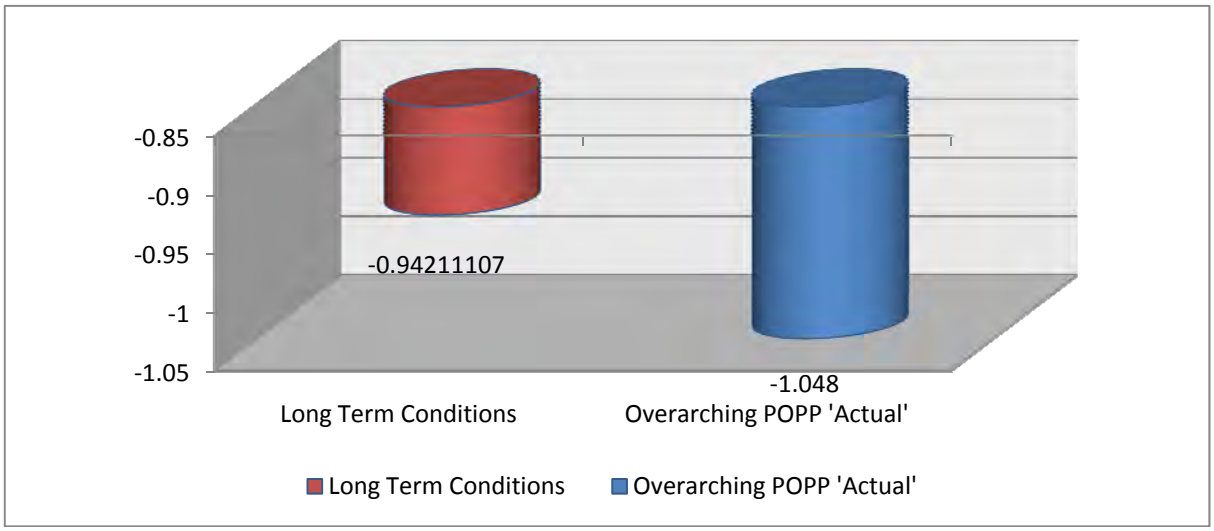
This group of projects includes the implementation of integrated complex care teams, such as clinical nursing staff to support community matrons and generic workers (either health or social care) providing on-going support to users or patients. Two hypotheses might be proffered with respect to any findings. First, as this population is likely to include frailer older people with a number of co-morbidities and who are therefore at risk of hospital admission, any positive change in their HRQoL is unlikely. Nevertheless, there could be some maintenance and, perhaps, a delay in deterioration. Second, as all four projects focused to a greater or lesser extent on the health needs of individuals, a change in HRQoL might be achieved. From Table 109 and Figure 84, it can be seen that this population was indeed deteriorating over time (standardisation % variation -1.93). Yet when their scores are explored, there was such a small change (-0.0043) that it can be strongly argued that their HRQoL was maintained. Indeed, when compared against the overarching scores, participants in projects in this particular group had less negative change (% difference: 0.1).

Table 109. Change in EQ-5D: Long term conditions (T1 & T2)

	Actual change	**Standardised change**	**BHPS quasi-control**
EQ5D 'score' pre-intervention (T2)	0.458512	0.458512	0.55531
EQ5D2 'score' post-intervention (T2)	0.454192308	0.44966107	0.53798
Absolute variation	**-0.004319692**	**-0.00885093**	-0.01733
% variation	**-0.94211107**	**-1.930359509**	-3.12078
% difference between overarching % variation and Long Term Conditions	**0.106**		
% diff between standardised and BHPS quasi-control	**1.190**		

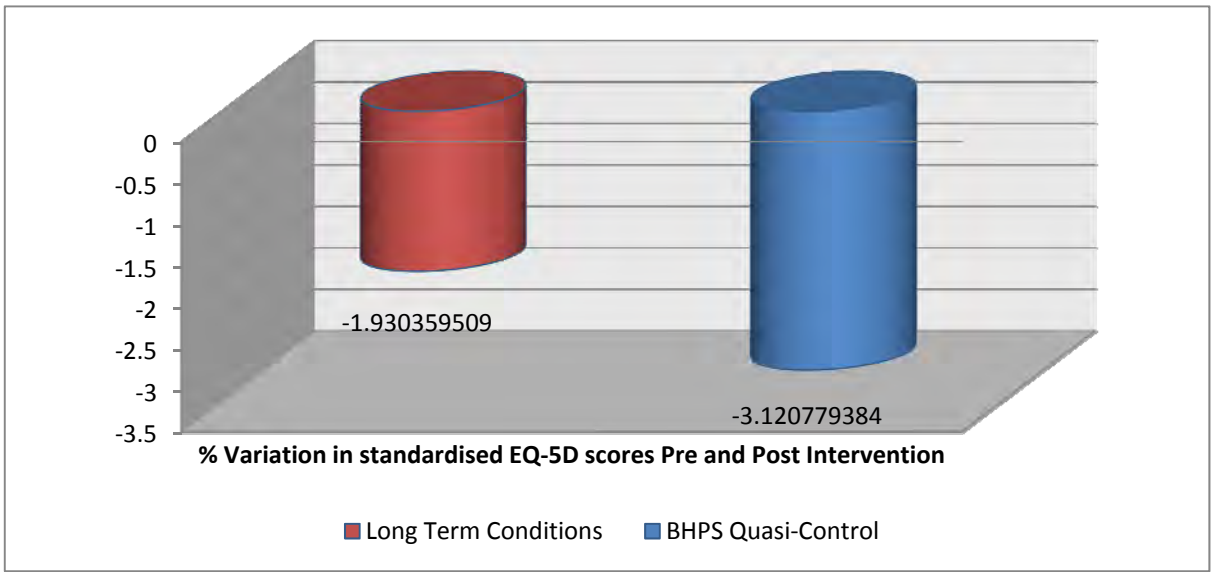
Friedman, p=0.62

Figure 84. Change in EQ-5D: long term conditions compared with POPP actual



It is clear, however, that the health of these users was deteriorating over time, as can be seen when the standardised scores are explored (see Figure 85). The average (or mean) scores fell, indicating that deterioration, although slowed, would continue for this population. Again, this sample deteriorated less than the quasi-control sample, indicating that POPP service users fared better than those not receiving a POPP service.

Figure 85. Change in EQ-5D: Long term conditions compared with BHPS sample



Long-term conditions – hospital discharge

People involved in two projects concerned with hospital discharge completed the QoL questionnaires: a total of 31 respondents with both Time 1 and Time 2 data. Both projects involved voluntary organisations facilitating safe and timely discharge. One project was led by the Rapid Response Team (statutory health and social care) within the local authority, while another was led by the VSO concerned. Exploring the changes in EQ-5D scores before and after the two interventions, it can be seen from

Table 110 that there was an actual overall drop of 4% and, when such figures are standardised, a drop of 1.6%. The actual scores are lower than those of the overarching sample (-4%), although the individuals had a lower rate of deterioration compared with the quasi-control group (-1.6%).

Table 110. Change in EQ-5D: Hospital discharge (T1 & T2)

	Actual change	Standardised change	BHPS quasi-control
EQ5D 'score' pre-intervention (T1)	0.623	0.62	0.55531
EQ5D2 'score' post-intervention (T2)	0.597	0.61	0.53798
Absolute variation	**-0.026**	**-0.010**	-0.01733
% variation	**-4.17**	**-1.637**	-3.12
% difference between overarching % variation and Hospital Discharge	**-5.247**		
% diff between standardised and BHPS quasi-control	**-4.757**		

n=30, Friedman, p=0.83

It could be argued it would be inappropriate to expect an increase in HRQoL among those involved in these projects. Neither was focused toward providing a health-related intervention. Rather, each concentrated on a practical response: preparing the house prior to discharge, escorting the person home, carrying out a simple home safety check and giving short-term assistance with cleaning and non-personal tasks. In studying the data more closely, we found that one project performed better than the other in terms of differences in HRQoL, and it is these differences that pulled down the overall mean score. For the VSO-led project, there was a percentage reduction pre- and post the intervention of almost a fifth, 17% (see Table 111).

VSO-led projects

Table 111. Change in EQ-5D: Hospital discharge (T1 & T2), VSO-led projects

	Actual change	Standardised change	BHPS quasi-control
EQ5D 'score' pre-intervention (T2)	.58247	.58247	0.55531
EQ5D2 'score' post-intervention (T2)	.48393	.43	0.53798
Absolute variation	**-.09854**	**-.15**	-0.01733
% variation	**-16.917**	**-25.342**	-3.121
% difference between overarching % variation and Hospital Discharge	**-17.965**		
% diff between standardised and BHPS quasi-control	**-28.462**		

In contrast, within the project that involved the third sector but was led by the local authority, there was a rise of 5% in the actual scores of users following the intervention, as shown in Table 112.

LA-led projects

Table 112. Change in EQ-5D: Hospital discharge (T1 & T2), LA-led projects

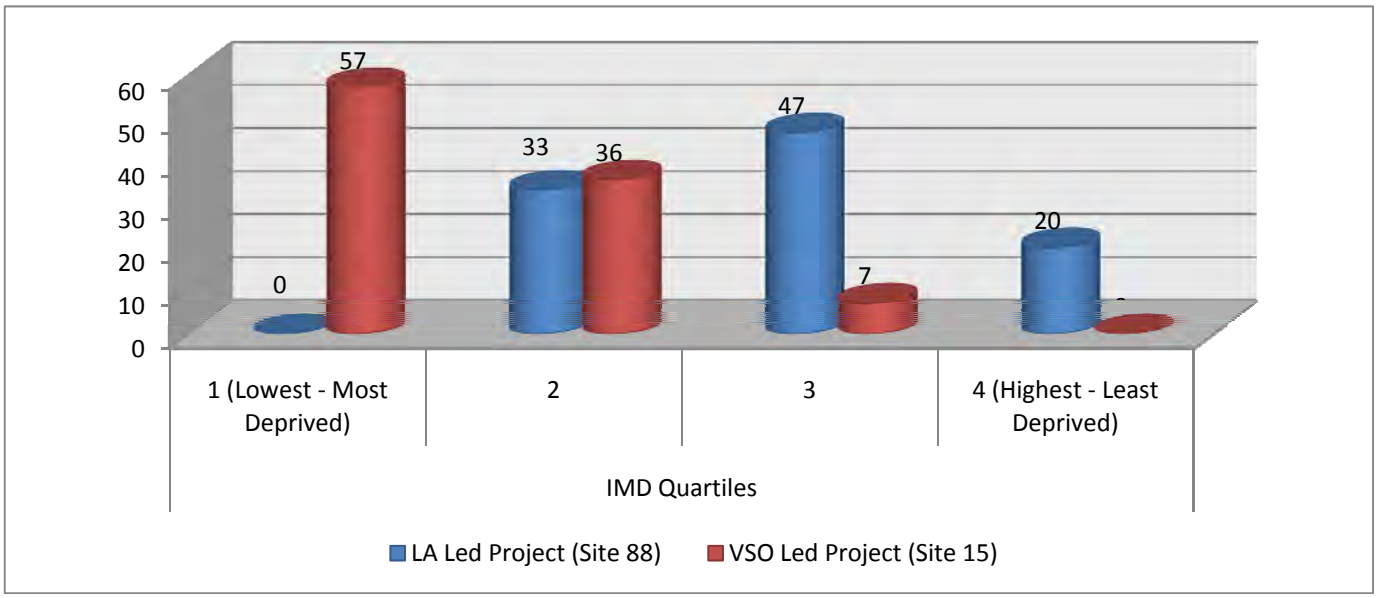
	Actual change	Standardised change	BHPS quasi-control
EQ5D 'score' pre-intervention (T2)	.66200	.66200	0.55531
EQ5D2 'score' post-intervention (T2)	.69694	.77	0.53798
Absolute variation	**.03494**	**.11**	-0.01733
% variation	**5.278**	**16.232**	-3.121
% difference between overarching % variation and Hospital Discharge	**6.326**		
% diff between standardised and BHPS quasi-control	**19.352**		

The variable of age was explored to see if the differences between the project participants was a result of the VSO-led project, which had a higher proportion of the 'older old' (75 and over), with the likely outcome of continued reduction in EQ-5D scores. The reverse was found, with the LA-led project having proportionally older individuals. Where a difference was seen, it was in the IMD scores: the majority of the population (57%) living within the most deprived communities. Indeed, their HRQoL scores were lower than their counterparts within the Local authority led project. As we know from prior research, and indeed within this particular database, those individuals from more deprived communities have higher morbidity levels (Baggott 2004, Marmot 1999).

Table 113. IMD Quartiles by project

	IMD quartiles			
	1 (lowest - most deprived)	**2**	**3**	**4 (highest - least deprived)**
LA-led project (site 88)	0%	33%	47%	20%
VSO-led project (site 15)	57%	36%	7%	0%

Figure 86. IMD Quartiles by project



It can be argued that the rationale behind the differences lies in the structure and process of the projects. It was not possible for the NE team to have the exact details of all 688 developed projects. Nevertheless, the LA-led project sat within – and was guided by – an integrated team. This enabled

those with any concerns around the health of particular individuals to quickly and appropriately refer them on to a single agency who could take further action. It is likely that it is this difference that led to the improved outcomes.

Specialised Falls Services

In exploring the five projects within this category (n=89), a small health-related quality of life change (0.01) was found among users, a 2% variation following the intervention. When the figures are standardised, we found a further slight increase of 4% variation.

Table 114. Change in EQ-5D: Specialist falls services (T1 & T2)

	Actual change	Standardised change	BHPS quasi-control
EQ5D 'score' pre-intervention (T2)	0.543	0.543	0.555
EQ5D2 'score' post-intervention (T2)	0.555	0.563	0.538
Absolute variation	**0.012**	**0.020**	**-0.017**
% variation	**2.210**	**3.721**	**-3.121**
% difference between overarching % variation and Specialist Falls	**3.258**		
% diff between standardised and BHPS quasi-control	**6.841**		

n=89, Friedman, p=0.69

6.9 EQ-5D and Needs Levels

The National Evaluation developed a further categorisation of the POPP projects, dividing them into three Needs Levels' to which they were addressed: Universal Services, Additional Support and Specialist Support. The first, often referred to as primary prevention, encompassed 'upstream' community orientated interventions, designed to support older people in maintaining independent lives within their own home. Additional Support (secondary prevention) includes those projects designed to support individuals 'at risk' of admission, whilst Specialist Support (or tertiary prevention) involve services that are targeted to support those at serious risk of imminent hospital admission owing to an exacerbation of chronic conditions, accident or care crises.

6.9.1 Universal Services (primary prevention)

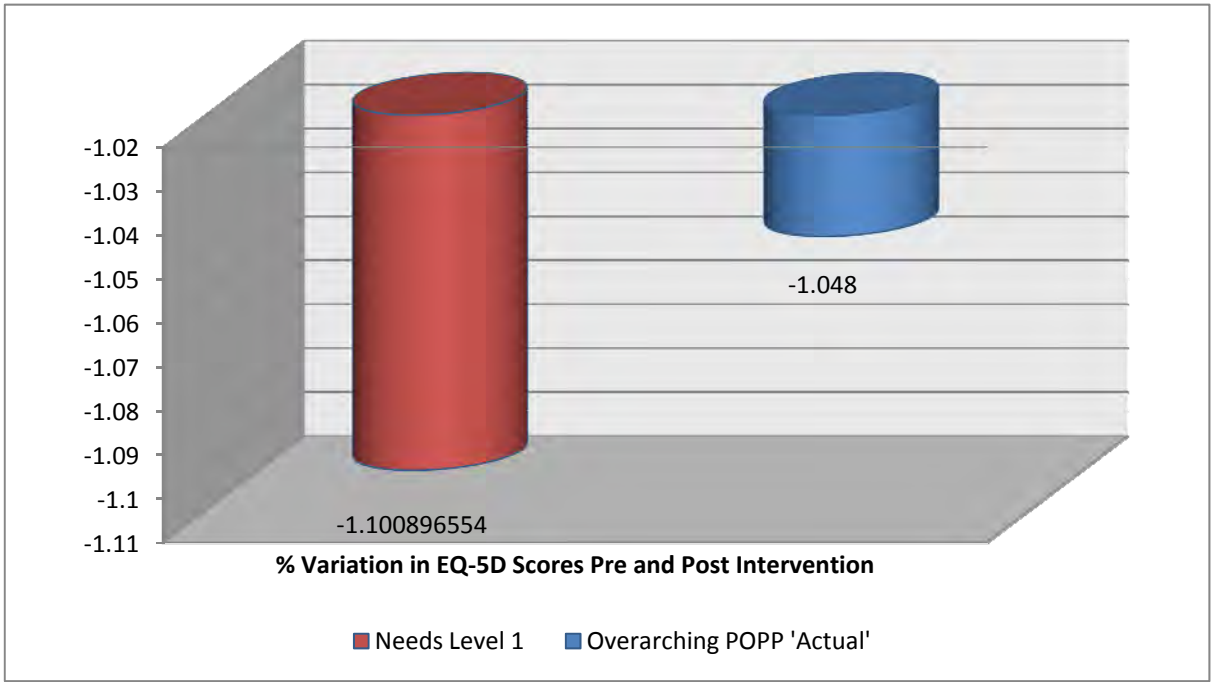
In exploring the change in low-level upstream projects – gardening, handyperson schemes, befriending, crime prevention etc – it can be seen that there is a very slight drop in the EQ-5D scores of participants, a percentage variation of minus one.

Table 115. Changes in EQ-5D Needs Level 1 (Primary Prevention)

	Actual change	Standardised change	BHPS quasi-control
EQ5D 'score' pre-intervention (T1)	0.633351429	0.633351429	0.55531
EQ5D2 'score' post-intervention (T2)	0.626378885	0.636587394	0.53798
Absolute variation	**-0.006972544**	**0.003235966**	-0.01733
% variation	**-1.113151197**	**0.508330177**	-3.12078
% difference between overarching % variation and Long Term Conditions	**-0.065**		
% diff between standardised and BHPS quasi-control	**3.628**		

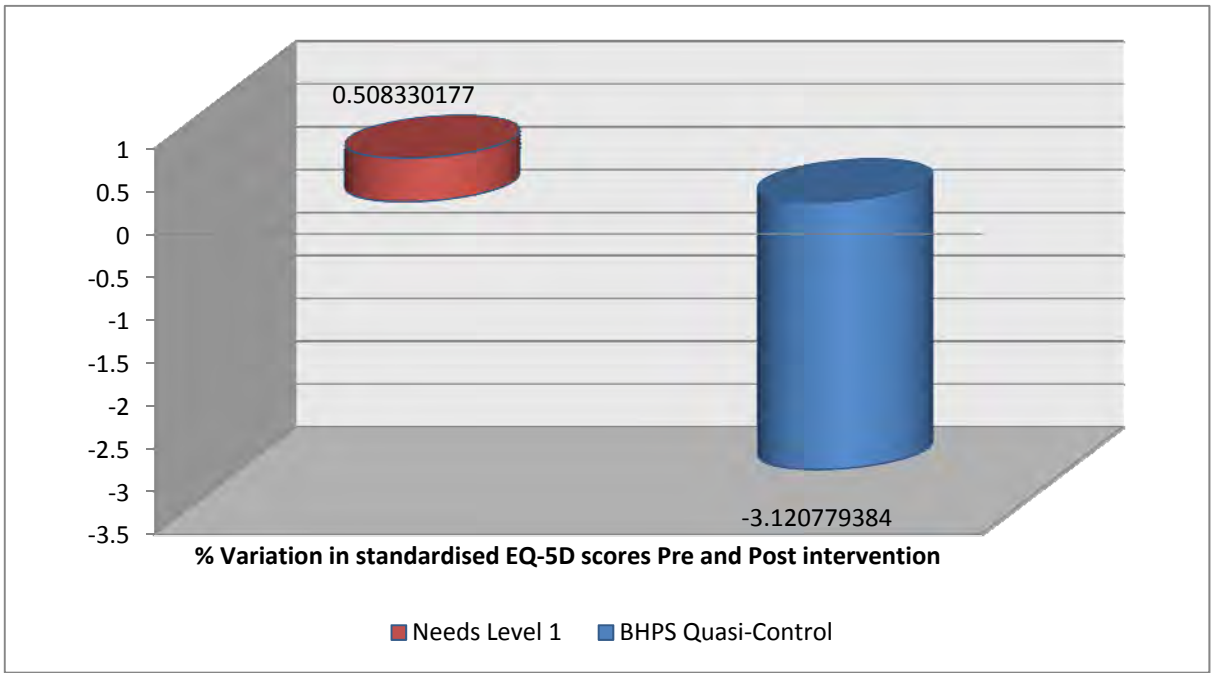
n=647, p=0.8

Figure 87. Changes in EQ-5D Needs Level 1 Primary Prevention compared to overarching POPP



When the EQ-5D changes are standardised, there is a difference between the POPP sample and the BPHS quasi-control of 4% (see Figure 88).

Figure 88. Changes in EQ-5D Needs Level 1 Primary Prevention as compared to BHPS



The nature of the services within this category makes it unlikely that they would produce changes in users' HRQoL. Of the 36 projects, none was set up solely to provide health advice or interventions. Rather, health advice or navigation came within the overall community and social care remit. In selecting out those projects that had health as part of their focus, differences could be seen in the outcomes. For example, within a project that provided low-level counselling support, a 0.23 (a 49%) improvement was seen in the EQ-5D scores following the intervention. Similarly, some of the projects that provided a level of 'assessment' produced a small increase in HRQoL, 0.01 (a 2% increase). However, for others with a similar focus, different outcomes are seen. For example, one project offered a range of practical services and information including telecare, befriending, environmental assessment, falls avoidance information, health checks, benefit checks and signposting. Similar to other projects within this category, it might be expected that this service would provide a small increase in HRQoL (e.g. 0.01), but in fact there was a relative decrease, in comparison to others, of 5%.

When further analysis was carried out, it would seem that although such variance might be expected, given the different shape and focus of the 36 projects, what is effectively having an impact on the findings is the level of deprivation. When the most deprived quartiles are removed (quartiles one and two), an increase of 0.01 is seen in EQ-5D scores. Within this particular Needs Level, almost three-quarters of the sample (74%) were within the first two quartiles of the IMD ranks, whilst almost half (42%) were within the most deprived areas. Nevertheless, when a regression analysis was carried out, such variance in the model was not explained by the IMD ranks.

Given the primary community focus of the projects, a question does remain as to whether the EQ-5D measure is appropriate as a means of designating outcomes as 'successful' or otherwise within this area.

6.9.2 Needs level 2: Additional Support (secondary prevention)

The projects in this category include health interventions or advice, falls services, medicines management, case or care management, and mental health support. Using the EQ-5D as a measure of outcome is more appropriate in this particular level of health care, although once again we see large variance between projects.

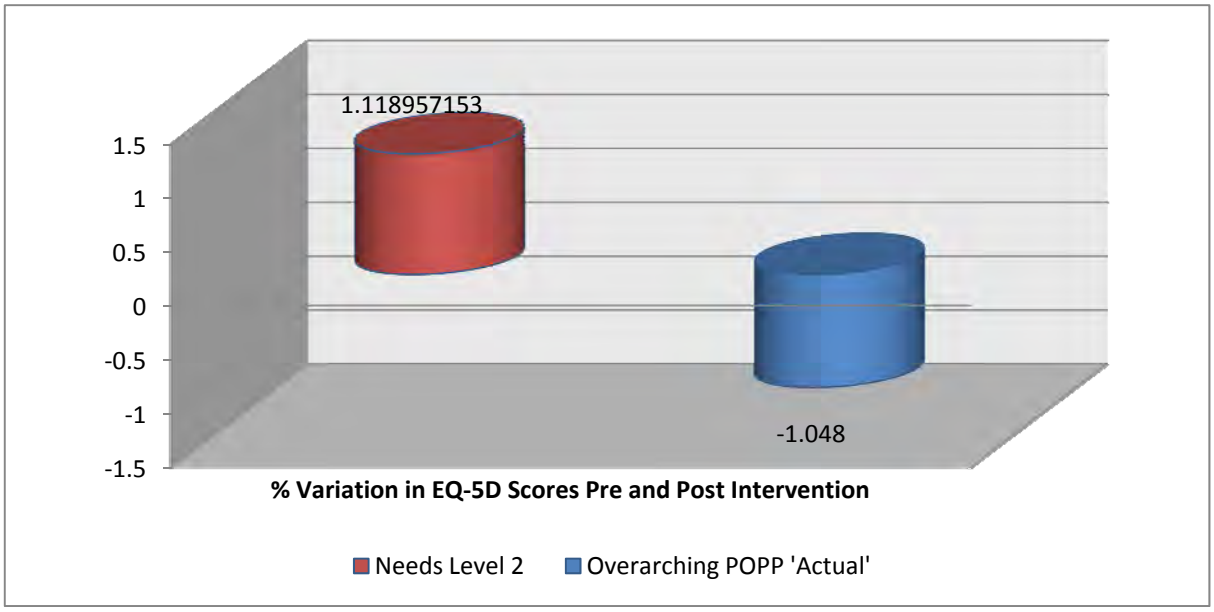
Table 116 shows that there is a small overall increase (1%) in the HRQoL scores for users of the 21 projects within this grouping.

Table 116. Changes in EQ-5D: Needs Level 2 (secondary prevention)

	Actual change	Standardised change	BHPS quasi-control
EQ5D 'score' pre-intervention (T2)	0.474417962	0.474417962	0.55531
EQ5D2 'score' post-intervention (T2)	0.479726496	0.498953074	0.53798
Absolute variation	**0.005308534**	**0.024535112**	-0.01733
% variation	**1.118957153**	**5.171623677**	-3.12078
% difference between overarching % variation and Additional Support (Secondary Prevention)	**2.167**		
% diff between standardised and BHPS quasi-control	**8.292**		

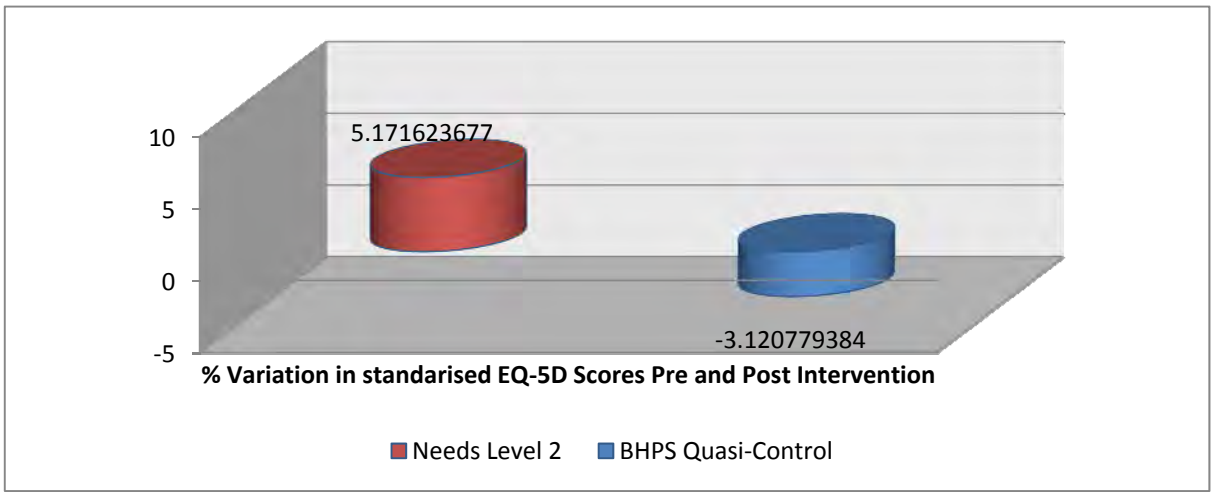
n=585, p=0.58

Figure 89. Changes in EQ-5D: Needs Level 2 (secondary prevention) compared to POPP actual



When the data are standardised to a year, the effect is increased, with a 5% increase on base-line: the difference between this and the BHPS quasi-control sample is 8%.

Figure 90. Changes in EQ-5D: Needs Level 2 (secondary prevention) compared to BHPS sample



In exploring the variance within this category, it would seem that the differences are due to the type of project undertaken, including its context, structure and process. For example, the mean score for users of a project in Site 82 falls by 0.1 before and after the intervention, a large relative drop. Yet closer examination shows that the people taking part in this particular project were in a residential care home, with a low EQ-5D baseline (0.39, 39% of perfect health) and a high mean age (91); one would not therefore expect an improvement in their HRQoL, although there could be an increase in their overall QoL.

6.9.3 Level 3: Specialist support (tertiary prevention)

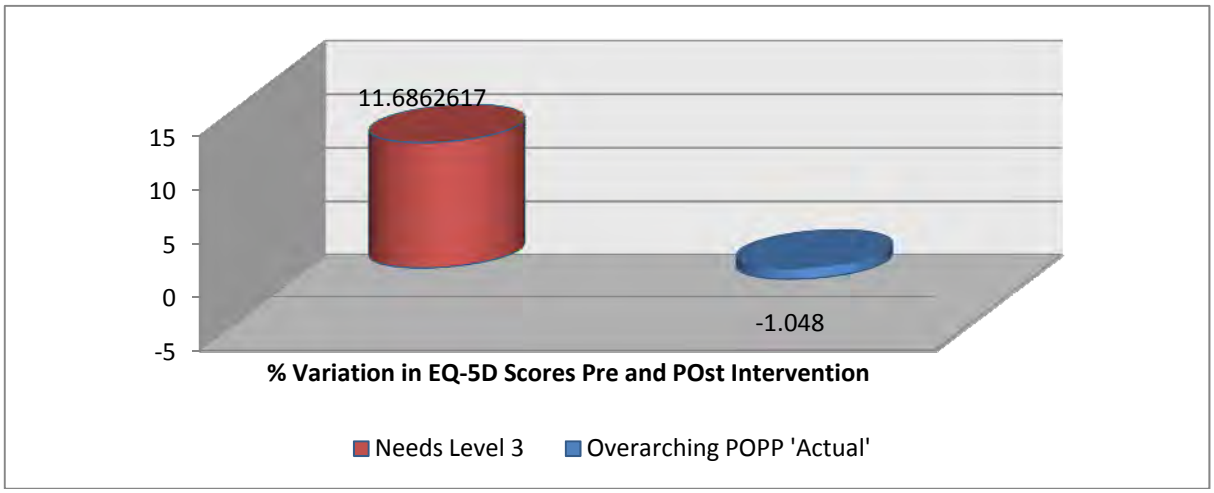
There is a substantial increase in actual and standardised HRQoL within this category, where projects are solely health focused.

Table 117. Changes in EQ-5D: Needs Level 3 (tertiary prevention)

	Actual change	Standardised change	BHPS quasi-control
EQ5D 'score' pre-intervention (T1)	0.448097561	0.448097561	0.55531
EQ5D2 'score' post-intervention (T2)	0.500463415	0.560946586	0.53798
Absolute variation	**0.052365854**	**0.112849025**	-0.01733
% variation	**11.6862617**	**25.18403012**	-3.12078
% difference between overarching % variation and Long Term Conditions	**12.734**		
% diff between standardised and BHPS quasi-control	**28.304**		

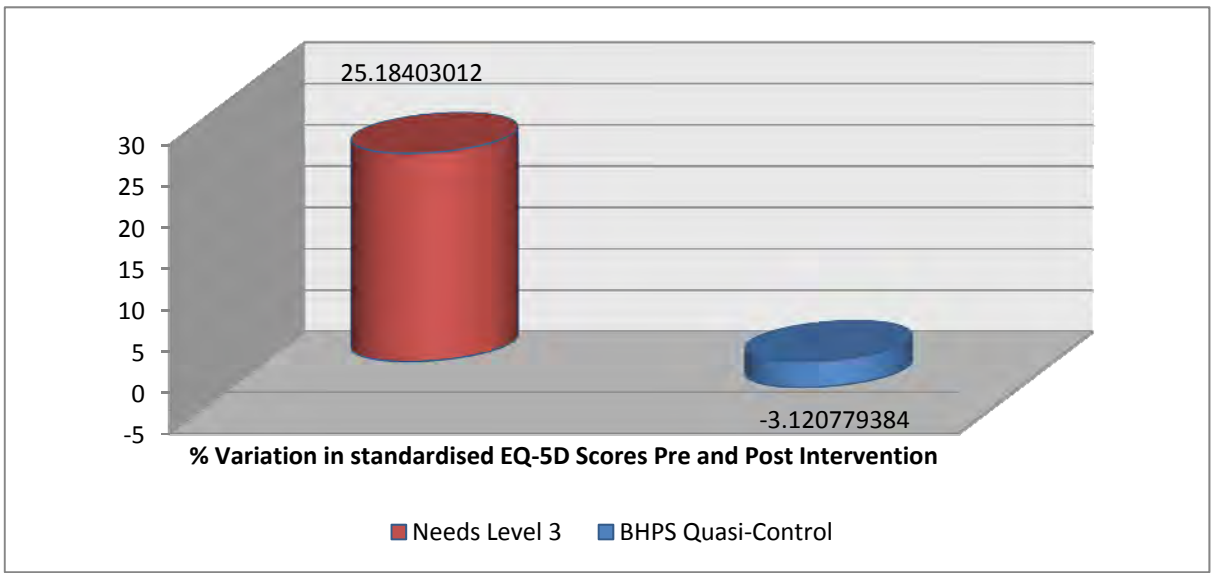
n= 30, Friedman, p=0.59

Figure 91. Changes in EQ-5D: Needs Level 3 (tertiary prevention) compared to overarching POPP



n=40, p=0.59

Figure 92. Changes in EQ-5D: Needs Level 3 (tertiary prevention) compared to BHPS sample



(n=40, p=0.59)

This particular group of projects encompassed only four projects and 46 individuals. The small sample has an impact on likely statistical significance. Nevertheless, when the projects are explored individually, there is variance both between and within the projects. There was a deterioration in the HRQoL of 0.05 for users in two projects run in one northern rural site (Site 47). In contrast, there was a 0.21 increase in one project (Site 51), a huge proportional increase of 81%. The question arises as to what caused such differences. Where there was an increase in the HRQoL of service users, the particular projects were solely health-focused and worked within an integrated clinical team. Appropriate management was available and team members were aware of referral routes and the individuals to whom to refer potential users.

In those projects where there was a deterioration in the HRQoL of users, in contrast, individuals reported low base-line levels of HRQoL (36% and 31% of health), although this was still 10% higher than those in the project demonstrating an increase. However, the focus of this project was 'holistic', rather than being solely a vehicle for delivering purely health interventions. Its focus was *'proactive case finding and integrated case management; aiming to maintain independence and manage risk'*

(Wagland et al 2006: 280), with a generic worker visiting and supporting older people, referring to the multi-disciplinary team if necessary.

Again, there is a question as to whether the measure of EQ-5D is appropriate to assess changes within psycho-social focused projects. Nevertheless, where projects are health related, they demonstrate positive changes in health-related quality of life.

6.10 EQ-5D & Community/Hospital Facing projects

The final categorisation of the POPP projects was Community and Hospital Facing. This division was initially developed to support the analysis of the Long Term Conditions Public Service Agreement. It also enabled a simple separation of those projects that were LA- or VSO-led. focused on psycho-social outcomes, and those within the primary, secondary or tertiary health sector concentrating on health interventions. An intervention was classified as Hospital Facing if its primary aim was reducing or preventing hospital or residential care admissions or A&E visits, with a total of 11 projects (380 participants). In contrast, there were 51 Community Facing projects (1017 participants).

Table 118. Total number of projects within community and hospital facing

	Number of projects	**Number of participants**
Community facing	51	1017
Hospital facing	11	380
Totals	**62**	**1397**

In analysing the findings, it can be seen from Table 119 and Table 120 that there is a small increase in the EQ-5D scores for participants in Community Facing projects and a small decrease for those in Hospital Facing projects. Both show positive change when the EQ-5D score is standardised to 12 months (see Table 119 and Table 120).

Table 119. Changes in EQ-5D: community facing projects

	Actual change	**Standardised change**	**BHPS quasi-control**
EQ5D score pre-intervention (T1)	0.58871	0.58871	0.55531
EQ5D2 score post-intervention (T2)	0.59113	0.61	0.53798
Absolute variation	**0.00242**	**0.02129**	-0.01733
% variation	**0.411068268**	**3.61638158**	-3.12078
% difference between overarching % variation and community facing projects	**1.050**		
% difference between standardised and BHPS quasi-control	**6.736**		

Table 120. Changes in EQ-5D: hospital facing projects

	Actual change	Standardised change	BHPS quasi-control
EQ5D score pre-intervention (T1)	0.45905	0.45905	0.55531
EQ5D2 score post-intervention (T2)	0.44658	0.46	0.53798
Absolute variation	**-0.01247**	**0.00095**	-0.01733
% variation	**-2.716479686**	**0.206949134**	-3.12078
% difference between overarching % variation and hospital facing projects	**-3.764**		
% diff between standardised and BHPS quasi-control	**3.326949134**		

Such outcomes are counter-intuitive, although the EQ-5D scores for those individuals involved in Hospital Facing projects were 10% lower than those of the participants using Community Facing services. However, throughout the analysis of the different sub-groups (Well-being, Information and Signposting, and so forth), it has been seen that where the intervention is concerned solely with health, there are better HRQoL outcomes as measured through EQ-5D. Owing to the categorisation, what is being seen is the variance within and between the projects: the age or participants, level of deprivation, accommodation and so forth. Such findings simply reflect the lack of referral criteria to the projects, with most being most population wide. Similarly, the lack of any selection criteria has an impact on what can be found via the standardised questionnaire. In large project groupings, the variance merely hides particular outcomes for participants, whether these are successful as measured against HRQoL or demonstrate deterioration.

6.11 Overarching quality of life

6.11.1 Introduction

Within the standardised questionnaire, there was a single question that asked individuals to 'rate' their quality of life as a whole. Such a question by necessity is multi-factorial. Perceived as consisting of *'happiness; life-satisfaction, well being, self-actualisation, freedom from want, objective functioning, balance, equilibrium; prosperity, fulfilment, psychological well-being, the good life, enjoyment'* (Rapley 2003), participants will inevitably interpret this question according to their individual circumstances, preference and beliefs. Expecting low-level and also short-term services to affect such a wide measure may not be appropriate. For example, some participants in the standardised questionnaire may have received transport on a weekly basis to a particular social club or health appointment. Such support may have reduced anxiety about obtaining and using transport, but it is unlikely to have had any great impact on how users perceived their overall quality of life. For the latter, more critical factors (e.g. perceived unsafe community, bereavement, low income etc) will undoubtedly be more important. One single project, however holistic, is unlikely to be able to change a person's overall quality of life in the time required for the responses (maximum of six months). It could be argued that such a question should not have been included within the questionnaire, given the type of projects and time-frame. Nevertheless, at the beginning of the POPP programme, there were concerns as to whether the use of the EQ-5D would be appropriate given the low-level focus of the projects. The requirement of a consensus to ensure wide acceptance of any tool precluded the inclusion of the more formal psycho-social measures of, for example, GHQ12, SF36 and others.

6.11.2 Findings

Overarching sample

Assessing changes across the full sample, it was found that individuals reported a small reduction in their perceived quality of life after the intervention, with fewer people reporting initially that their

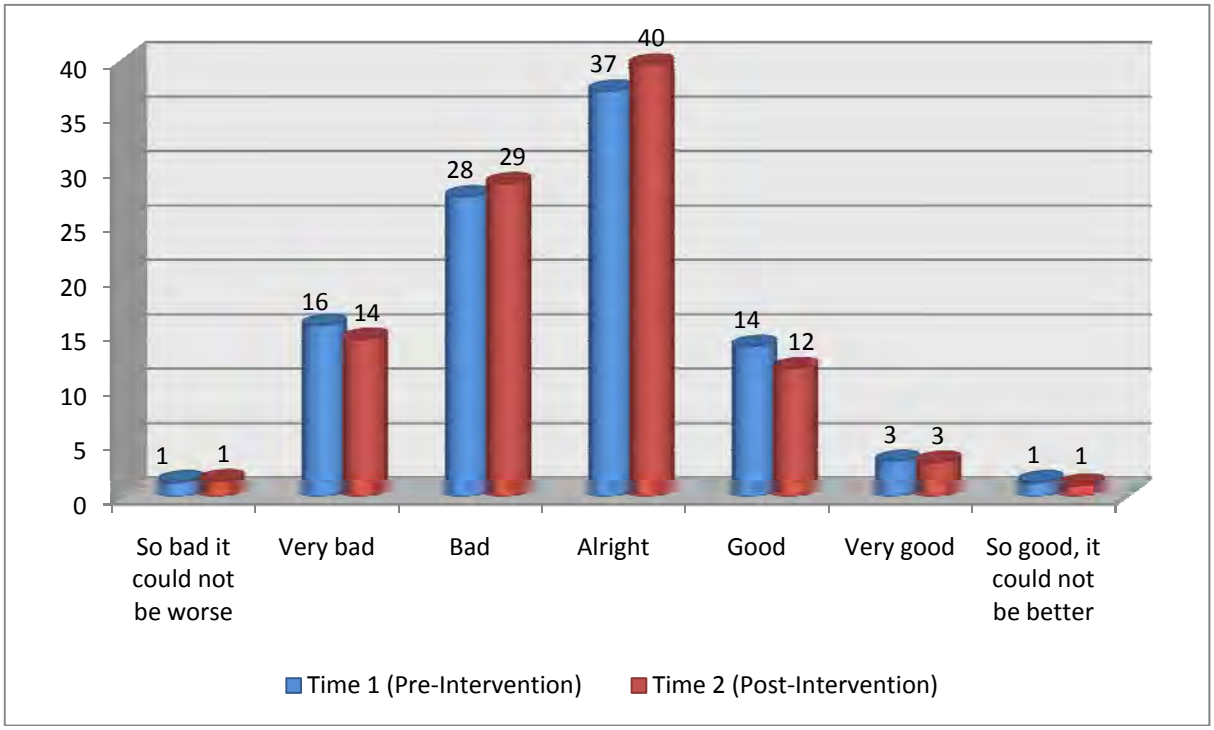
life was 'good' and moving their perception to the lower scales of 'alright' or 'bad' (see Table 121 and Figure 93).

Table 121. Changes in quality of life (T1 & T2) overall sample

QoL 'scale'	Time 1 (pre-intervention %)	Time 2 (post-intervention %)
So bad it could not be worse	1	1
Very bad	16	14
Bad	28	29
Alright	37	40
Good	14	12
Very good	3	3
So good, it could not be better	1	1

n = 1456, Friedman X^2 = 3.900, d*f* = 1, p = 0.048

Figure 93. Changes in quality of life (T1 & T2) overall sample



Such reported change was small, a mean change of -0.04. In exploring those groups of individuals reporting a reduction in their overarching quality of life, it was found that the factors of deprivation (as measured through LSOA) and age had a notable impact. Fewer individuals in the most deprived areas reported that their quality of life remained the same following the intervention, with a greater percentage of the population reporting in the lower scales. Conversely, the higher the age range, the less the quality of life was perceived to have changed. For those individuals aged 85 and over, a greater percentage reported that their quality of life remained the same, compared with the other age groups, and a greater number reported that their quality of life had improved following the intervention.

To try to explain such differences (the variance in the model), a hierarchical linear regression analysis was carried out. However, the amount of 'background noise' within the dataset did not allow any explanation of the effects.

Project focus categories

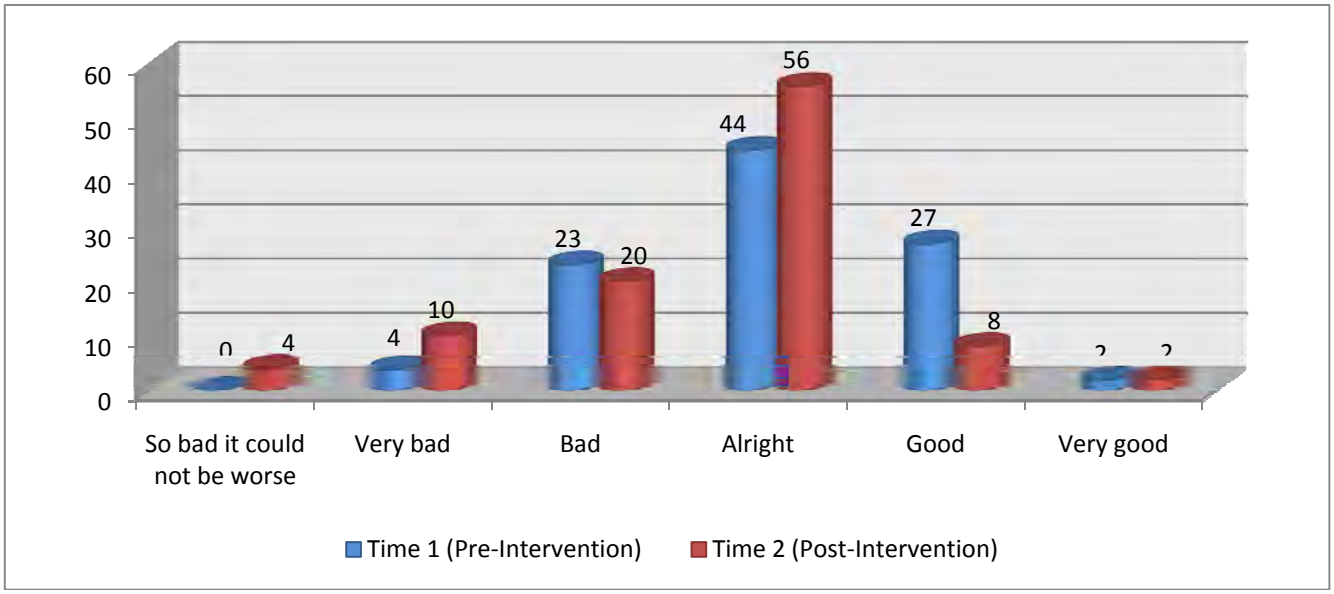
Within the project focus categories, only two were found to have statistically significant changes: Well-Being – Physical Health and Carers Services. Within the former, although there was a very strong positive change in HRQoL, this did not seemingly affect individuals' quality of life as a whole (see Table 122 and Figure 94).

Table 122. QoL changes in well-being -Physical health.

QoL scale	Time 1 (pre-intervention)	Time 2 (post-intervention)
So bad it could not be worse	0	4
Very bad	4	10
Bad	23	20
Alright	44	56
Good	27	8
Very good	2	2

n = 50, Friedman X^2 = 11.842, d*f* = 1, p = 0.001

Figure 94. QoL changes in well-being-physical health.



Again, the levels of deprivation had an impact on how individuals responded to this question following the intervention. Table 123 shows that, of those individuals in the most deprived area, less than half of the sample reported that their overarching QoL remained the same, and nearly two thirds (60%) indicated that their quality of life was reduced by one or two scales.

Table 123.QoL changes by IMD scores in well-being-physical health

'Movement' in QoL scores	IMD quartile 1 (most deprived)	IMD quartile 2	IMD quartile 3
Score ***reduced*** by two scales (e.g. Very Good to Alright)	1 (10%)	0 (0%)	0 (0%)
Score ***reduced*** by one scale (e.g. Very Good to Good)	5 (50%)	2 (15%)	2 (20%)
QoL remained same (T1 & T2)	4 (40%)	10 (77%)	8 (80%)
Score ***increased*** by one scale (e.g. Alright to Good)	0 (0%)	1 (8%)	0 (0%)

n = 33, Friedman X^2 = 33.000, d*f* = 1, p = 0.000

The category of Carers Services was developed to encompass three different interventions when using the standardised questionnaire. But at the end of the project, only one intervention had provided data. This was specifically a training course designed to support carers in increasing their skills and coping strategies, and data is only available for these 22 individuals. They reported that following the intervention, their overarching quality of life reduced ($n = 22, Friedman\ \chi 2 = 8.000, df = 1, p = 0.005$). Nevertheless, given the discrete focused project, it is unlikely that this could indeed have affected their overall quality of life. Such changes are more likely to be due to the continued and perhaps increased demands of their caring role.

That the quality of life is multi-factoral is indicated by the number of variables that seemingly have a statistically significant impact on any movement across both categories. The individual's type of accommodation (residential and sheltered), whether they live alone, their age (younger age groups) and gender (female) all have an impact on reporting individuals within these groups.

Needs levels

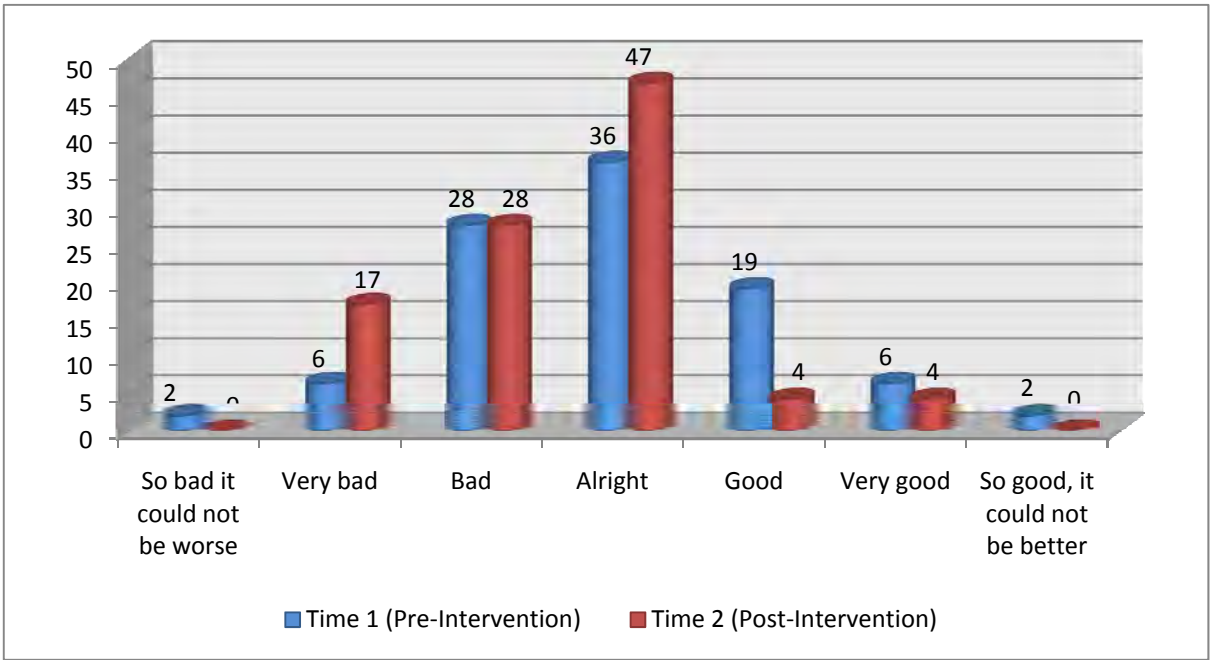
In exploring quality of life across Needs Levels, a statistically significant deterioration in overall quality of life was reported by those individuals within those projects focused on providing support to people at imminent risk of hospital admission (see Table 124 and Figure 95).

Table 124. QoL changes for users of services within Level 3 projects (tertiary prevention)

Quality of Life 'scale'	Time 1 (pre-intervention)	Time 2 (post-intervention)
So bad it could not be worse	1 (2%)	0 (0%)
Very bad	3 (6%)	8 (17%)
Bad	13 28%)	13 (28%)
Alright	36%)	22 (47%)
Good	9 (19%)	2 (4%)
Very good	3 (6%)	2 (4%)
So good, it could not be better	1 (2%)	0 (0%)

n = 46, Friedman X^2 = 7.538, d*f* = 1, p = 0.006

Figure 95. QoL changes for users of services within Level 3 projects (tertiary prevention)



The users within this category are the eldest: three-quarters (74%) of the sample were aged 75 and over compared with 59% in the overall sample. Similarly, a higher proportion of this sample lived alone or lived in sheltered housing, all risk factors for reduced quality of life.

6.11.3 Comment

It is questionable whether the projects, measured over the short term and given their range, would have a perceived impact on quality of life. The multi-variant nature of quality of life – '*a subjective lived experience which exists in multiple realities that are constructed and reconstructed by individual older people within the context of their individual lives and life histories*' (Bond & Corner 2006: 155) – is unlikely to be measured through a single question.

6.12 Impact of the POPP interventions on benefit receipt

A further measure of the effectiveness of POPP concerned benefit take-up. It is known that state benefits continue to be a major source of income for individuals over state pension age (Age Concern 2008) and that those entitled to specific benefits are not necessarily aware of entitlement or find the forms difficult and inaccessible. Two specific questions were included within the standardised questionnaire to explore if receipt of benefit changed following the POPP programme. Requesting the pilot sites to include these questions proved to be a challenge: many of the sites felt that asking older people about the type and amount of benefit received was intrusive and would negatively affect the relationships that providers were trying to build with their users. To ensure sign-up to the questionnaire, these questions became 'opt-in' rather than core. Such questions were also seemingly felt to be inappropriate by users completing the questionnaire. Although, 577 individuals answered the question on whether they received benefits, only 266 responded to the question about the amount received in benefits each week (missing values of 311 individuals or 46%). We do not know whether they felt that this question was intrusive, did not wish to respond for fear their income would be reported to statutory agencies, or were simply not aware of their weekly benefits income.

A small increase in benefits of £5.25 per week was found post-intervention (see Table 125). If this is extrapolated to the number of individuals responding to this question, a total of a further £1034 was

available per week, equivalent to an extra £4,136 per month or £53,768 per year. It is likely that such changes are under-reported.

Table 125. Weekly benefits received by POPP sample

Users weekly benefits	Time 1(pre-intervention)	Time 2 (post-intervention)
Weekly benefits	£107.20	£112.45

t=-1.806, df=268, p<0.05 (one tail test)

In exploring benefit receipt by the different categories, it was found that there was a greater increase in benefits in particular categories: Well-being - emotional/social isolation, Proactive Case Co-ordination and Long-term Conditions -complex care. However, the variance within the data again hid some of changes. For example, an analysis of benefit receipt among users of projects providing Information, Signposting and Advice found a reduction in receipt. Yet when the projects were examined separately, it was found that for some, the amount of benefit claimed had increased. An information, advice and signposting service in the South-East of England (Site 51) produced a mean weekly increase of £8.70, in effect a total of £34.80 per month or an extra £452.40 per annum. If the change is multiplied by the 51 people who responded to this question, the total amount of extra benefits claimed would be £23,073.

In exploring the type of benefits received (see Table 126), a statistically significant increase was found for receipt of Attendance Allowance ($Friedman\ \chi 2 = 17.280, df = 1, p = 0.000$).

Table 126. Type of benefits received

	Time 1 (pre-intervention)	Time 2 (post-intervention)
Income support	82 (15%)	84 (15%)
Family credit	9 (2%)	10 (2%)
Jobseekers allowance	2 (0%)	2 (0%)
Housing benefit	125 (22%)	133 (23%
Statutory sick pay	8 (1%)	1 (0%)
Disability living allowance	120 (22%)	114 (20%)
Incapacity benefit	31 (6%)	28 (5%)
Attendance allowance	154 (28%)	194 (34%)
Tax credit	4 (1%)	1 (0%)
Retirement pension	254 (46%)	257 (45%)

7 The Impact of POPP and Costs

Key points

Costs of the individual projects per user

- The cost per user was heavily dependent on the number of service users at any time; in the first round, the median cost per person per year dropped from over £62K in the first year to £366 in the second, as there were many more service users by that time. The equivalent figures for the second round were £391 and £221 respectively.

- Overall, the mean cost per person per week (excluding the first year of operation of round 1) was £7; including the first year of Round 1, the mean cost per person per week rises to £303.

- The costs per user varied considerably with the focus of projects: those aimed at primary prevention cost £4 per user per week, compared to £7 for projects aimed at secondary prevention. Such costs are still low compared with other social and health care interventions.

- All these findings must be treated with caution, due to some probable inaccuracies in reporting and a high level of missing data.

Impact of the POPP projects on the emergency bed-day use as compared to non-POPP localities

- The reduction in hospital emergency bed days resulted in considerable savings, to the extent that for every extra £1 spent on POPP services, there has been approximately a £1.20 additional benefit in savings on emergency bed days. This is the headline estimate drawn from a statistically valid range of an £0.80 to £1.60 saving on emergency bed days for every extra £1 spent on the projects.

- Hospital Facing projects showed signs of diminishing effect, but not economies of scale, i.e. larger projects seemingly produced lower potential savings on emergency bed days. This may be partially due to the limit in the number of people who can be easily diverted from hospital by such projects.

- Community Facing' projects showed increasing returns against economies of scale, i.e. the larger the project, the greater the saving. These may require a 'critical mass', but once they are large enough, can seemingly reduce the need for emergency secondary care.

- Although there are inherent limitations to the certainty which can be placed on such analysis, within the context of this research, POPP projects can be recommended as a cost-effective policy option.

The cost-effectiveness of projects, compared to 'usual care' in other areas, using the cost-effectiveness acceptability curve (CEAC) and the 'willingness to pay' cut-off figure of £30K for a point increase in QALY employed by the National Institute for Health and Clinical Excellence (NICE).

- Considering the POPP projects as a whole, there was a very high probability (86%) that they were cost-effective, compared with usual care, with some variation by type of project. Within three categories of project, there was greater than a 98% probability that at £10,000 or less per point increase in QALY, such projects were cost-effective compared with 'usual care'.

- There was a high probability (80%) that projects focused on primary prevention were cost effective, compared with usual care. This figure was lower (71%) for projects addressing secondary prevention, but these varied considerably. Projects addressing tertiary prevention were much more costly, being focused on people with very high levels of need, but there was nonetheless a very high probability (96%) that they were cost effective compared with usual care.

- Commissioners will need to decide on the level of 'risk' around funding such projects. One operational example can be given by focusing on those projects that improve well-being through the provision of practical help, small housing repairs, gardening, limited assistive technology or shopping. For an extra spend of £5,000 per person – £96.15 per week – there is a 98% probability that such projects are cost-effective compared with 'usual care'. Commissioners putting in place such projects could be reasonably confident that only around 0.2 projects in 10 would not be cost-effective.

Changes in use of health and social care services (and costs) before and after the POPP project, based on 1,529 service users who completed the standardised questionnaire

- Overall, hospital overnight stays reduced by almost half (47%) and use of Accident & Emergency Departments by almost a third (29%). Reductions were seen in physiotherapy/occupational therapy and clinic or outpatient appointments by almost one in ten. Such change had a notable impact on costs, with a total reduction of £328 per person over the median administration period of six months. This mean figure is affected by variation in the data, so that when the 62 projects were categorised into eleven specific types, some of this variance was eliminated and a reduced cost of £2,166 per person was found.

- There was considerable variation in use of services depending on the type of projects; the highest reductions were in projects focused on hospital discharge and the lowest for specialist falls services.

- This evidence of the POPP projects leading to cost-reductions in secondary, primary and social care was similarly demonstrated by many of the local evaluations. The main difficulty for sites was translating the evidenced cost-reduction into a cost saving. Moving monies around the health and social care system was seemingly a huge challenge, and proved an insurmountable one where budgets were the responsibility of more than one organisation.

For instance, monies could be moved from residential care budgets to home care budgets within a local authority, but a claim for monies by a local authority from either primary or secondary health care budgets did not prove possible.

7.1 Introduction

The previous section set out the benefits obtained by service users from the POPP programme, noting that many experienced an increase in their health-related quality of life, as well as obtaining more state benefits. In this section, we explore whether those gains were cost-effective, as well as the extent to which the POPP programme affected the overall health and social care economy.

Four sets of analyses are undertaken. First, we present a simple analysis of the costs per person of the activity reported by each site by project (see section 5). Secondly, we examine whether there was a reduction in emergency bed days in the sites with POPP programmes, compared with non-POPP sites, in an interest in understanding the impact of the POPP programme on the wider health economy.

Third, the cost effectiveness of the POPP projects is examined. The changes seen in participants' HRQoL (reported in Section 6) are calculated into a utility score, a 'Quality Adjusted Life Year' (QALY). Utility scores represent the value placed on a specific health status (or a change in that status), and the QALY here is calculated from estimates of the length and quality (benefit) of a patient's life following the POPP intervention. The costs are then used to compare the relevant gains from different forms of care and treatment. In this analysis, we compare the changes in the utility scores in our sample with those arising from the 'usual care' received by participants in our quasi-control BHPS sample. Finally, we examine changes in service use at user level and assess whether service use – and therefore costs – have risen or fallen and, if so, where savings are being made.

In providing such analyses, we are hampered to a certain extent by the requirement that the National Evaluation provides a 'synergy of the evidence'. As with the analysis of changes in HRQoL, the variance within and between the projects is difficult to assess. We have made changes to the groupings following that analysis and thus reduced the variance. Nevertheless, we cannot provide the information that would be most useful: a micro-level analysis of what type of projects, with which staff and managed in which particular way provide better and more cost-effective outcomes.

7.2 Cost per person

A simple analysis of cost per person by project within the POPP programme was undertaken, using estimates from the activity data (see Appendix K) and project costs (excluding management costs). It will be remembered that there were considerable difficulties in obtaining appropriate and robust data from the sites and some of the activity data may therefore be under- or over-reported. However, the following provides an analysis of the cost per person, where the activity was correctly reported and project costs provided. An initial exploration sets out the mean cost per person (per annum) across the three years of operation and the two programme 'waves' (see Table 127).

Table 127. Mean cost per person by project 'rounds'

Project Round and Year	Number of projects (total number of projects reported)	Mean cost per person	Maximum cost per person	Standard deviation
Round 1- year 1 (2006/7)	81 (210)	£839	£25,251	£2,902
Round 1 - year 2 (2007/8)	84 (200)	£1,611	£54,599	£6,041
Round 1 - year 3 (2008/9)	53 (68)	£584	£5,698	£1,032
Round 2 - year 1 (2007/8)	21 (25)	£721	£2,555	£770
Round 2 - year 2 (2008/9)	25 (29)	£609	£4,294	£972

It can be seen that the mean cost per person per year ranged from £584 to £1,611. However, the standard deviation provides a strong indication of the extent to which the mean was from a true

representation of the real cost. For example, in the second year of operation of Round 1, the standard deviation was six times the stated mean. Given such variance, the median costs are given in Table 128.

Table 128. Median cost per person by project 'rounds'

Pilot site round and year	Inter-quartile cost		
	25%	Median cost	75%
Round 1- year 1 (2006/7)	£26,241	£62,638	£119,521
Round 1 - year 2 (2007/8)	£118	£366	£1,191
Round 1 - year 3 (2008/9)	£47	£170	£628
Round 2 - year 1 (2007/8)	£127	£391	£1,243
Round 2 - year 2 (2008/9)	£130	£221	£472

It can be seen that for Round 1, the median (and inter-quartile costs) reflected the increased activity; as more interventions were set up, there was a higher throughput of users. In the first year, the median cost per person was £62,628, but by the end of year two, the cost had reduced to £366 per person. If this is translated into a weekly cost (assuming a 42 week activity, five day week) the cost per person was low, only £4.

Such costs compare favourably with other types of social care interventions for older people. For example, Schneider et al (2007) reported that the net cost of providing an occupational therapy service within a care home was £16, whilst Nelson et al (2004: 153) found that where physical functioning needs were high (similar to the POPP sample), the total social care costs were £12. However, such costs were only the median and it can be seen that the inter-quartile range at 75% was high. Estimating the cost on Round 1, Year 2 at the highest inter-quartile range, the cost per person per week becomes £15, higher than the costs reported for a similar sample (Nelson 2004).

Table 129 provides the cost per person per week based on a 42 week activity, 5 day week.

Table 129. Cost per person per week based on a 42 week activity, five day week

Pilot site round and year	Inter-quartile cost					
	25%	Costs per person per week @ lowest quartile	Median Cost	Cost per person per week @ median cost	75%	Cost per person per week @ upper quartile cost
Round 1- year 1 (2006/7)	£26,241	£625	£62,638	£1,491	£119,521	£2,845
Round 1 - year 2 (2007/8)	£118	£3	£366	£9	£1,191	£28
Round 1 - year 3 (2008/9)	£47	£1	£170	£4	£628	£15
Round 2 - year 1 (2007/8)	£127	£3	£391	£9	£1,243	£30
Round 2 - year 2 (2008/9)	£130	£3	£221	£5	£472	£11

Not surprisingly, the cost range is affected by the number and type of projects put in place. As previously indicated (see Section 3), those projects directed toward users at risk of admission or at imminent risk of admission (Secondary and Tertiary Needs Levels respectively) involved social and clinical care practitioners as well as higher levels of other resources (e.g. step-down beds) and therefore entailed a higher cost. Seperating this data out,

Table 130 indicates the median, inter-quartile and cost per person per week for people with Level 1 needs.

Table 130. Median, inter-quartile and cost per person per week for needs level 1

Pilot site round and year	Needs level 1: Primary Prevention					
	25%	Costs per person per week @ lowest quartile	Median cost	Cost per person per week @ median cost	75%	Cost per person per week @ upper quartile cost
Round 1- year 1 (2006/7)	£77	£2	£154	£4	£504	£12
Round 1 - year 2 (2007/8)	£90	£2	£224	£5	£484	£12
Round 1 - year 3 (2008/9)	£16	£0	£50	£1	£156	£4
Round 2 - year 1 (2007/8)	£124	£3	£207	£5	£799	£19
Round 2 - year 2 (2008/9)	£93	£2	£210	£5	£840	£20

It can be seen that the costs per person per week ranged between £0 and £20 for the lowest needs levels. It is difficult to benchmark such findings, as much of the literature does not provide robust data on the costs of activities such as lunch clubs, gardening, care and repair, information and signposting services, often set up as social enterprise units. However, only the Round 2 costs at the upper quartiles fell above the £12 costs of social care for older individuals. That the costs were higher in Round 2 is more likely to be due to accuracy in reporting than to profligacy of spend, with few project costs not reported by the second 'wave'.

The range of higher level (Needs Level 2 and 3) costs can be seen in Table 131. Again, if the findings reported by Nelson et al (2004) are used as a benchmark, the total care costs for individuals with physical functioning difficulties, dementia or depression would be £35. It is only at the upper quartile range reported by Round 2 Year 2 that the costs reached this comparator.

Table 131. Median costs by Needs Level 2 and 3

Pilot site round and year	Needs level 2 & 3: Secondary and Tertiary Prevention					
	25%	Cost per person per week @ lowest quartile	Median cost	Cost per person per week @ median cost	75%	Cost per person per week @ upper quartile cost
Round 1- year 1 (2006/7)	£49	£1	£163	£4	£549	£13
Round 1 - year 2 (2007/8)	£78	£2	£321	£8	£833	£20
Round 1 - year 3 (2008/9)	£110	£3	£338	£8	£784	£19
Round 2 - year 1 (2007/8)	£135	£3	£391	£9	£1,432	£34
Round 2 - year 2 (2008/9)	£112	£3	£164	£4	£389	£9

Regrettably, such estimations are hampered by the amount of missing data, together with variation within and across the different pilot site programmes. To provide an adequate and robust cost analysis, it is necessary to undertake three further types of analysis: the impact of POPP on emergency bed-days; the cost-effectiveness of projects; and cost changes arising from changes in service use.

7.3 Impact of the POPP Programme on emergency bed-days

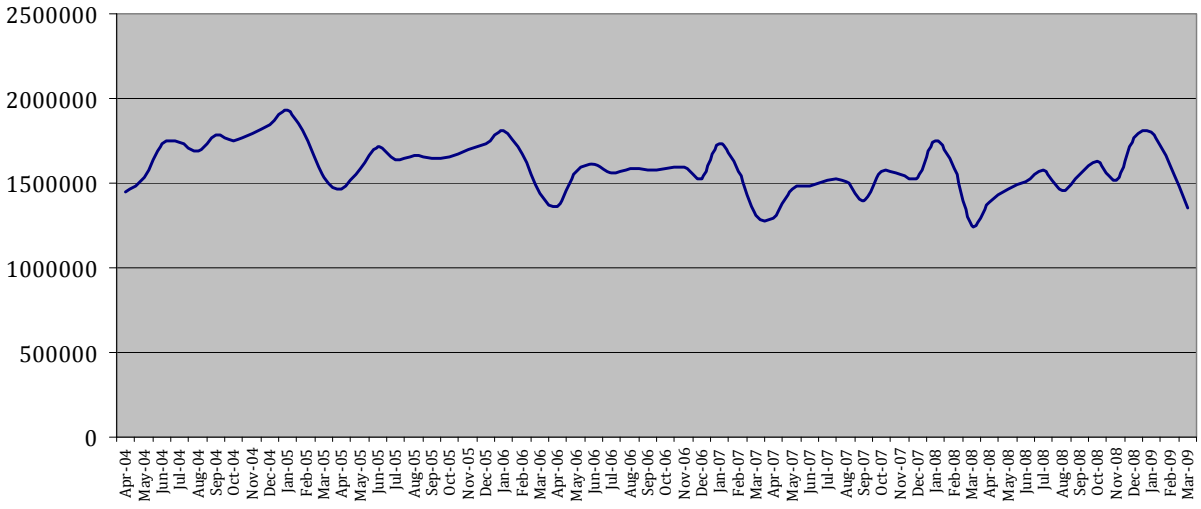
7.3.1 Introduction

In principle, POPP projects could potentially bring substantial benefits by reducing the inappropriate use of hospital beds. Such benefits accrue both from the savings arising from a reduced use of hospital services and from the better outcomes for people who then stay in their own home. Our study was concerned to test the extent to which the former proved the case, i.e. the cost savings.

This analysis considers the impact of POPP projects on emergency bed-days (EBDs) and updates previous analysis, set out in interim reports. We use data on EBDs from April 2004 to March 2009, within the old boundaries of PCTs (as these were used at the beginning of the project). Therefore, we currently have 18,180 PCT-months of data (303 PCTs across 60 months). The data were drawn from HES by the Health and Social Care Information Centre. We include both round 1 (48 PCTs) and round 2 (29 PCTs) POPP projects. We use updated information on population at PCT and council level to calculate per capita rates.

The methodological challenges for this analysis have been outlined in previous reports (see also Appendix W). Essentially, they arise from the difficulties of estimating the likely usage of emergency beds within POPP sites in the absence of the POPP projects. We make such estimates by benchmarking the likely performance of these POPP sites against the bed usage of non-POPP sites. A statistical model is used to establish a time trend on average for all PCTs over the 60 months. It also estimates how the 303 PCTs differ at a given time. This allows a prediction of emergency bed-day use for any PCT and month combination. The statistical analysis then assesses whether the data show a systematic difference in bed-day use for those PCTs that have POPP projects at the time when the projects were up and running. Furthermore, to improve precision, we use the (differing) amounts of spend on POPP that each POPP site reported at different times (see Appendix W for more detail).

Figure 96. Total bed-days per month – over 65s, England Aug 04 to Mar 09



Source: Hospital Episode Statistics (smoothed)

Figure 96 shows the trend in emergency bed-days for people over 65 in total for England.[8] The seasonality of the trend continues to show as before, as does the overall gentle reduction in number of bed-days over time.

Table 132 shows the number of emergency bed-days involving people over 65, and the associated 12 month change. The figures in the table are simple averages, indicating, for example, that bed-day use is slightly lower in POPP sites than in other PCTs. But if we are to assess the impact of the POPP projects, we need to understand the counterfactual: what EBD use would we expect in POPP sites if the projects had not been undertaken. In particular, we know that EBD rates are falling over time in any case, so this trend and all other confounding factors must be accounted for in this assessment.

Table 132. Total emergency bed-days and average change in last 12 months per PCT – over 65s, April 2004 to December 2006

		N	Total bed-days per month per PCT	Standard deviation	Min	Max
All PCTs, all times	total	18180	5240	2420	80	18170
	12 month diff	14544	-130	890	-7430	7020
POPP PCTs, POPP time	total	2424	5030	2220	510	16250
	12 month diff	2424	-90	750	-5750	4470
Non-POPP PCTs, non-POPP times	total	15756	5280	2450	80	18170
	12 month diff	12120	-140	920	-7430	7020
POPP PCTs, pre-April 06	total	1848	5560	2500	1070	18170
	12 month diff	924	-230	780	-4580	4720

7.3.2 Analysis

We use an expenditure difference approach to estimate bed use in POPP PCTs with and without the POPP projects. This looks at the impact on bed-day use per capita for difference levels of expenditure on POPP projects (where non-POPP sites have zero spend). Using expenditure data allows us to differentiate not only between POPP sites and non-POPP sites at different times, but also the size of the projects within POPP sites where we would expect greater effect in total for bigger sites.

7.3.3 Costs

The financial returns cost data for projects was used in the analysis. These data are available in six month periods for three years from April 2006. We use the total project costs for each site, as provided. Due to uncertainty about the size of management overhead costs, we use four options, with assumed management costs running from 0% to 30% of the project cost. The cost of an emergency bed day will depend on the nature of the admission. We do not have specific information on this, so we need to use an average figure. Given the uncertainties, we again consider different scenarios. Costs may be as low as £158 per day using an average across all admissions, or as high as £274 per day if we use the 08/09 tariff value for non-elective inpatient short stay admission for unexplained symptoms without complications. Per diem cost is then uniformly applied to the emergency bed day use outlined in the Table 132 for each PCT to give a total expenditure on emergency bed days per month, per PCT. This spend total is divided by the 65+ population of the PCT to give a per capita expenditure figure. Table 133 gives descriptive information about these costs for POPP sites.

[8] The trend is smoothed for March and April, which as the beginning and end of the in-year period are truncated. The sum of bed-days for these two months is unchanged following this smoothing.

Table 133. Costs per capita 65+, POPP sites

	Mean	Std. Dev.	Min	Max
Project spend £ per capita 65+ per month	0.81	0.59	0.03	3.12
EBD cost £ per capita 65+ (@ £158 per day) p.m.	31.28	8.67	14.16	60.34
EBD cost £ per capita 65+ (@ £274 per day) p.m	54.24	15.03	24.55	104.65

Overall, the distribution of costs was good, with relatively little departure from a normal distribution (in both POPP and EBD cases, the distribution of costs was slightly skewed to the right as is common, i.e. some sites had very high expenditure).

7.3.4 Results

Statistical estimates always have a degree of uncertainty (statistical error) and in addition to presenting the headline 'point' estimate; we also give a range (the statistical confidence interval). The point estimate is useful shorthand. Nevertheless, strictly speaking the 'actual' value can lie anywhere in the range. The estimates also depend on the assumptions made about costs and also the nature of the relationship between POPP expenditure and EBD use. In the modelling we allow a non-linear relationship, but we also estimated models which assumed linear relationships. We tested two forms of non-linear model: a squared power on the POPP expenditure variable and a squared power of the EBD variable (see Appendix W for details).

The main result of the estimations is a significant and negative relationship between spending on POPP projects and the costs of emergency hospital bed-days for people over 65 ($p < 0.01$). As to the size of the effect, the non-linear models produced similar results. Table 134 gives the results in terms of the so-called 'marginal effect': that is, the implications of extending POPP activity. The table gives both the point estimate and the range. For example, with a management overhead of 10%, then spending £1 extra on POPP projects per month in POPP PCT (at POPP time) would lead to the equivalent of a£1.20 (point estimate) reduction in required spending on emergency bed occupants. Or, more accurately, a reduction of between £0.80 and £1.60. Because the relationship between POPP expenditure and emergency bed day use is non-linear, the marginal effects will differ according to what cost baseline we assume.

Non-linear models allow that the impact of POPP projects varies with their scale (in this case measured as the level of expenditure per month per POPP PCT). If we use a linear model, then the results do not allow for scale and instead produce the *average* effect of every £1 spent. The linear model produced a (non-variant) marginal effect saving of £0.60 (between £0.30 and £0.80).

Our previous result (in an interim report) was that +£1 POPP spend would be associated with a £0.50 reduction in required emergency bed day spending, but that result was calculated at a time when the latest POPP project data were unavailable and only using the bed days data available at the time (see Table 135). Retrospective application of the latest POPP cost data to the previous data produces a marginal effect result that is very similar to the latest result.

Table 134. Effect of POPP on emergency bed-days use – to March 2009

Effect of…	Management Overhead	Effect size	Effect on…	Lower CI	Upper CI
+£1 spend on POPP project per month in POPP PCT (at POPP time)	30%	-£1.00	Cost per month per PCT of bed-days	-£1.30	-£0.70
	20%	-£1.10		-£1.50	-£0.80
	10%	-£1.20		-£1.60	-£0.80
	0%	-£1.30		-£1.70	-£0.90

Table 135. Effect of POPP on emergency bed-days use – to September 2008

Effect of…	Effect size	Effect on…	Lower CI	Upper CI
+£1 spend on POPP project per month in POPP PCT (at POPP time)	-£0.50 (£1.00)*	Cost per month per PCT of bed-days	-£0.90	-£0.20
Average POPP project compared to no POPP project (in same POPP PCTs)	-65	Bed-days per month	-107	-23

Notes *With most recent POPP cost data

Sensitivity

As with any analysis of this type, there is a degree of uncertainty in the results. We present confidence intervals, which represent a range of values within which we are 95% certain that the 'actual' result will lie. In addition we used a range of different estimation models in order to explore the sensitivity of the results from the statistical modelling (see Appendix W for details). The results are potentially sensitive to the assumptions made in modelling e.g. how we measure the impact of POPP projects on hospital beddays and on the unit costs we use. There was some volatility in the results, but more in the standard errors rather than the marginal effect. In all cases the effect remained statistically significant.

We found that one particular PCT with the highest spend per capita in its category, had a big influence on the size of the overall result. If this PCT was removed from the analysis, the marginal effect falls by about a third. On the other hand, the distribution of spending on POPP in POPP PCTs was not particularly skewed or leptokurtic (skew = 0.60 and kurtosis = 4.49) so there is no indication that this site was an outlier. Rather, it seems likely that we are seeing a non-linear relationship with the largest spending areas having the greatest effects.

7.3.5 Trend results

The effect of the POPP programme is best understood as a deviation away from the underlying trend. Figure 97 and Figure 98 show the underlying, cyclical and downward trend in bed-day use. Against this trend, the figures show the estimated size of the deviation that occurs in POPP sites.

Figure 97. Emergency bed-day use per PCT – underlying trend and POPP deviation, POPP PCTs (smoothed by quarter)

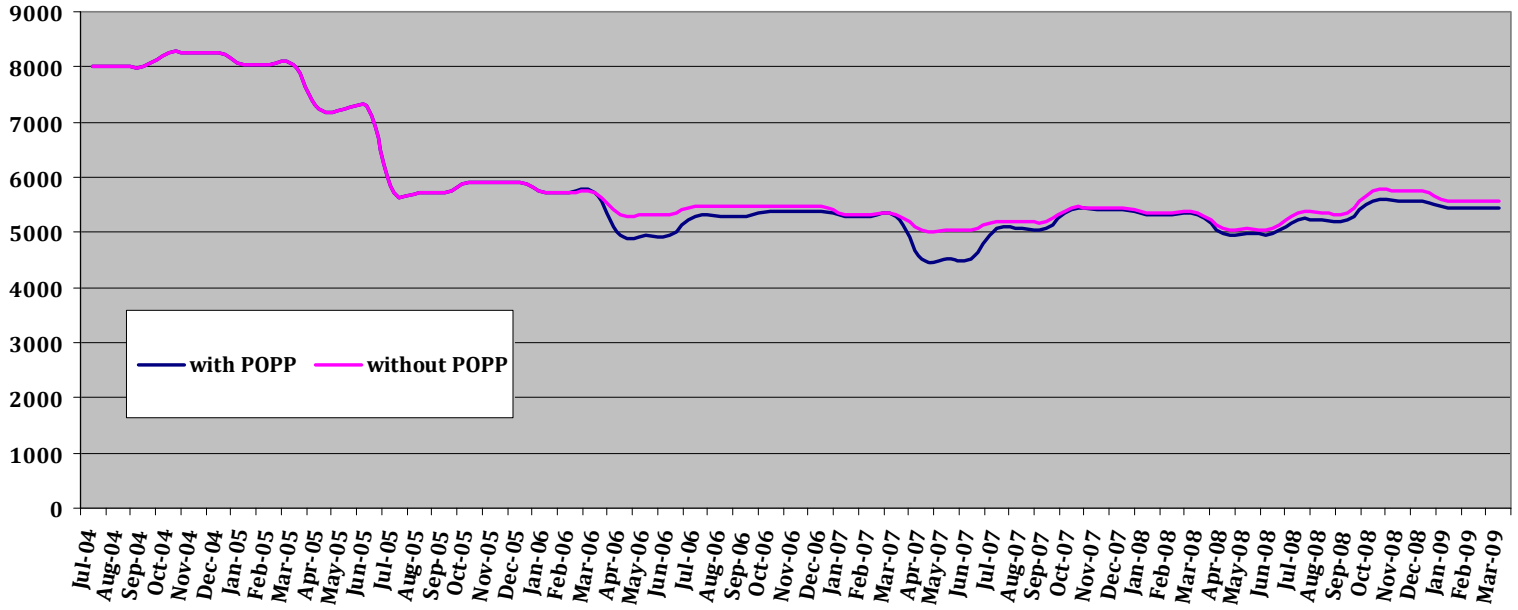
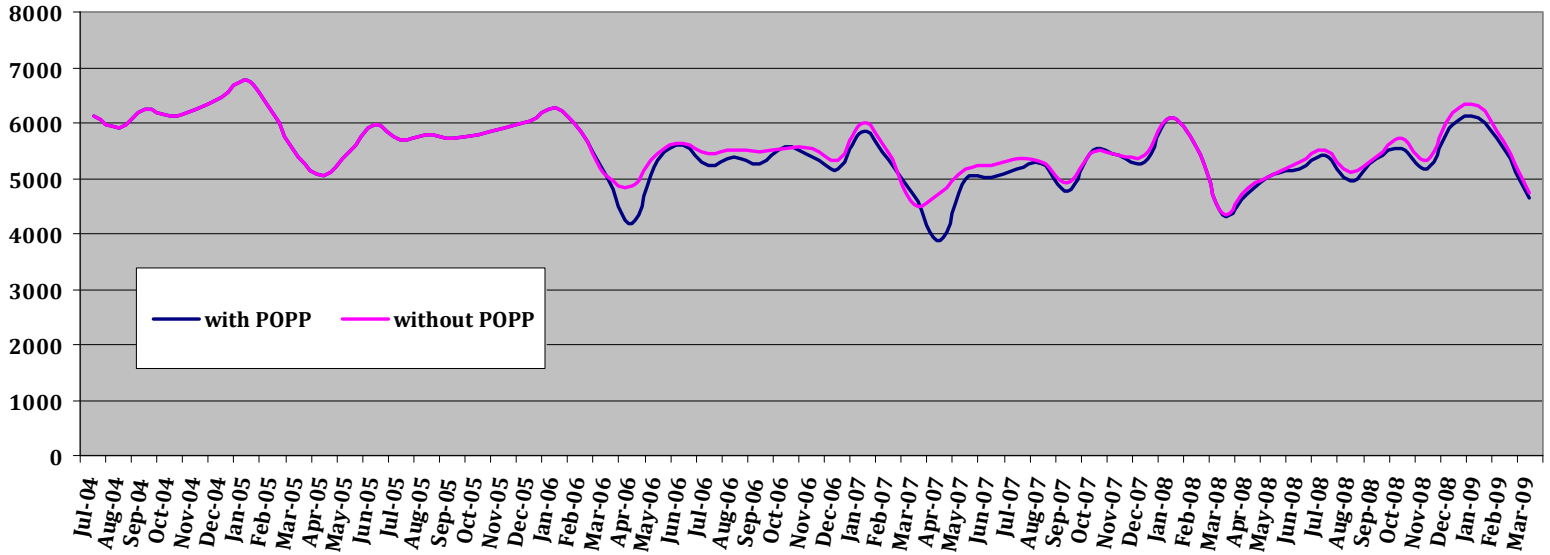


Figure 98. Emergency bed-day use per PCT – underlying trend and POPP deviation, POPP PCTs (by month)



7.3.6 Breaking down the results

Scale

The results above are described in terms of the impact of a small increase in the amount of spending on POPP. This result tells us about the cost-effectiveness of changes in expenditure from the current position. However, because economies of scale and similar often apply, marginal effects tend not to be constant (i.e. not unchanging across projects of different sizes). Usually, we would expect effectiveness to improve as the size of a project grows, with diminishing returns eventually setting in for very large projects. Because we have significant variation in the size of projects between the POPP sites, we can investigate this effect. As outlined above, we used non-linear models to account for scale effects. We also use a linear model to approximate the average effect of the POPP projects in the study.

We found that the size of the impact of an additional £1 is greater for larger projects in the study i.e. confirming our expectation that there are economies of scale. The data suggest that the average effect of spending £1 on POPP to reduce EBD spend is about half the marginal effect (see above results). We should note that the average applies to the projects in the study and that if the projects were bigger or smaller, on average, than in the study, then the corresponding average effect would change.

These results mean that 'total' effect of a POPP project is not as great as the marginal effect. Put in a more direct way, the average spending on POPP projects is just under £24,000 per month per POPP PCT (with 10% overheads or about £80,000 per month per POPP council). This level of spending would have produced a total reduction of EBD cost of £12,000 per month per PCT. But this figure is misleading as to the potential of POPP projects. In almost all services, fixed costs (for buildings, staff, infrastructure etc.) must be incurred before effects accrue. If the impact of projects was evaluated at the point where they had only invested in the fixed costs then it would not be surprising to find little effect. Instead, to gauge potential we need to look at their impact *at their optimal size*. The marginal effect is a much better indicator of this potential than the average effect.

Prevention type

Thus far we have been concerned with the overall impact of POPP projects. However, the projects themselves varied considerably in their aim, scope and intended effect. Around 70% of the POPP PCTs had projects that can be classified as secondary or tertiary prevention services, rather than primary prevention support. In the short run especially, we would expect secondary and tertiary prevention programmes to have a more direct impact on hospitalisation rates. Indeed, some of these projects were specifically aimed at reducing inappropriate hospital admissions or facilitating discharge from hospital. The classification of councils/PCTs into prevention type was largely based on the balance of expenditure across the individual projects in each site.

Although this study uses aggregated data at the PCT level (meaning that we cannot gauge the effect of individual projects) we can see whether (PTC-level) POPP effects were stronger in those PCTs where projects were predominantly secondary or tertiary prevention compared to PCTs with primary prevention projects.

The analysis (described in Appendix W) suggests that secondary or tertiary prevention PCTs had an effect that was 20% greater than the overall effect. Primary prevention PCTs had a 50% lesser effect. Standardising on the overall results outlined above and for size of project, this implies:

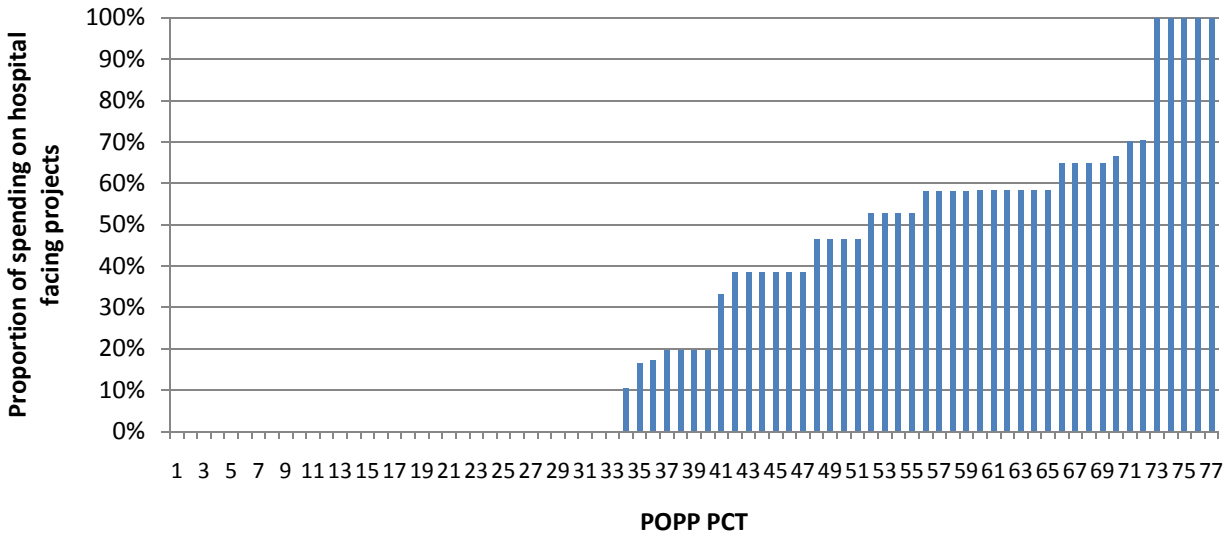
- Secondary and Tertiary prevention PCTs: headline saving of -£1.40 on EBDs for £1 extra POPP spend, with a range of -£1.00 to -£1.90.
- Primary prevention PCTs: : headline saving of -£0.70 for £1 extra POPP spend, with a range of £0.10 to -£1.40

Strictly speaking, because the range (the statistical confidence interval) for primary prevention PCTs straddles zero, it may be that these PCTs have no effect on EBDs.

Facing

We also looked at differences in impact between Hospital Facing and Community Facing services. In particular, we divided POPP expenditure for each site between their Hospital Facing and Community Facing projects. Figure 99 gives a breakdown of these proportions. Overall, just over 30% of project funding was to Hospital Facing projects. Furthermore, average spending per capita on Community Facing projects was around a third lower than the average for Hospital Facing projects.

Figure 99. Proportion of project spending on hospital facing projects – 77 POPP PCTs

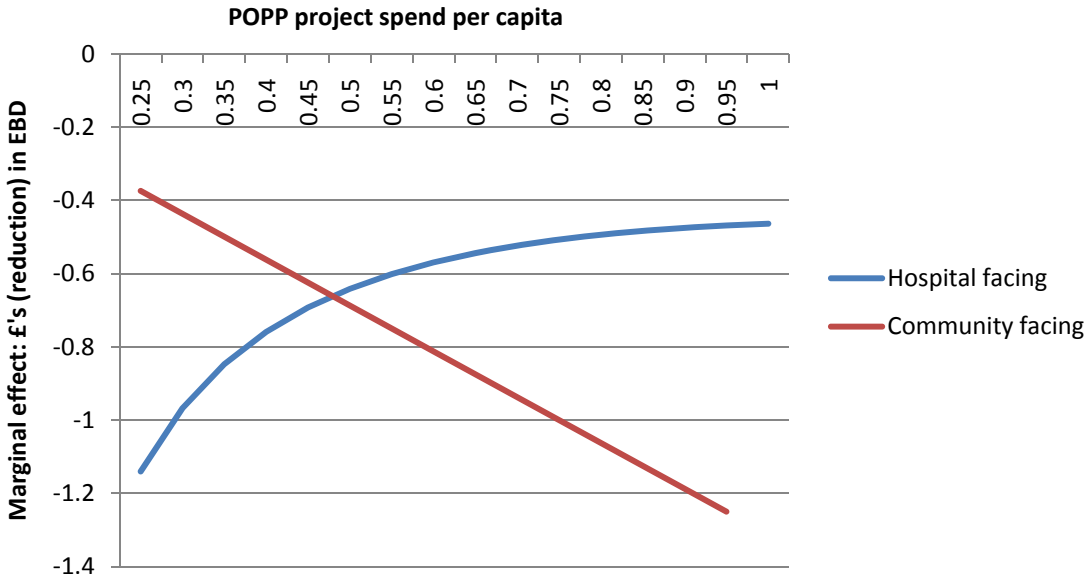


The pattern of POPP spend and bed-day use is especially complex when this distinction was made. Consequently, there is more uncertainty associated with the results of this modeling. The results suggest that Hospital Facing projects show signs of diminishing effect, not economies of scale (i.e. lower savings on EBDs for larger projects). The more prevalent Community Facing projects, however, showed increasing returns (i.e. economies of scale). This result can be partially explained by (a), the limits on the number of people who can be easily diverted from hospital by Hospital Facing projects and (b), that Community Facing services will need time to have an effect and potentially require a 'critical mass'.

Figure 100 shows this result: the graph lines show the approximate savings on emergency bed day costs from an additional £1 POPP spend for projects of different sizes (as measured by the total spend per capita). The implications are twofold. First, the average total effect of spending on Hospital Facing projects has a greater saving on emergency bed day cost than Community Facing project spend. Thus, in total, the Hospital Facing projects produced more total savings. Second, the marginal effects of Community Facing projects are greater than those of Hospital Facing projects, depending on the size of the project. So Community Facing projects generate greater levels of additional saving as they get bigger, but the converse appears to be the case for Hospital Facing projects. The convolution of scale effects and project type effects (i.e. Community Facing or Hospital

Facing) means that the results are more tentative and the policy implications more difficult to draw out. (It also means that the 'average' of the independent effect of Hospital and Community Facing projects need not correspond to the results in Table 134.) Nonetheless, making this distinction of project type is clearly meaningful, and the results warrant further investigation. A clearer implication is that once they are large enough, Community Facing projects can reduce the need for emergency secondary care.

Figure 100. Differences in saving for +£1 spend on POPP for projects of different sizes



7.3.7 Discussion

Overall, POPP projects have a significant effect in reducing the use of hospital emergency bed-days. On the basis of previous analyses described in the interim reports, this effect appears to be stabilising through the time the projects have been running. The headline result is that additional investment in these services produces greater than a £1 saving on EBDs for an extra £1 invested in POPP. There is uncertainty associated with this result as to be expected in a study of this nature. But the results are promising enough to justify the continuation of these services. Moreover, we are considering here only the pure cost saving implications. POPP services are presumably valued in their own right by people using them, benefits which accrue in addition to cost saving benefits outlined above.

As to a break-down of the results, the analysis suggests that larger projects are more effective, other things equal. A classification of sites into those with predominantly secondary/tertiary prevention projects rather than primary prevention projects, shows the former to be more effective. The results of the break-down of services into hospital facing and community facing are more tentative. Further investigation is merited, but there is some suggestion that community services can be cost-effective in saving EBDs, as long as they are sufficiently big. Significant variation within these categories remains however, which hampers our ability to isolate exactly which kinds of projects work best in analysis at this level. We therefore need to turn to the individual level analyses in this regard.

Whilst the large number of data points give us confidence with the results, we must always flag the caveats and these particularly concern the quality of the data and its classification, and the attribution of effects in aggregate analyses. Furthermore, the size of the effect is sensitive to the

assumptions we have made about POPP unit costs, especially management overhead costs. There will always be limits to what evaluations of this type can say with certainty, but within the context of this research, POPP projects are to be recommended as a cost-effective policy option.

7.4 Cost-effectiveness of those POPP projects within the standardised questionnaire

7.4.1 Introduction

To assess how far the POPP projects within the standardised questionnaire were cost-effective at the £20,000-£30,000 level (the levels used by the National Institute for Health and Clinical Effectiveness to indicate the appropriateness of funding technologies, given the willingness to pay), the different project sub-groups were analysed using the cost-effectiveness acceptability curve (CEAC). A CEAC analysis provides an evaluation of the cost-effectiveness of a programme in respect to alternative care (or treatment). In this work, the comparison used is the same as where there is no POPP programme: the quasi-control sample of the BHPS. The CEAC was used instead of the Incremental Cost-Effectiveness Ratio, as internal variance in the data resulted in challenging confidence intervals and the CEAC enables an illustration of '*the uncertainty surrounding the estimate of cost-effectiveness'* (Fenwick & Byford 2005: 106). Prior to presenting the data, it may be helpful to provide an explanation of how a CEAC is constructed and how it is interpreted.

The CEACs given below are developed from the project costs (incremental costs) and the reported changes in the health-related quality of life scores (incremental effects) drawn from the standardised questionnaire (see Section 2 and 6). Taking these joint distributions, a statistical analysis (non-parametric bootstrapping of the observed data) is then undertaken. The main advantage of using the non-parametric bootstrap approach is that it does not depend on parametric assumptions relating to the joint distribution of the costs and effects. Three specific outcomes are then available. The first is a scatter plot (e.g. Figure 101), with the variation found per person in their HRQoL along the horizontal axis. In our sample, the measure used was the EuroQoL or EQ-5D. This score is calculated as a utility score, represented by the Quality Adjusted Life Year (QALY). The benefits of (predominantly) health care are measured in QALYs, a single outcome measure that incorporates the effects of an intervention (or treatment) on both the quality (benefit obtained) and the quantity of life (number of extra life years). The vertical axis gives the costs per thousand pounds (£000). Looking at Figure 101, it can be seen that there are two lines (rays) that bisect the scatter plot. The first 'ray' (pink) is set at the cost of £20,000 per extra QALY (an increase of 1 within EQ-5D), whilst the second (green) is set at £30,000 per extra QALY. The blue scatter plot gives the variation of each individual within the overall sample. The 'dots' to the right side of the 'rays' are cost-effective, the dots to the left, that show a decrease in EQ-5D, are not. From the data presented in Figure 101, 86% of the population are to the 'right' of the 'ray', indicating cost effectiveness at the £30,000 level. This means that there is an 86% probability that all projects (for which we have data) within the POPP programme are cost-effective when compared with usual care (drawn from the

BHPS quasi-control sample) at the £30,000 level per extra QALY. This data is summarised in Table 136), which is then given as a chart or curve (e.g. Figure 101). The curve represents the effectiveness of the POPP programme as a whole. An advantage of the CEAC over confidence interval estimation is that the probability that the intervention in question is not cost-effective (the one-sided hypothesis test most appropriate for decision-making) is immediately apparent from the curve. Additionally, the curve quantifies this probability for all potential values to the ceiling ratio. The horizontal axis plots different monetary values (denoted by λ lamda): the maximum acceptable ceiling ratio or the maximum willingness-to-pay for a unitary increase in the QALY. The vertical axis indicates the level of probability of the maximum acceptable ceiling ratio (0–100%).

In exploring the cost-effectiveness of the projects included within the standardised questionnaire, we first examine the overarching POPP sample and then move onto three sub-groupings: Project Focus categories, Needs Levels, and Community Facing and Hospital Facing projects.

7.4.2 The Overarching POPP Programme

Much of the explanation for the following methods of analysis has been given above. From the scatter plot, it can be seen that, taking the actual incremental costs and effects (see Figure 101), there is an 86% probability that the overarching POPP programme is cost-effective, compared with usual care, at the £30,000 level.

Figure 101. Scatter plot of estimated joint density of incremental costs and incremental effects: Overarching POPP

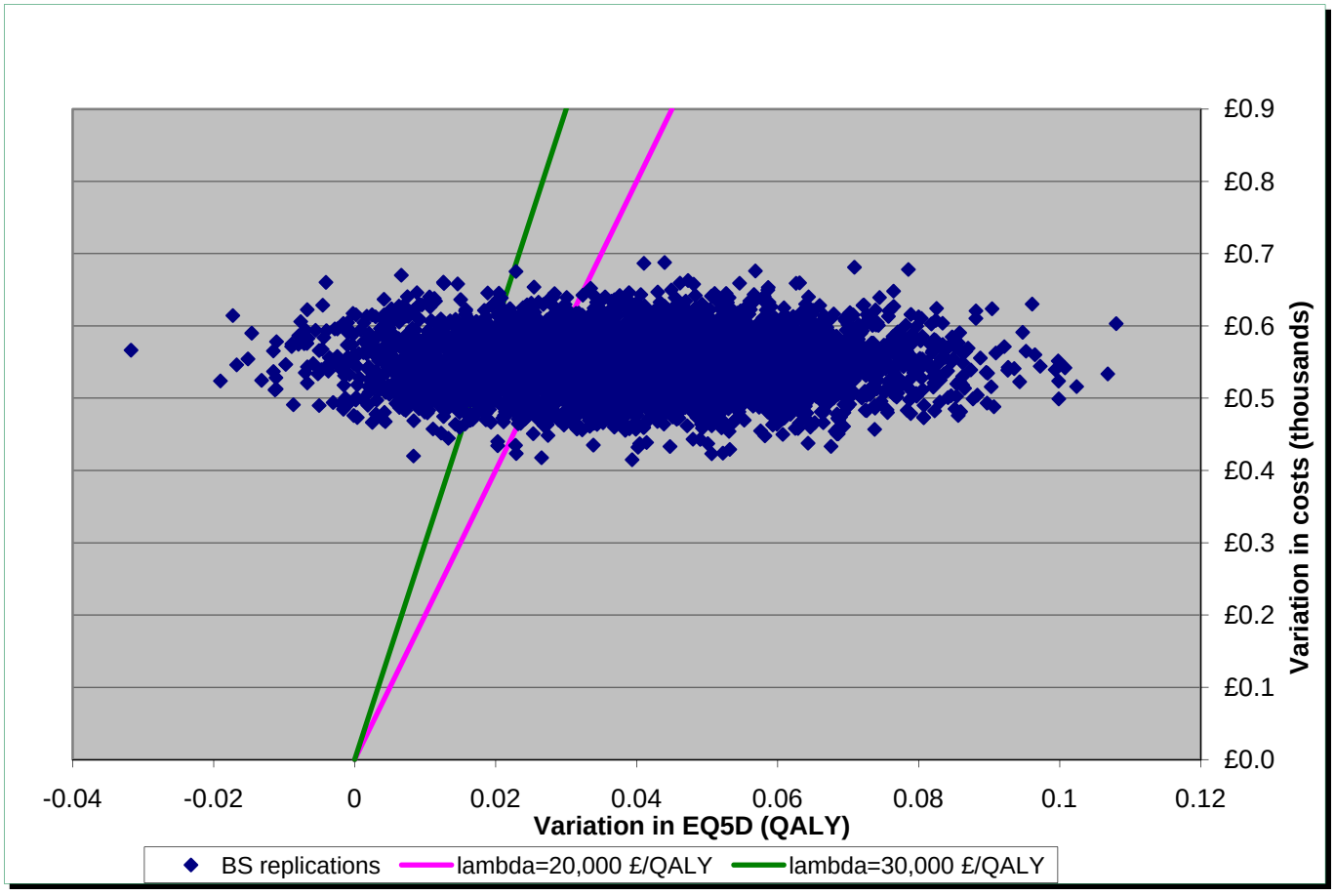


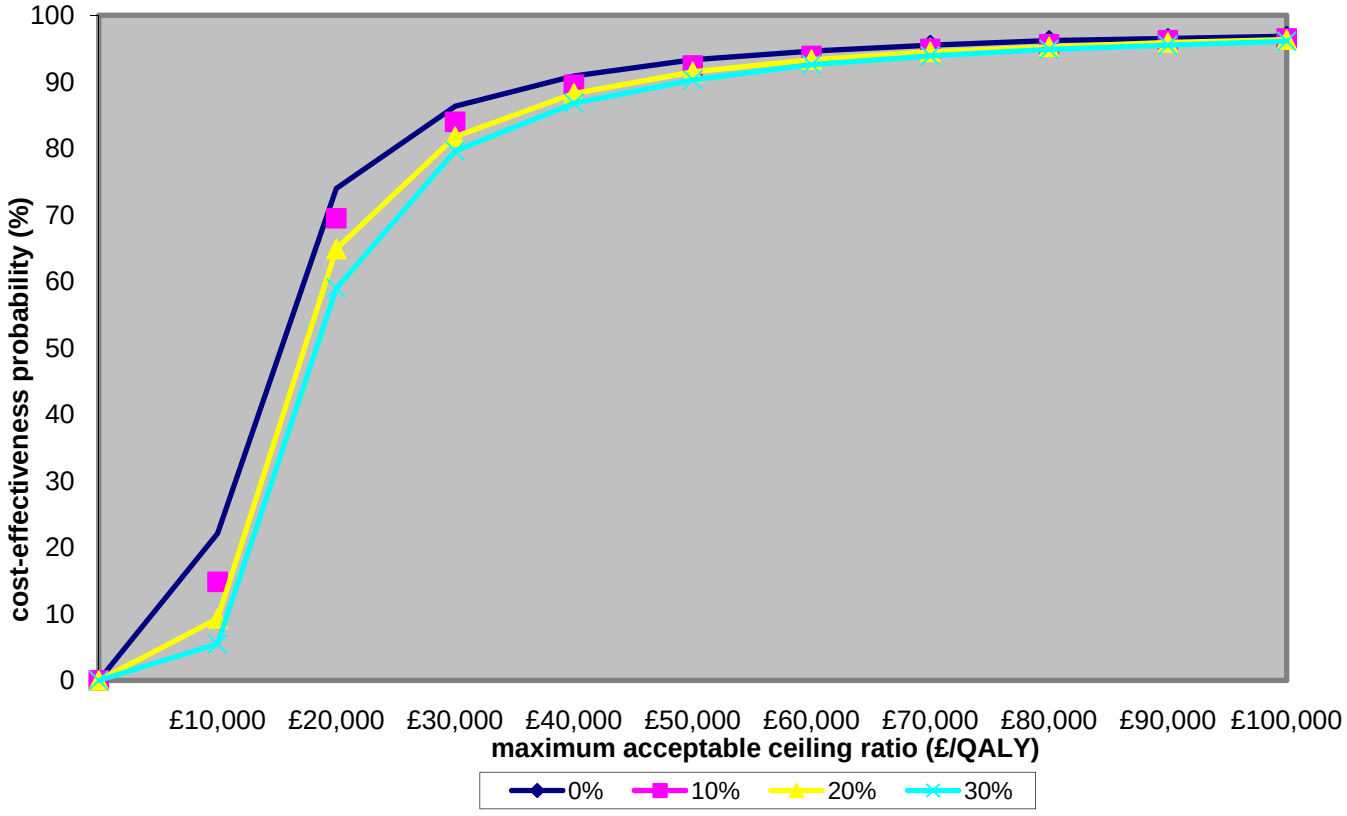
Table 136 breaks down the range of values for willingness to pay (Lamda λ) and the levels of probability.

Table 136. Overarching POPP: cost-effectiveness

	Overarching POPP: cost-effectiveness (managerial costs scenarios)			
Cost (lambda value)	**0%**	**10%**	**20%**	**30%**
£5000	0.04	0.00	0.00	0.00
£10000	22.10	14.82	9.30	5.48
£15000	57.06	49.20	41.80	35.00
£20000	73.96	69.48	64.86	58.96
£30000	86.30	83.98	81.74	79.60
£50000	93.32	92.44	91.48	90.28

With an assumption of no managerial costs and using project costs only, if there was a willingness to pay only £20,000 per extra QALY, there is a 74% probability that the POPP programme would be cost effective, compared with usual care. This probability falls as assumptions about management costs rise. Under an assumption of 30% management costs, on top of the actual project costs, the probability of cost-effectiveness is 80%. The following figure illustrates the data within the CEAC.

Figure 102. POPP 'Overarching' CEAC



That the 100% probability is not achieved in this analysis is not surprising, given the range and variation of the projects. The 62 projects range from low-level services such as lunch-clubs and photography courses, to higher level support services, such as hospital at home schemes and falls services. There is an 86% probability of cost-effectiveness at the £30,000 level. By analysing the data by the agreed groupings of the projects (Project Focus categories, Needs Levels and Community/Hospital Facing), a more complete picture of the probability of cost-effectiveness can be developed.

7.4.3 Project categories

Introduction

As noted elsewhere, the projects reported within the standardised questionnaire were grouped according to their focus into 11 categories. In reporting changes in the EQ-5D scores, it was argued that for some categories, that measure was not appropriate, because the project concentrated on non-relevant outcomes, such as purely psycho-social ones. It would be similarly inappropriate to include such categories in the assessment of cost-effectiveness; as a result, the sub-groups of Well-being-emotional/social, Well-being-geographical, Involving Older People and Carers' Services are excluded from the analysis. Moreover, within the category Hospital Discharge, it was found that although the measure was suitable, the variance between the two projects was large (one did extremely well and the other quite poorly) and, although there was a rationale for such findings, this category is also excluded from this analysis.

Well-being – practical

A total of nine projects were included in this category: four 'handyperson' services, a teleshopping project, home security, low-level assistive technology, volunteer driver scheme and a gardening service. A total of 119 individuals responded to the standardised questionnaire before and after the intervention. From the CEAC analysis, it can be seen from Figure 103, Table 137 and Figure 104 that, given a maximum acceptable ratio of £5,000 per 'point' (improvement of one in EQ-5D), the probability that these projects are cost-effective compared with 'usual care' is 99%. On an assumption of management costs of 30%, this probability falls to 97%.

Figure 103. Well-Being - Practical

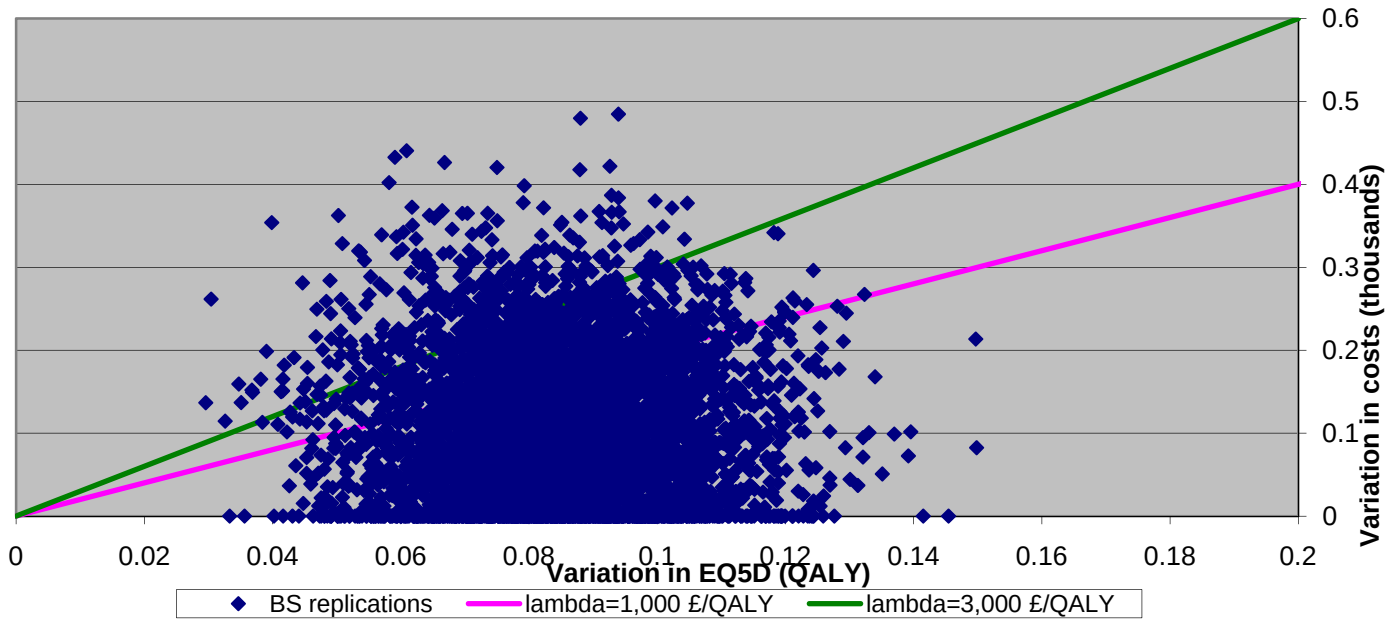
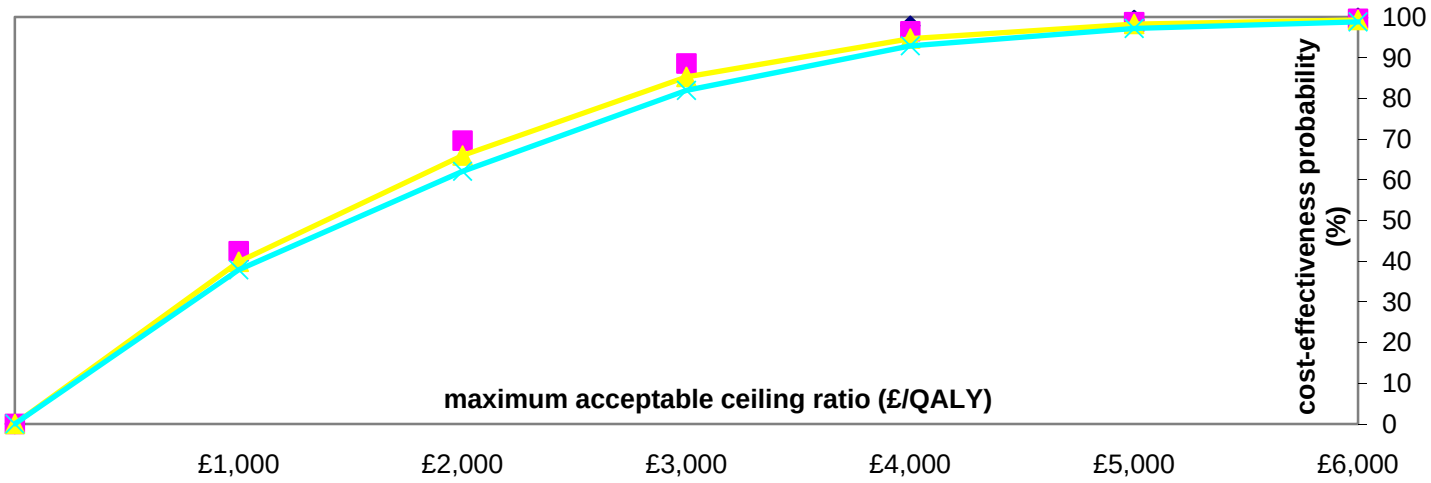


Table 137. Well-Being - Practical

	Well-Being Practical: cost-effectiveness (managerial costs scenarios)			
Cost (lambda value)	**0%**	**10%**	**20%**	**30%**
£1,000	45.28	42.46	39.84	37.88
£2,000	74.74	69.62	65.94	62.08
£3,000	92.06	88.58	85.26	81.96
£4,000	97.88	96.50	94.68	92.92
£5,000	99.26	98.74	98.26	97.20
£20,000	100.00	100.00	100.00	100.00
£30,000	100.00	100.00	100.00	100.00

Figure 104. Well-Being-Practical: CEAC



Well-Being – physical health

Four projects are included within this category (n=53): one time-limited exercise at home course, a T'ai Chi course, a chiropody service focused toward individuals within the BME community and a rehabilitation course carried out by a voluntary organisation. From the scatter plot (Figure 105), it can be seen that given a maximum acceptable ratio or willingness-to-pay of £15,000, just over half the sample (59%) are to the right of the ray, the area of cost-effectiveness. Setting the cost per QALY at £20,000, the total population within the area of cost-effectiveness is 89% (see Table 138). Given the maximum acceptable ratio of £30,000 per QALY, there is a 99% probability that these POPP projects are cost-effective compared with usual care.

Figure 105. Well-Being - Physical Health

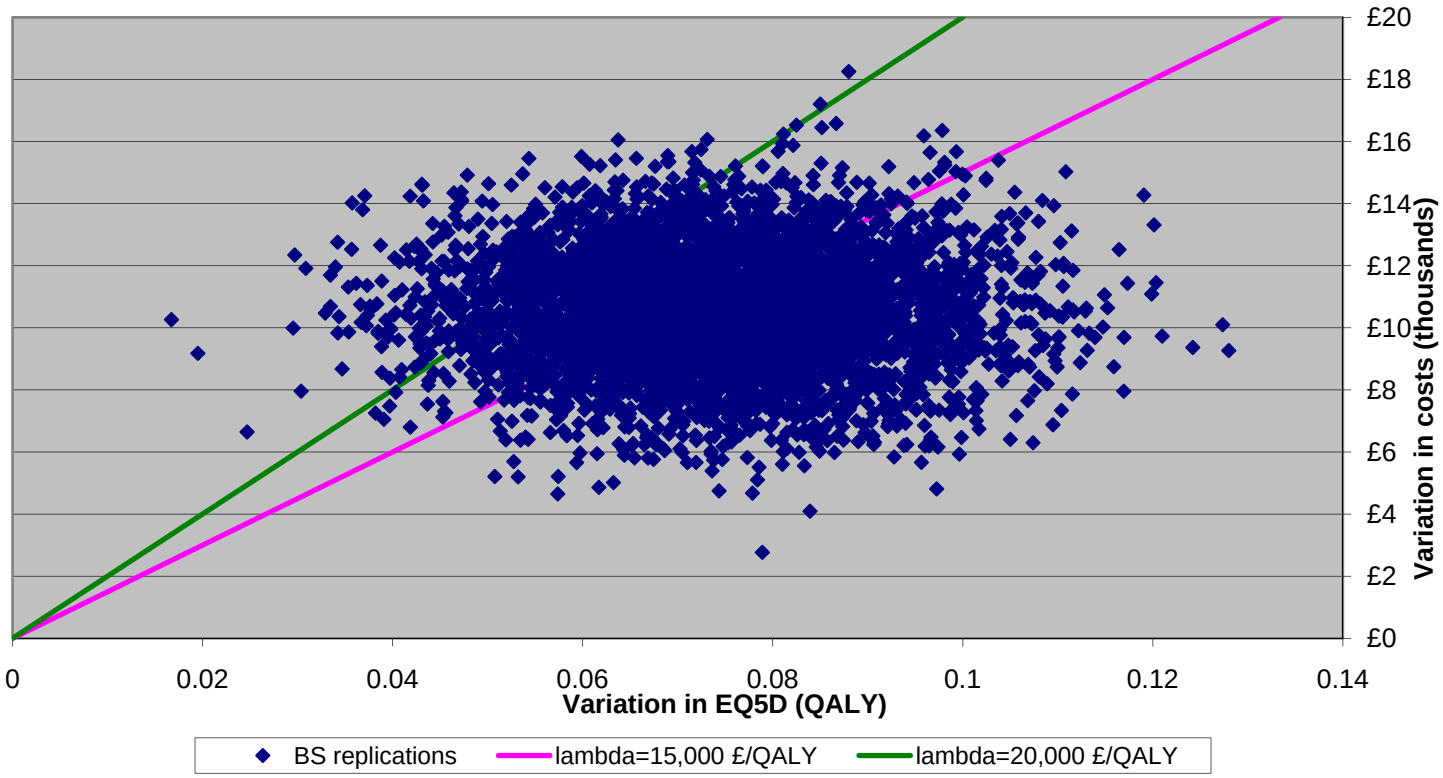
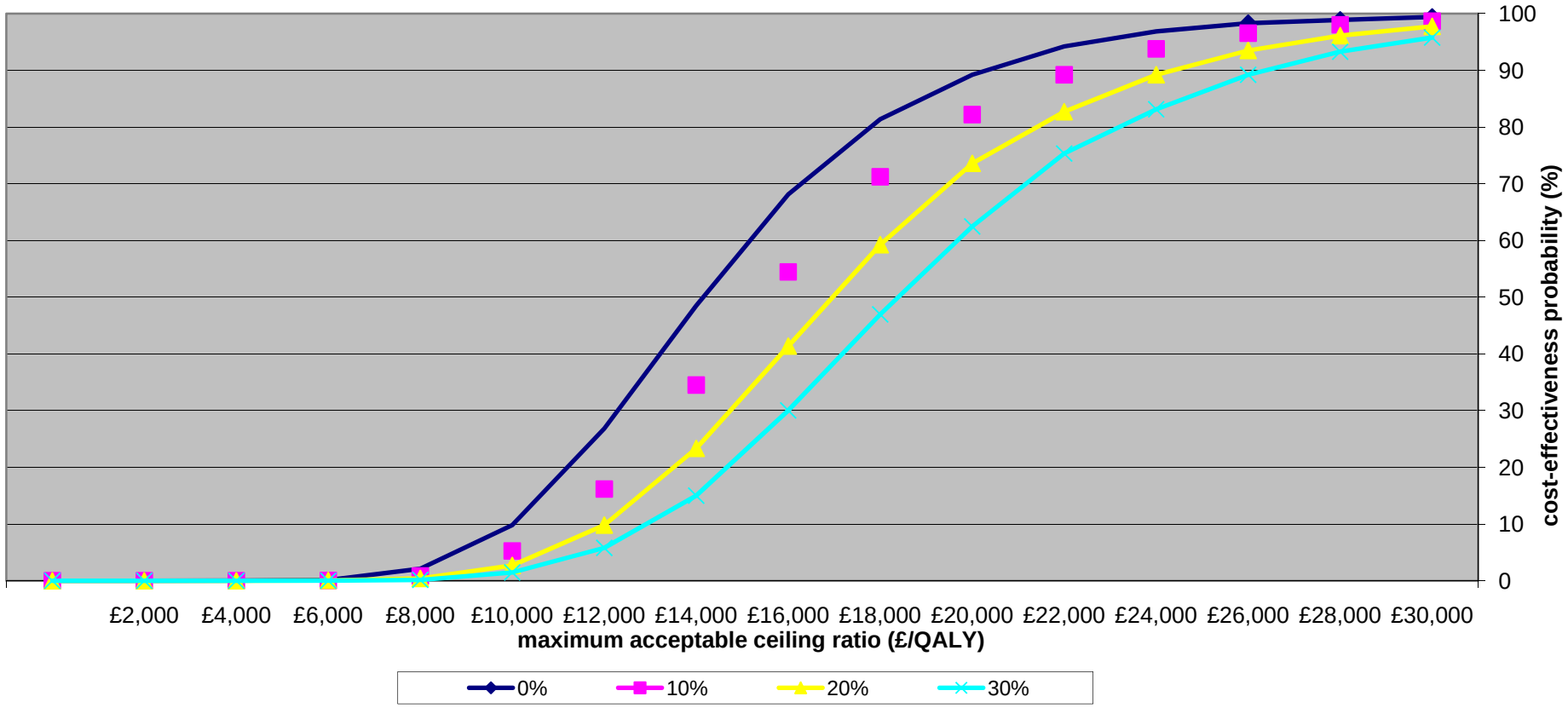


Table 138. Well-Being - Physical Health

	Well-being physical health: cost-effectiveness (managerial costs scenarios)			
Cost (lambda value)	**0%**	**10%**	**20%**	**30%**
£5,000	0.06	0.02	0.02	0.02
£10,000	9.82	5.26	2.70	1.48
£15,000	59.26	44.72	32.06	22.20
£20,000	89.22	82.20	73.60	62.48
£30,000	99.42	98.68	97.76	95.78

Figure 106. Well-Being - Physical Health: CEAC



Information & signposting

If users are to be able to exercise greater control and choice around welfare services (DH 2005, 2006), they need to make informed choices. To make informed choices, users need to be able to access information and advice services. Putting People First gave as a key objective the development of *'A universal information, advice and advocacy service for people needing services and their carers irrespective of their eligibility for public funding'* (HM Gov 2007: 3). Within this category (n=91), five projects are included. All involve face-to-face information and advice giving. Of these, operational staff in two projects carry out home visits on a time-limited basis, working with the user, *'increasing their chances of finding relevant information*' (Baxter et al 2007). Information services that provide home visits and on-going support are likely to be more expensive than simple drop-in services.

In exploring the probability of cost-effectiveness within this category, a variation of the outcomes across the projects is evident. At the £20,000 acceptability ratio, there is a 75% probability that such services are cost-effective, compared with usual care. At the £30,000 maximum acceptability ratio, an 83% probability is reported (see Figure 107,Table 139 and Figure 108).

Figure 107. Information, Signposting and Access

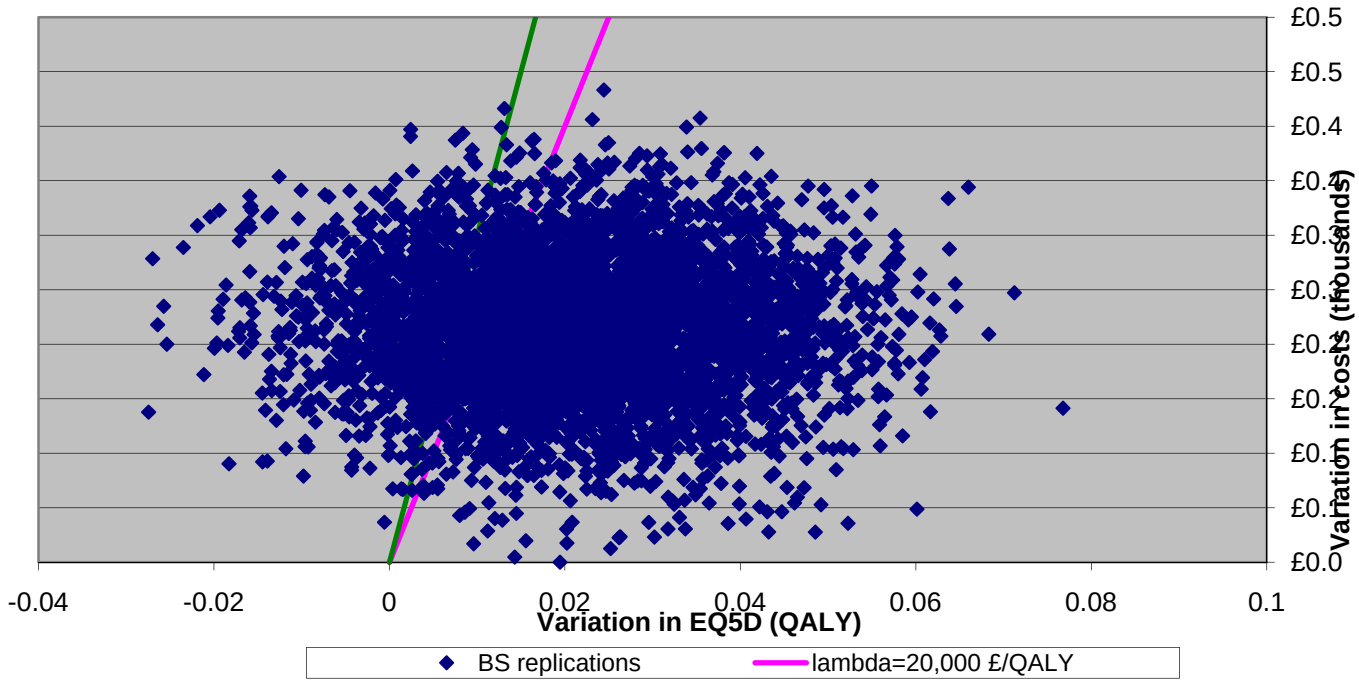
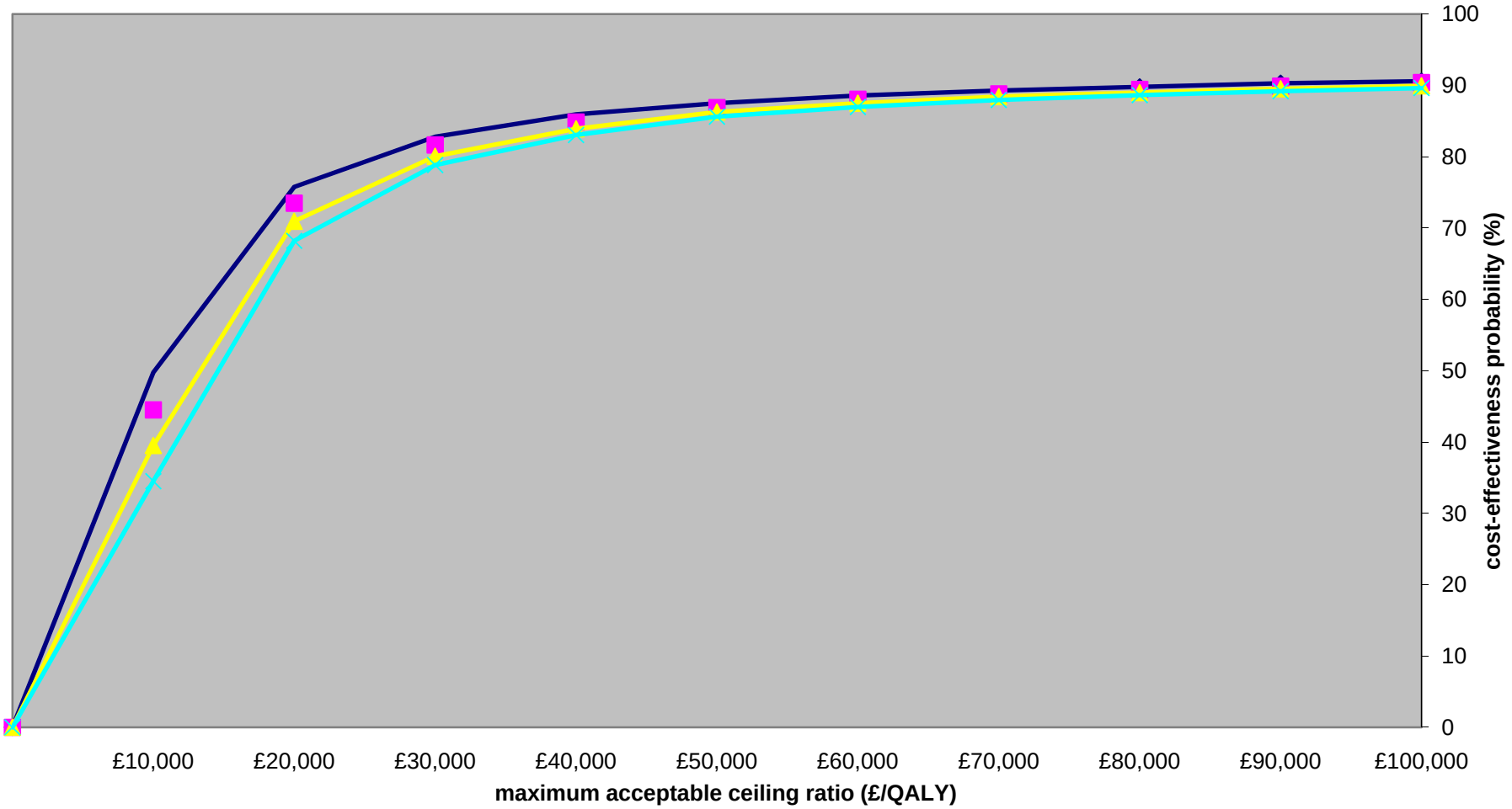


Table 139. Information, Signposting and Access

	Information, Signposting and Access: cost-effectiveness (managerial costs scenarios)			
Cost (lambda value)	**0%**	**10%**	**20%**	**30%**
£5,000	13.40	10.02	7.46	5.74
£10,000	49.74	44.50	39.50	34.50
£20,000	75.76	73.48	70.94	68.20
£30,000	82.80	81.64	80.06	78.82
£50,000	87.50	86.88	86.26	85.60

Figure 108. Information, signposting and access: CEAC



Proactive Case Co-ordination

This category includes eight projects (n=444), ranging from health based care management and nursing support to generic social care workers. Table 140 shows that at the maximum acceptability ratio of £30,000, there is an 81% probability that the grouping of Proactive Case-Co-ordination is cost-effective. It is only at £50,000 per further QALY that there is 95% probability that such projects are cost-effective against usual care. The summary table is further illustrated by Figure 108 and Figure 109.

Table 140. Proactive case co-ordination: cost-effectiveness (managerial costs scenarios)

	Proactive case co-ordination: cost-effectiveness (managerial costs scenarios)			
Cost (lambda value)	**0%**	**10%**	**20%**	**30%**
£10,000	0.48	0.10	0.02	0.02
£20,000	48.54	37.62	27.96	19.62
£30,000	81.00	75.10	68.82	62.72
£40,000	91.06	88.82	85.78	82.18
£50,000	94.60	93.32	91.96	90.38

As assumptions regarding management costs rise, the probability of cost-effectiveness necessarily drops. For example, with an assumption of a further 10% management cost, there is a 75% probability that the grouping of Pro-active Case Co-ordination is cost-effective at the maximum acceptability ratio (£30,000).

Figure 109. Proactive case co-ordination

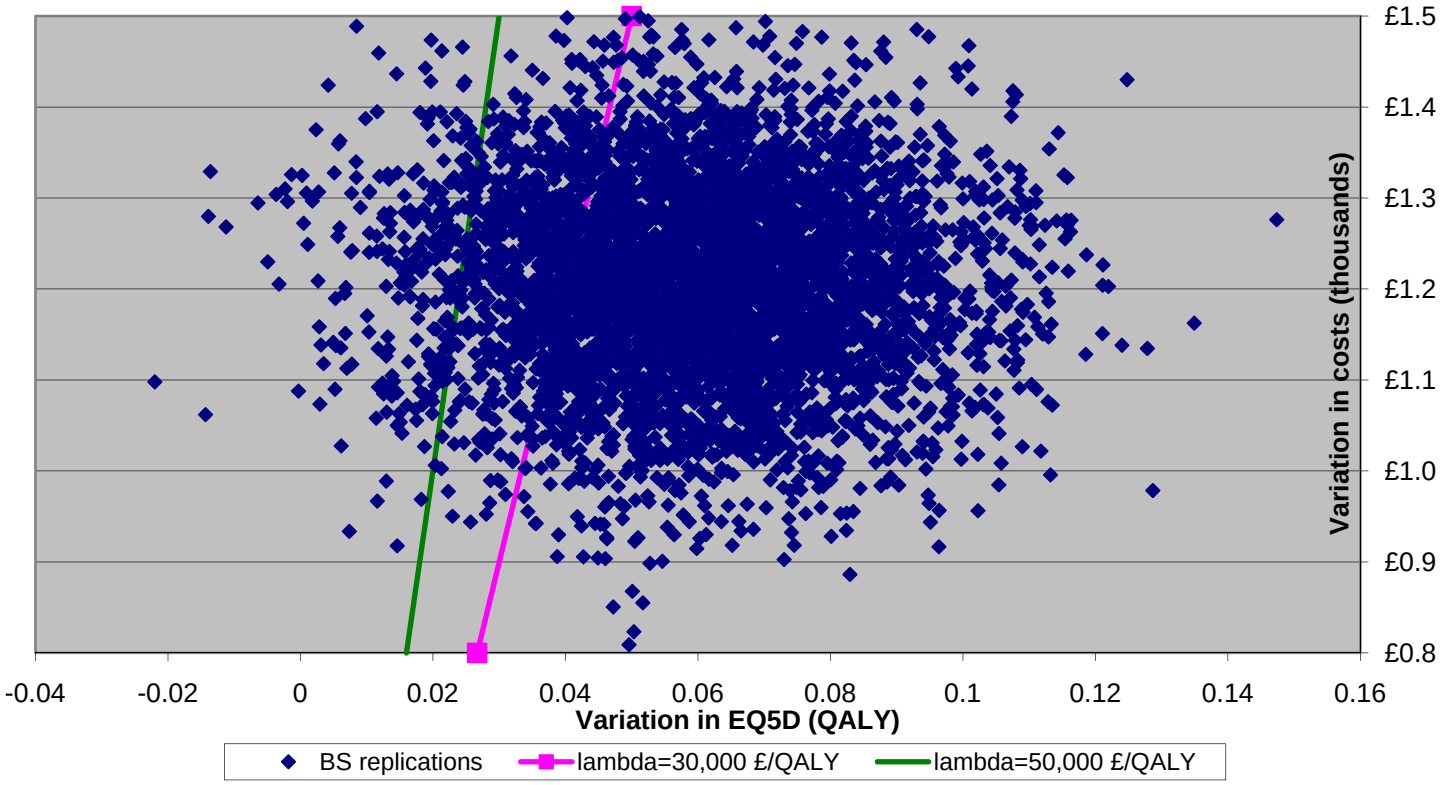
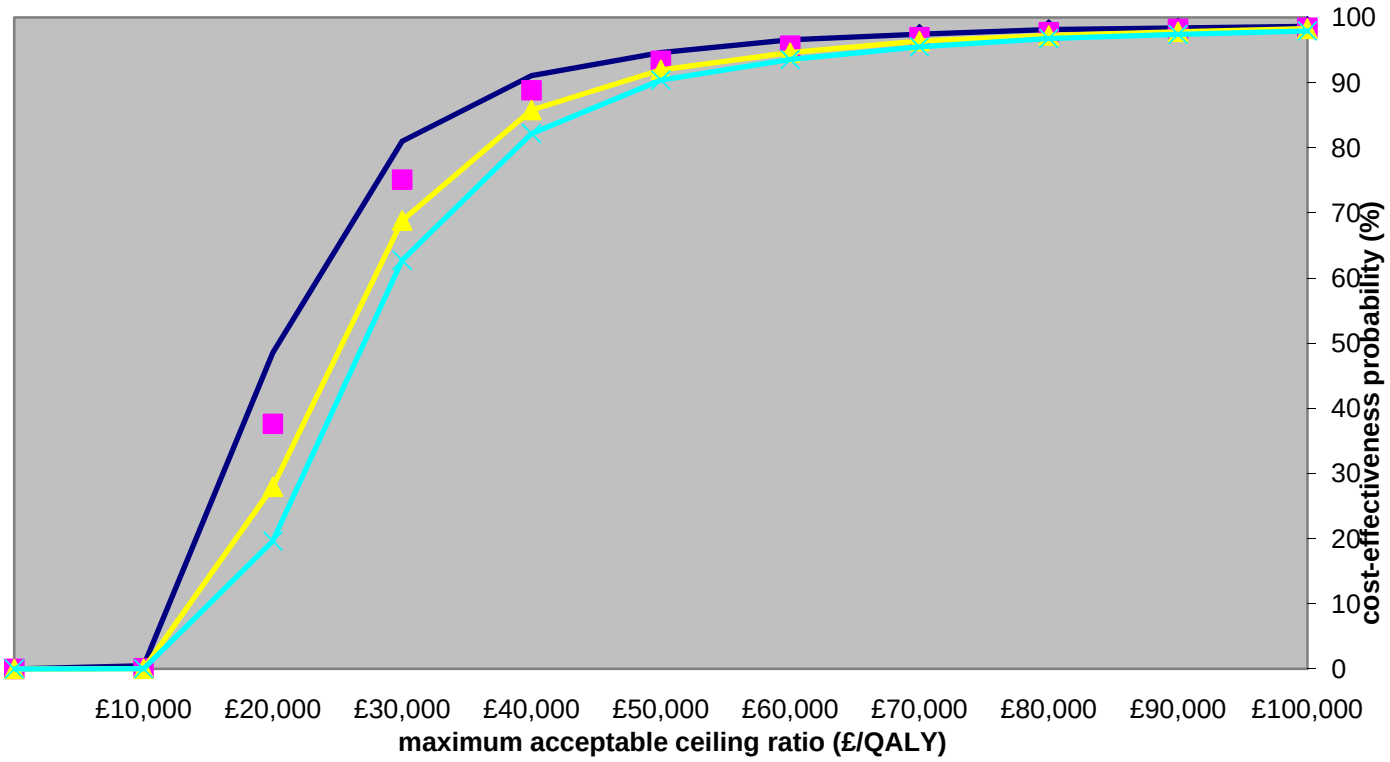


Figure 110. Proactive case co-ordination: CEAC



Long-term conditions: complex care

In the introduction to this section, we discussed the necessity to provide a synergy of data and the impact of high variance between and within the projects on outcomes. Summary data are useful but can hide good and poor performance. Within this group, the variance was particularly high. Following analysis of outliers and further documentary analysis, two projects were removed from the analysis, resulting in a 'grouping' of two projects (n=55). Given a willingness to pay a further £10,000 per extra QALY, there is a 98% (97.98%) probability that Long-Term Conditions – Complex Care is cost-effective, compared with usual care (see Table 141). At the maximum acceptable ratio of £30,000, there is a 100% probability rating, even incorporating assumptions about further management costs, ranging from a further 10% to 30%. The percentage population to the right side of the ray is reflected in the scatter-plot (Figure 112), whilst the curve illustrates the probability of cost-effectiveness when compared to normal care (Figure 113).

Table 141. Long Term conditions –Complex care: Cost-effectiveness (managerial cost scenarios)

	Cost-effectiveness (managerial costs scenarios)			
Cost (lambda value)	**0%**	**10%**	**20%**	**30%**
£10,000	97.98	88.62	64.38	33.42
£20,000	100.00	100.00	100.00	100.00
£30,000	100.00	100.00	100.00	100.00
£40,000	100.00	100.00	100.00	100.00
£50,000	100.00	100.00	100.00	100.00

Figure 111. Long-term conditions: complex care

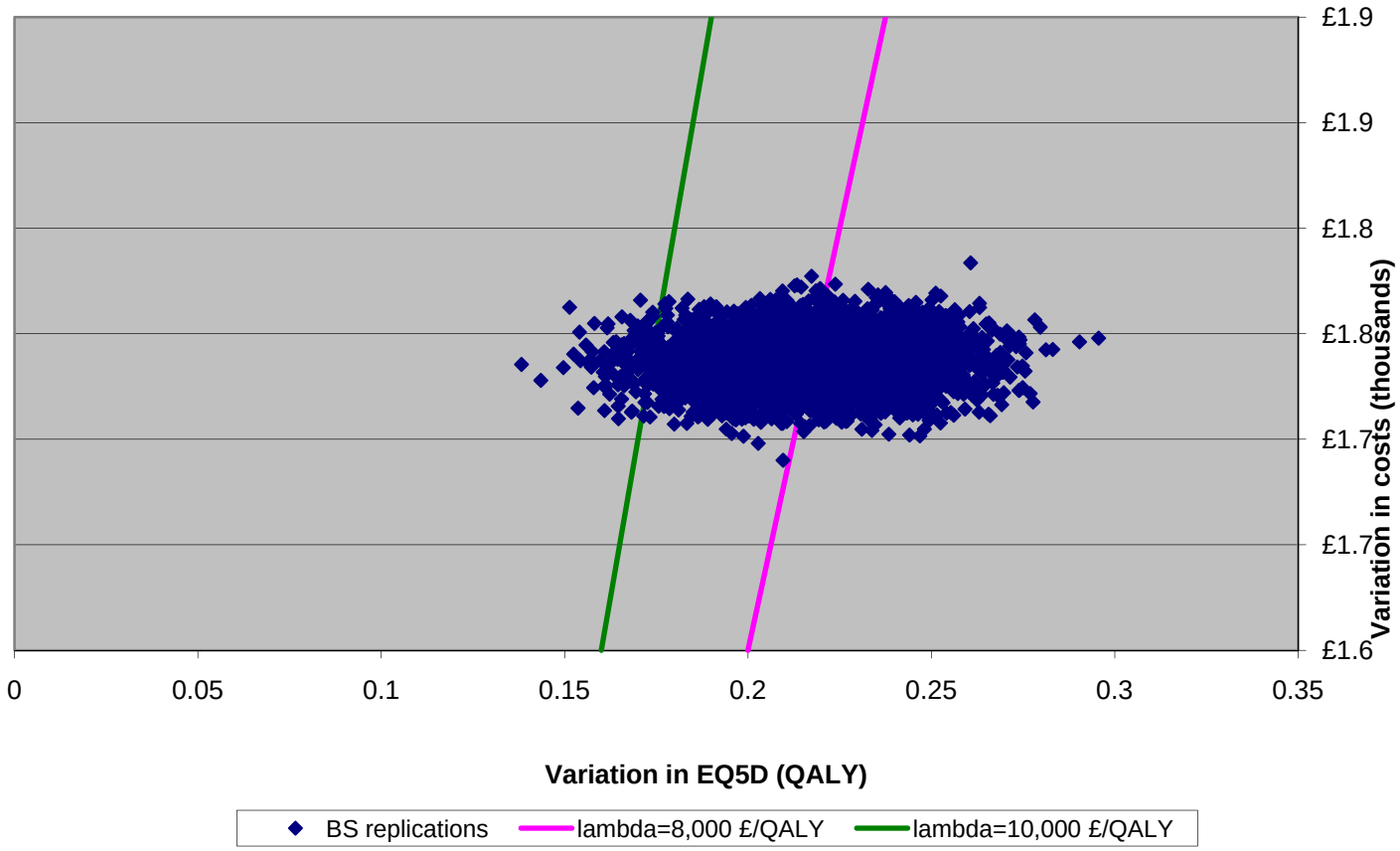
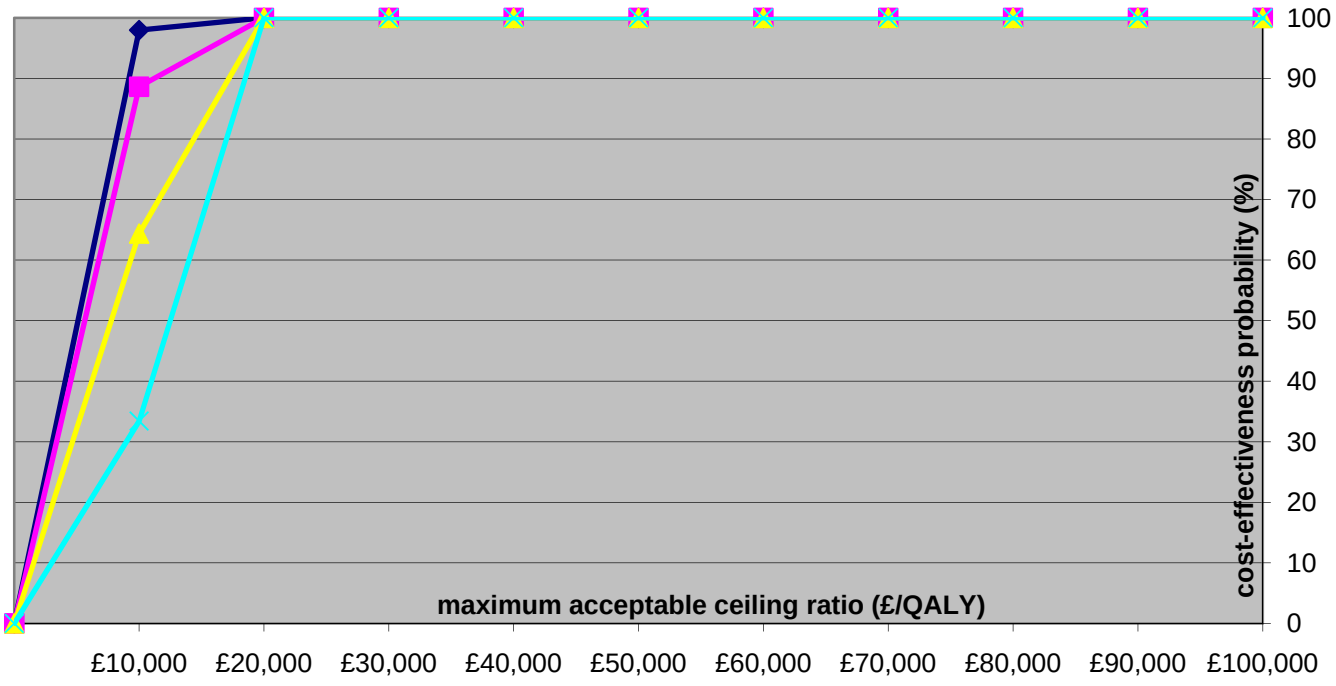


Figure 112. Long term conditions - complex care: CEAC



Specialist falls

Five projects were included in this category. The majority of people using these services (n=89) received treatment from a specialist falls team (specialist falls nurse, specialist physiotherapist, occupational therapist and support worker), managed through primary care and based within the local community hospital. The remaining sample were first assessed by a rehabilitation team and then either went on to receive physiotherapy and/or a falls prevention exercise programme, hospital or leisure-centre based. All the projects were time limited.

At a £10,000 per point increase in QALY, there is a 99% probability that such programmes are cost-effective, compared with usual care (see Table 142 and Figure 113). A great deal of evidence is available indicating that multi-factorial falls prevention programmes reduce the risk of falling and are likely to increase HRQoL (e.g. see Chang 2004, Easterbrook 2001, Gillespie 2004, Feder 2000). However, there is limited evidence regarding cost-effectiveness (Cusimano 2008). Our finding strengthens the evidence base around falls prevention programmes.

Table 142. Specialist falls services: cost-effectiveness

	Specialist Falls Services: cost-effectiveness (managerial costs scenarios)			
Cost (lambda value)	**0%**	**10%**	**20%**	**30%**
£2,000	1.46	1.04	0.82	0.72
£4,000	24.30	17.02	11.98	8.60
£6,000	71.22	59.76	47.86	38.72
£8,000	93.80	88.68	81.86	74.22
£10,000	98.78	97.36	95.40	92.18
£20,000	100.00	100.00	99.98	99.94
£30,000	100.00	100.00	100.00	100.00

Figure 113. Specialist falls

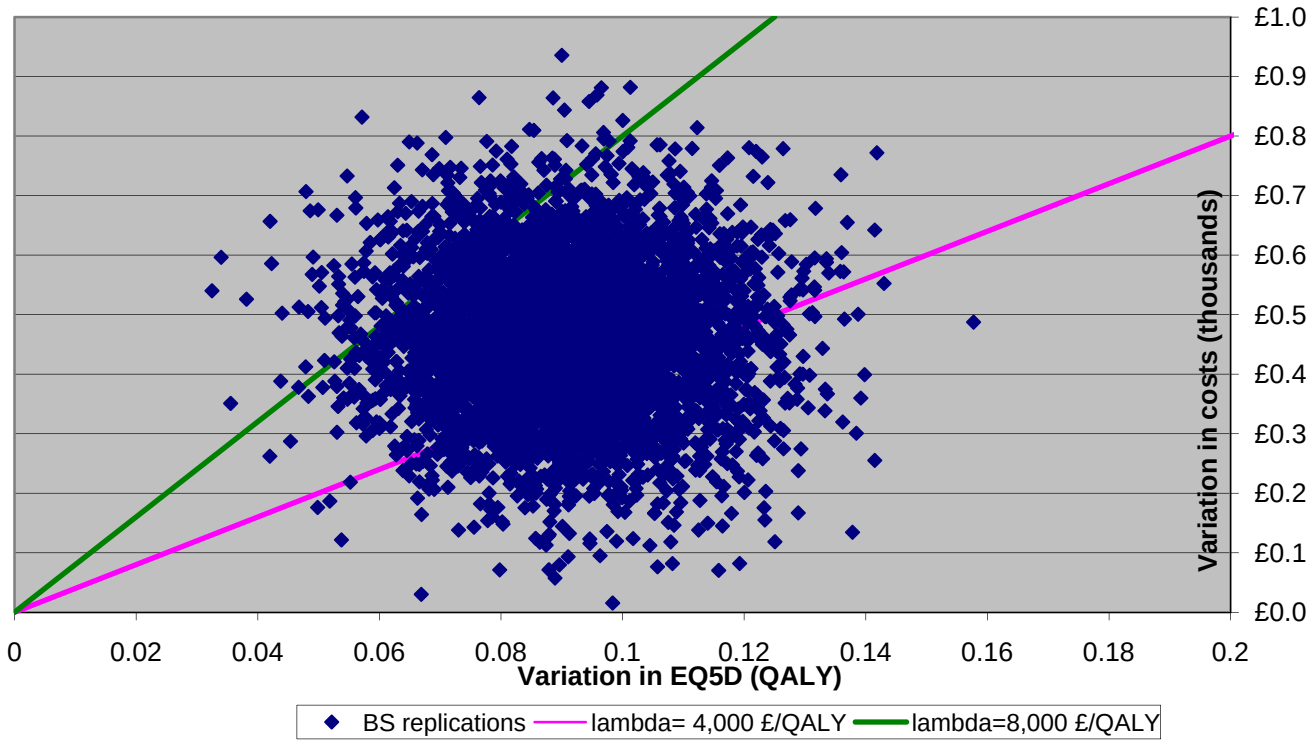
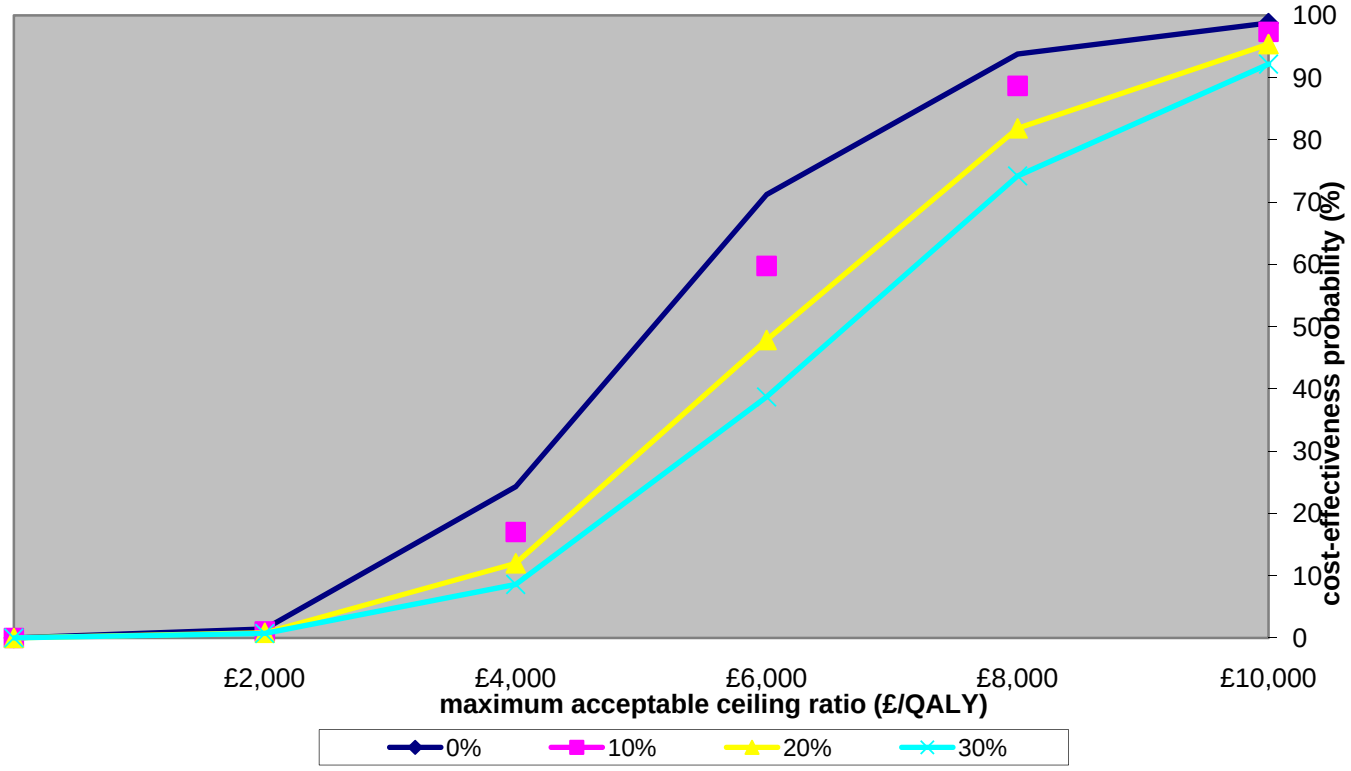


Figure 114. CEAC (cost-effectiveness acceptability curve) for specialist falls



7.4.4 Needs levels

Introduction

The projects were categorised into three Needs Levels to which they were addressed: effectively Primary Prevention, Secondary Prevention and Tertiary Prevention. Such categorisations are necessarily broad and do not allow the development of as strong a picture of their outcomes, or cost-effectiveness, as might be desirable. Moreover, the great range and variety of the projects, despite careful coding and categorisation, meant that their classification could shift from one category to another. Similarly, the focus of some projects changed throughout the three years of operation: for example, the criteria of referral being extended to include co-morbidities. Where possible, we have undertaken a re-coding of such projects. However, such an exercise is dependent on reports received from the pilot sites, and these were not always fully accurate.

Needs Level 1: Primary prevention

From Table 143, it can be seen that at the maximum acceptable ratio of £30,000 per unit increase in EQ-5D, there is an 80% probability that those projects working within Primary Prevention (n=37 projects) are cost-effective, compared with usual care. At £40,000 per unit increase, there is an 84% probability of cost-effectiveness. If assumptions about some management costs are included, the probability does fall, but the initial probability of 84% is still high.

Table 143. Primary prevention: cost-effectiveness

	Primary prevention: cost-effectiveness (managerial costs scenarios)			
Costs (lambda value)	**0%**	**10%**	**20%**	**30%**
£5,000	13.18	9.70	7.16	5.16
£10,000	48.88	43.48	38.48	34.12
£20,000	73.88	71.74	69.20	66.76
£30,000	80.84	79.50	78.64	76.80
£40,000	84.00	83.00	82.04	81.24

Figure 115. Needs level 1: primary prevention

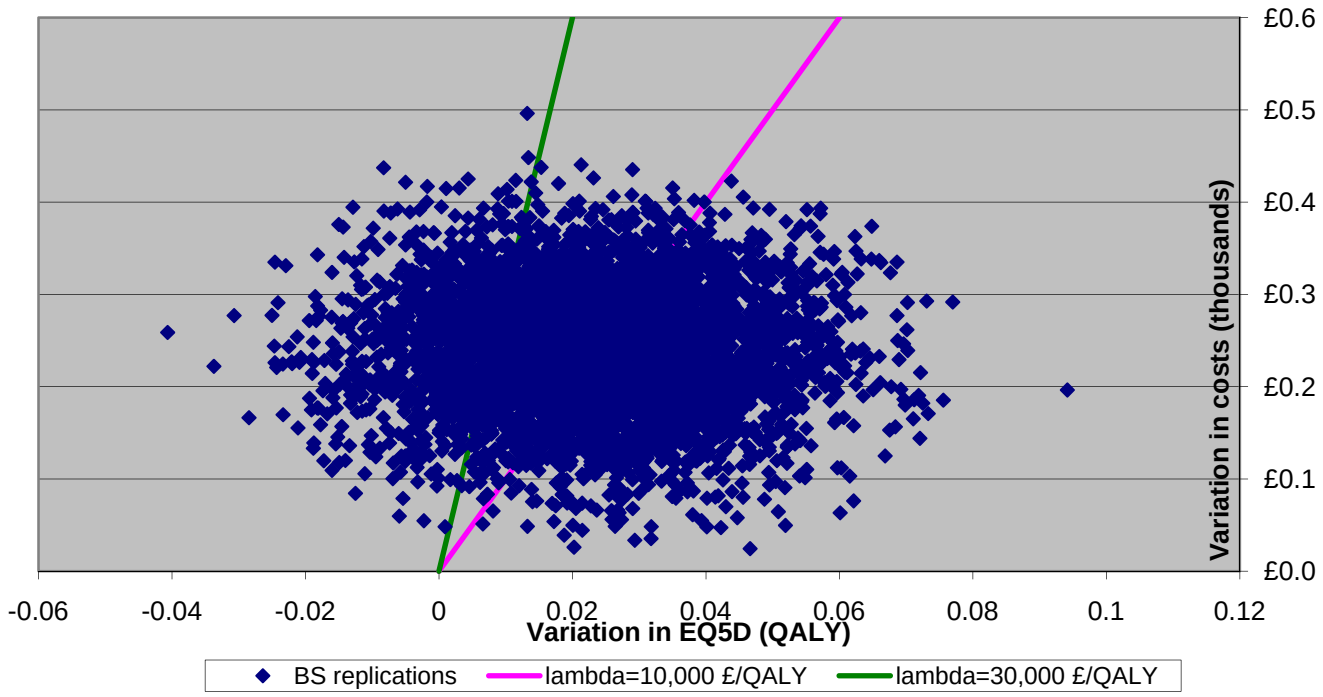
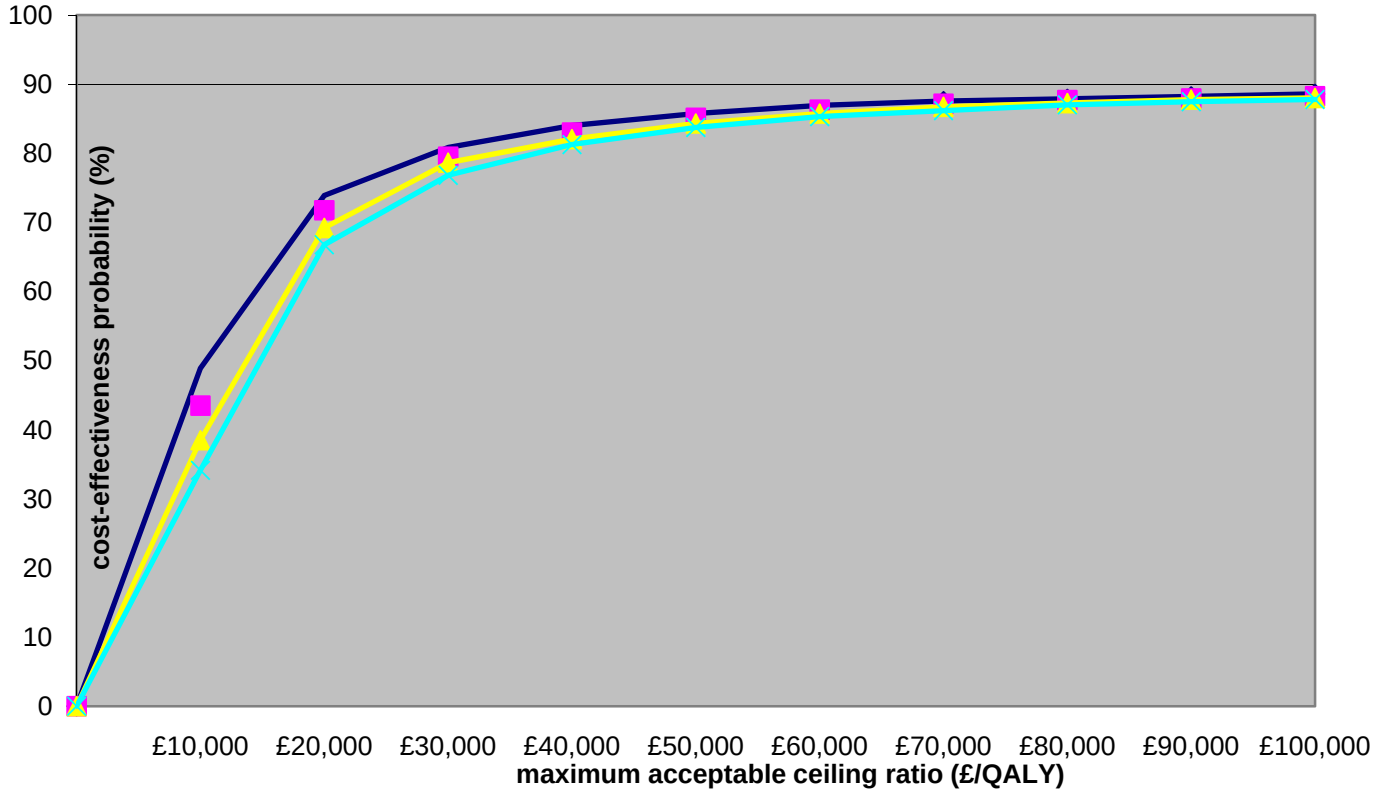


Figure 116. Needs level 1: primary prevention: CEAC



Needs Level 2: Secondary Prevention

There are 21 projects grouped under Secondary Prevention, ranging across interventions providing case management and support, falls services, falls rehabilitation, talking therapies and medicines management. In comparison with Primary Prevention, there is a lower probability that such projects are cost-effective compared with usual care, if the ceiling of willingness to pay is £30,000: a 71% probability (see Table 144). It is only at £40,000 per unit that the probability moves above 80%, although if assumptions about some management costs are included, the probability that such projects are cost-effective decreases.

Table 144. Secondary prevention: cost-effectiveness

	Secondary prevention: cost-effectiveness (managerial costs scenarios)			
Cost (lambda) value	**0%**	**10%**	**20%**	**30%**
£10,000	0.08	0.00	0.00	0.00
£20,000	33.06	23.52	15.60	9.44
£30,000	70.78	63.66	56.00	48.34
£40,000	85.38	81.46	77.18	72.42
£50,000	91.12	88.98	86.84	83.88

Figure 117. Needs Level 2: secondary prevention

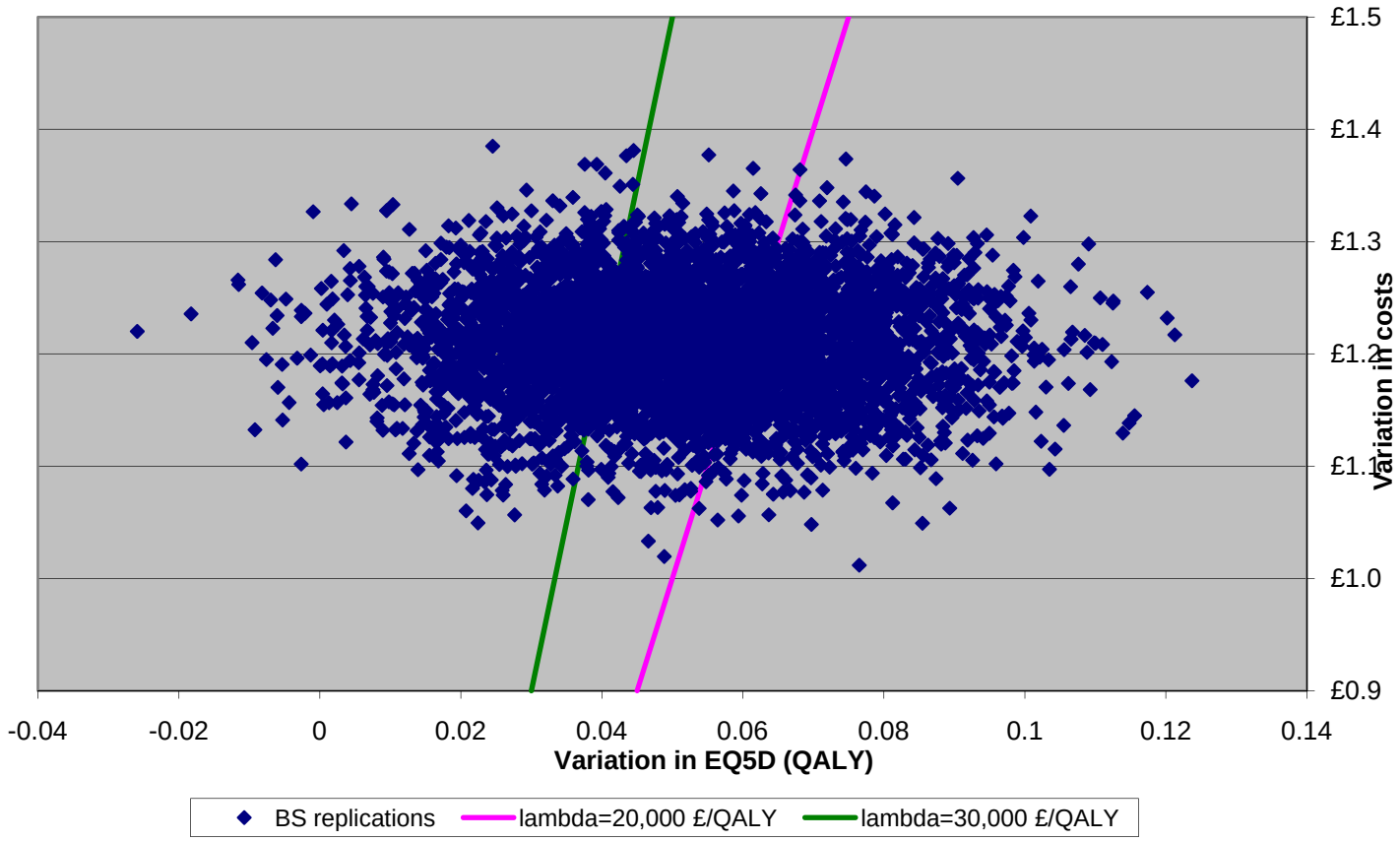
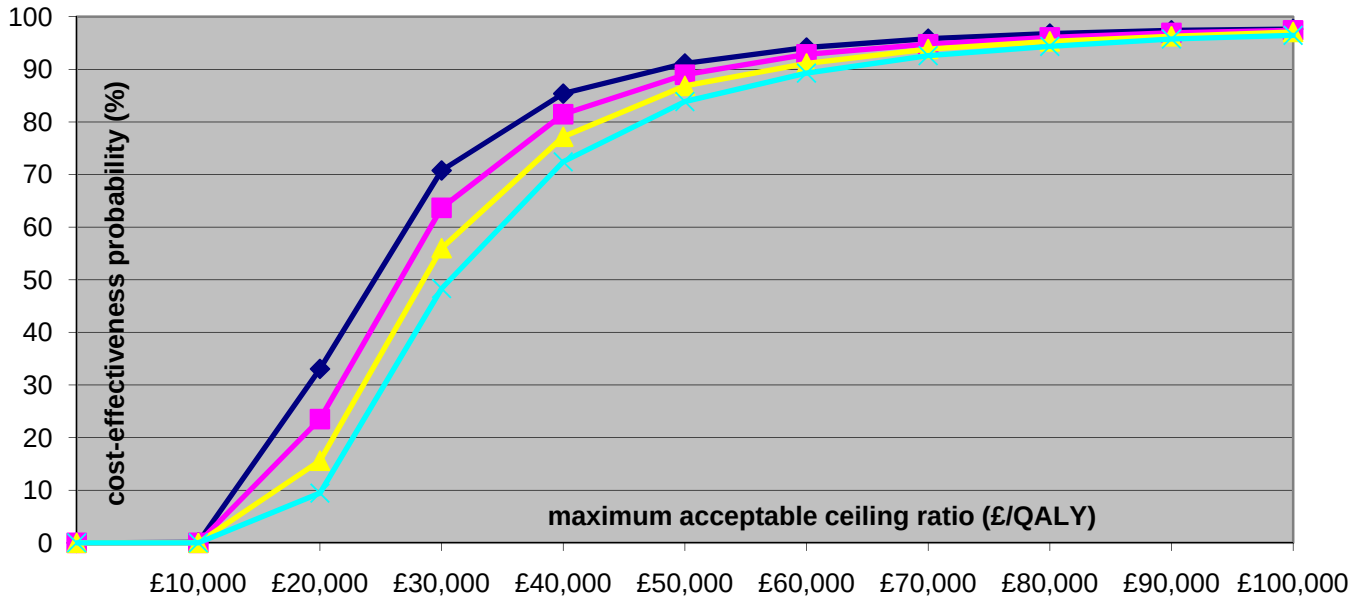


Figure 118. Needs Level 2: secondary prevention: CEAC



Needs Level 3: Tertiary Prevention

Four projects are included within the highest level of need (n=4), where services are supporting those at imminent risk of admission. Such small numbers reduce the variance seen across the other Needs Levels. The projects focus on very frail older individuals, reporting around 34% of perfect health (0.34, EQ-5D), in comparison to the 'normal population' who would report around 73% of perfect health. If appropriate support is to be provided within this area, multi-disciplinary teams are needed, with statutory and clinical staff. Such structures, by necessity, are more costly than projects providing support to people with lower level needs. For example, two of the projects within this category have a total cost of £2,391,781: 4% of the budget provided to the overall POPP programme (£60million).

Nevertheless, at the maximum 'willingness to pay' of £30,000, there is a 96% probability that these services are cost effective, compared with usual care.

Table 145. Needs Level 3: cost-effectiveness

	Needs level 3: cost-effectiveness (managerial costs scenarios)			
Cost (lambda) value	**0%**	**10%**	**20%**	**30%**
£10,000	11.54	7.94	5.64	4.08
£20,000	73.68	64.52	55.04	46.68
£30,000	96.20	93.50	89.70	85.16
£40,000	99.14	98.70	97.86	96.70
£50,000	99.76	99.56	99.22	98.94

Figure 119. Needs Level 3: tertiary prevention

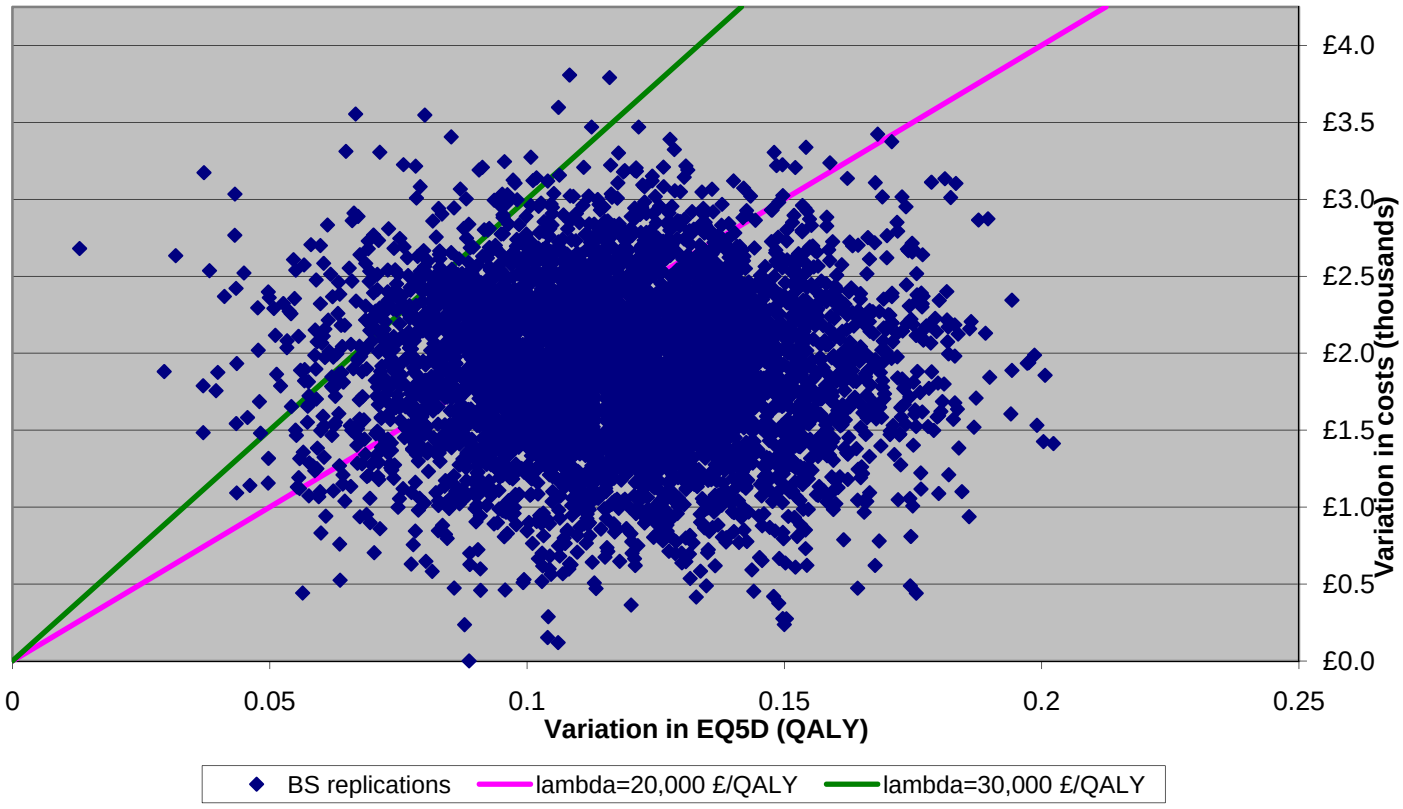
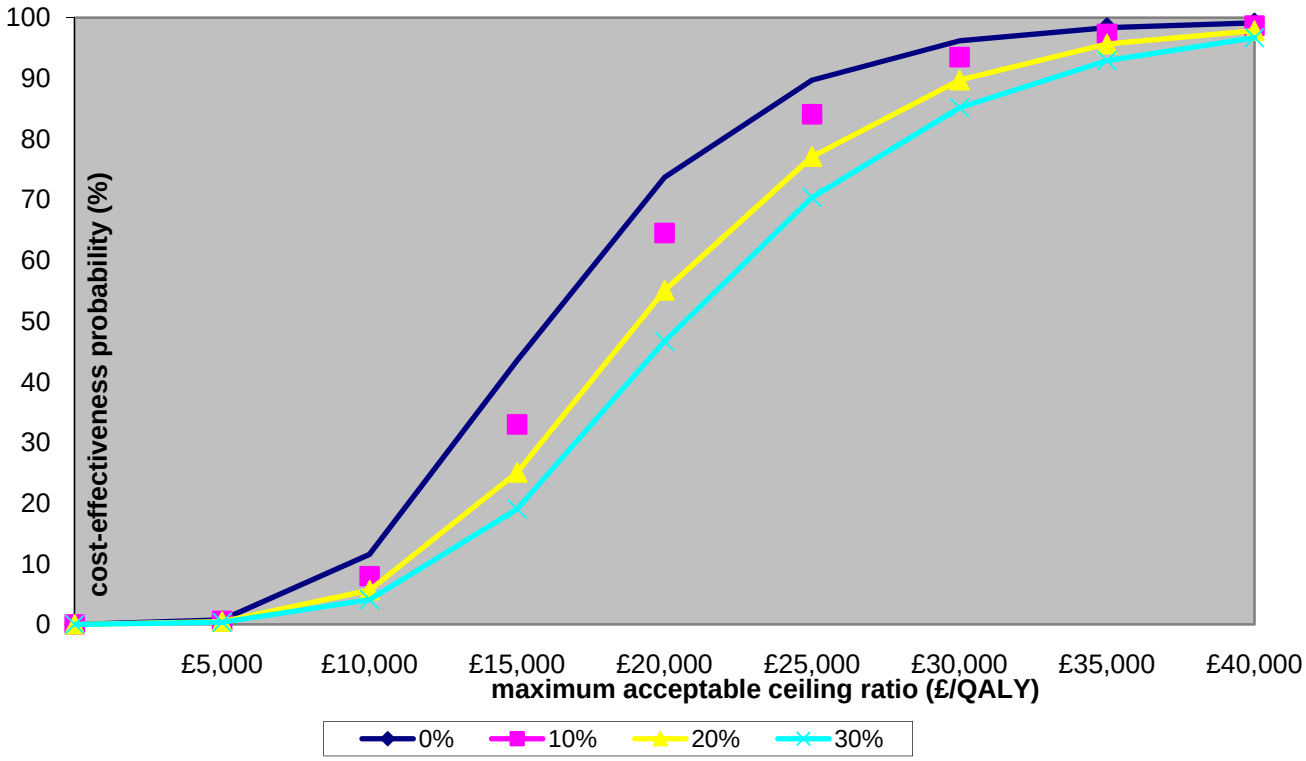


Figure 120. Needs Level 3: tertiary prevention



7.4.5 Community/Hospital Facing projects

Introduction

The final categorisation of the projects is whether they are Community Facing or Hospital Facing. These are very broad categories, with 51 projects within the former and 11 within the latter.

Community Facing

Despite huge variance across the 51 different projects, if the decision-makers' willingness to pay was set at £15,000 per extra QALY, there would be an 82% probability that such projects were cost-effective, compared with 'usual care'. Moreover, at £20,000, that probability rises to 92% (see Table 146).

Table 146. Community Facing: cost-effectiveness

	Community facing: cost-effectiveness (managerial costs scenarios)			
Cost (lambda) value	**0%**	**10%**	**20%**	**30%**
£7,500	26.02	16.02	9.64	5.26
£10,000	55.54	46.60	37.72	28.48
£15,000	82.72	78.02	72.84	67.68
£20,000	91.62	89.32	86.62	83.78
£30,000	96.58	96.10	95.42	94.48

Figure 121. Community Facing projects

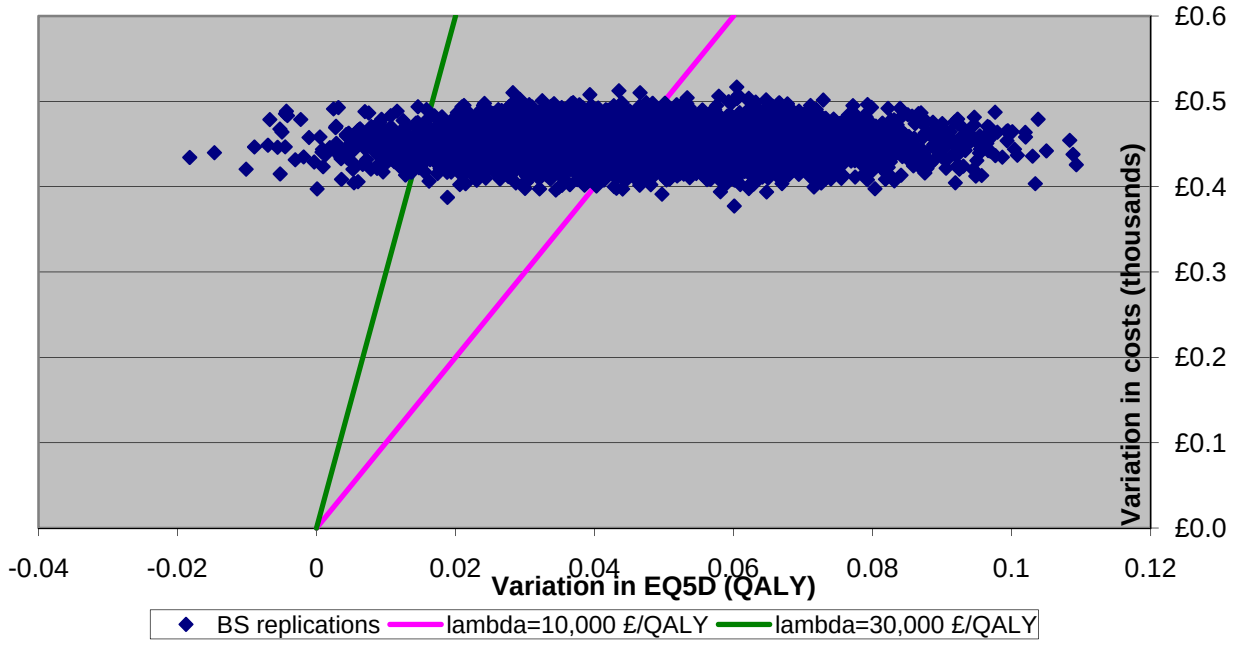
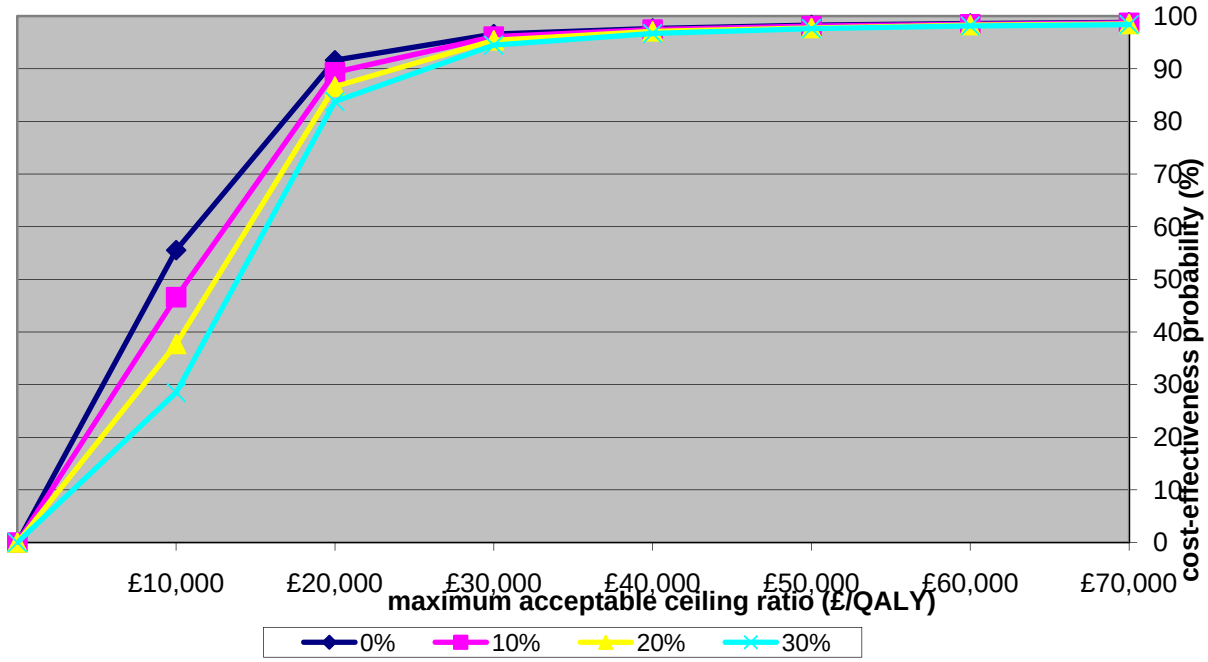


Figure 122. Community Facing: CEAC



Hospital Facing projects

In discussing outcomes from Needs Level 3 projects, it was argued that these higher level projects absorbed a greater cost and worked with frailer individuals, who were unlikely to improve their

HRQoL. Nonetheless, when their cost-effectiveness is explored, at the maximum willingness to pay of £30,000, there is a high probability (86%) that these projects are cost-effective, compared with usual care.

Table 147: Hospital facing projects: Cost-Effectiveness

	Hospital Facing : cost-effectiveness (managerial costs scenarios)			
Cost (lambda value)	**0%**	**10%**	**20%**	**30%**
£10,000	10.28	7.76	6.26	5.24
£15,000	27.14	21.26	17.24	14.12
£20,000	52.14	43.24	35.20	28.66
£30,000	86.68	80.06	73.44	66.10
£40,000	96.98	95.02	92.12	87.94
£50,000	99.24	98.58	97.60	96.20

Figure 123. Hospital Facing

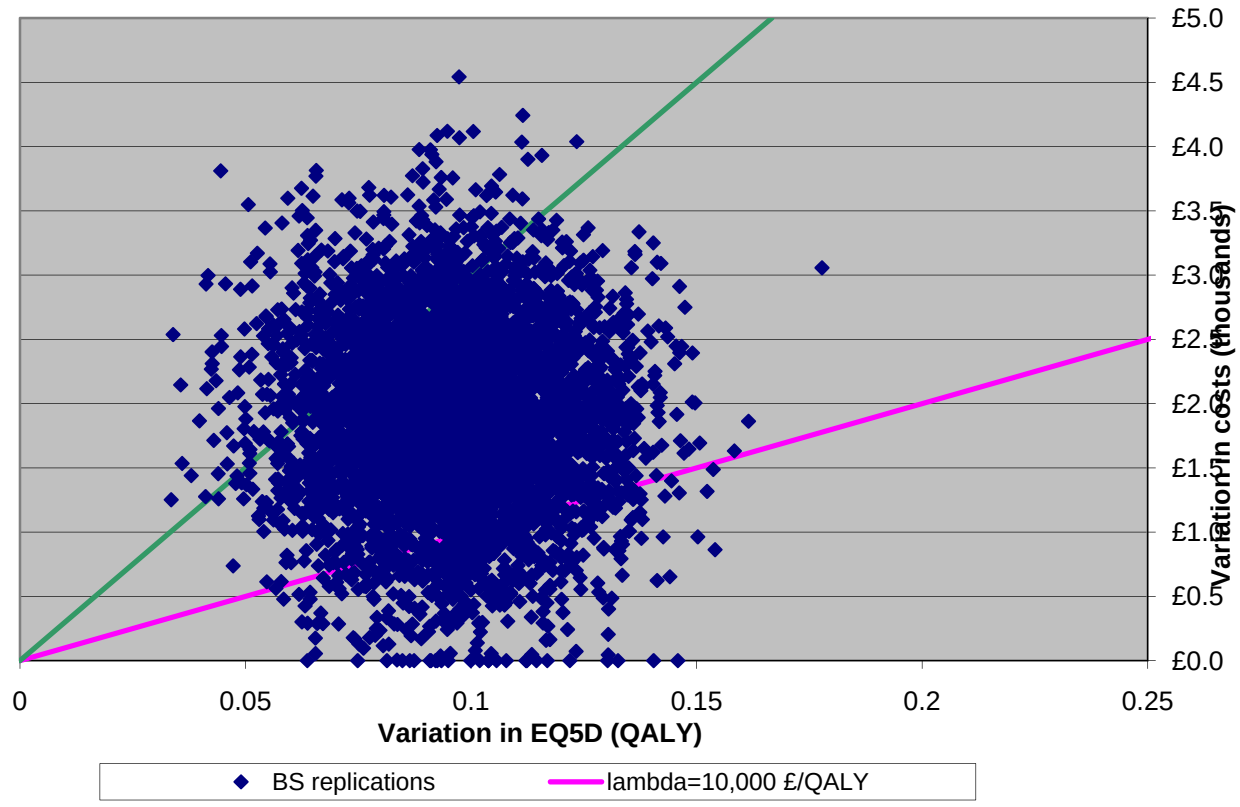
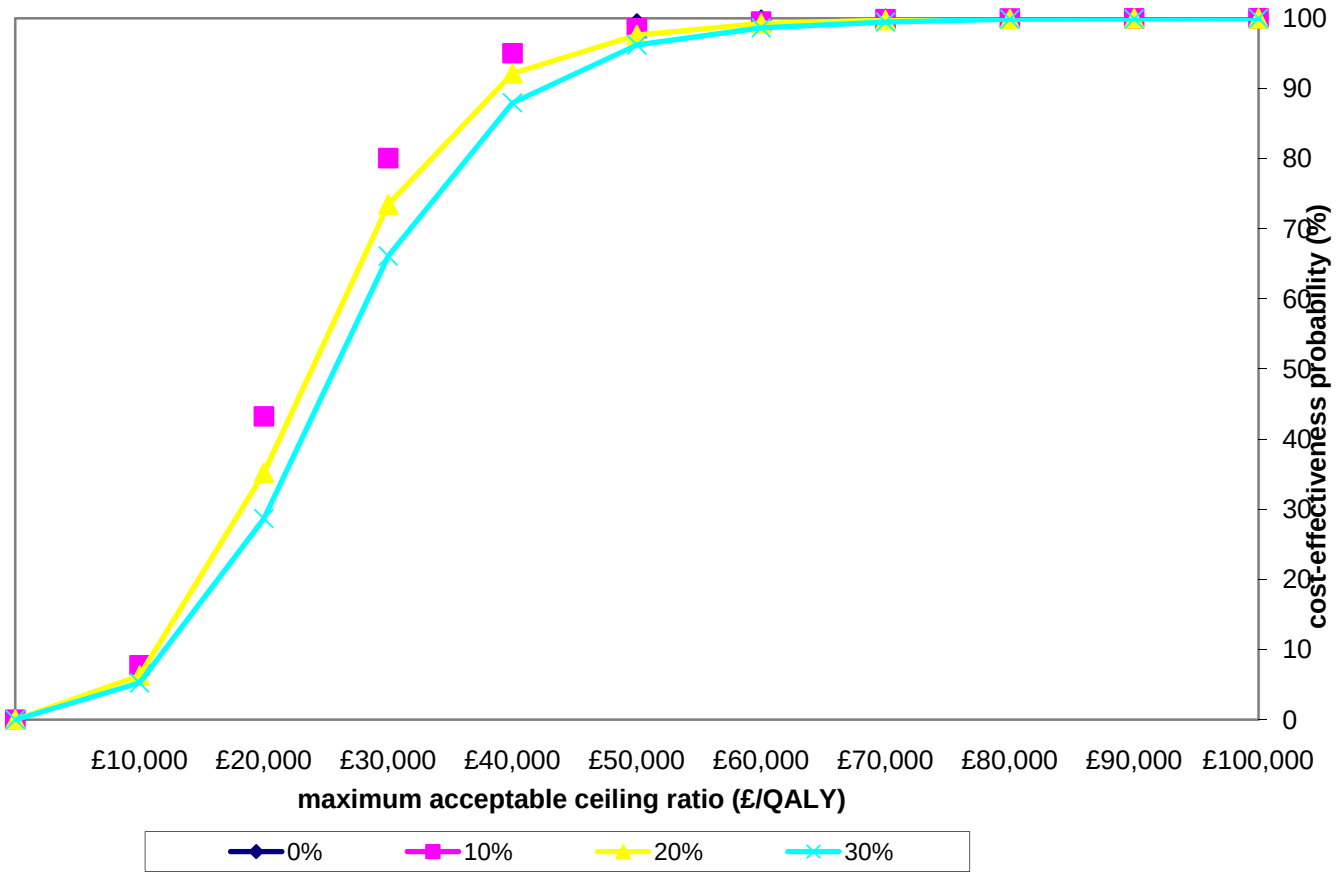


Figure 124. Hospital Facing projects: CEAC



7.4.6 Implications for commissioners arising from the CEACs

Within the analysis of the CEACs, there is a range of probability as to the level of cost-effectiveness of the POPP projects as measured against usual care. The measure of cost-effectiveness allows an assessment of improvement in benefit to users (measured through the EQ-5D) and if that benefit is achieved within the cost limit for new technologies (between £20,000 and £30,000) as compared to usual care. The improvement of one point within the EQ-5D tool is equivalent to an individual moving from, e.g., 38% to 48% of perfect health. To do this, individuals would have improved in at least one of the five domains (mobility, self-care, usual activities, pain/discomfort, anxiety/depression). For example, a user who prior to the POPP project responded that they were extremely anxious or depressed would indicate that they were no longer anxious and depressed following the POPP intervention.

Commissioners would therefore need to make a decision as to whether the level of probability of cost-effectiveness is high enough. For example, commissioners would need to ask themselves if a 14% area of risk in setting up a similar local POPP programme, (that 1.4 projects in 10 may not be cost-effective as compared with usual care), is too great.

Such findings do give commissioners a choice around the type of projects that could be commissioned: given that there is an even greater level of uncertainty in many commissioned and on-going services for which there is a complete absence of cost-effectiveness data. For example,

many non-POPP sites have commissioned voluntary organisations to undertaken low-level practical tasks for users. Nevertheless, there has been no previous cost-effectiveness evidence available on which to base such commissioning decisions (e.g., see Curry 2006). The type of projects where the probability of cost-effectiveness is seemingly high and the cost of the per point increase in EQ-5D, low include; Well-Being Practical, Long-Term Conditions Complex Care and Specialist Falls services. Commissioners will need to look closely at the other evidence and decide the level of risk that they are prepared to bear in commissioning such services.

7.5 Changes in individual service use and costs following the POPP intervention

7.5.1 Introduction

The Client Services Receipt Inventory (Beecham & Knapp 1992) was adapted and included within the standardised questionnaire (see Appendix H). Respondents were asked to record the type and total usage of secondary care services (hospital), primary care services (local surgery or health centre) and those interventions received within their own home (social worker, meals on wheels etc.) three months prior to the POPP intervention and either two or three months following involvement in the project, depending on the time-frame of administration. The type of services used and the extent of use were then costed (Curtis 2008, Curtis & Netten 2006, King et al 2000, NHS Health & Social Care Information Centre 2004/5) and inflators added where necessary to ensure parity with 2008 costs (see Appendix L for the full breakdown). Respondents were not asked to detail the reason for attendance or the 'specialty' of the service used. For example, although many reported the use of hospital beds, it was not known if the person was admitted to a cardiac, medical or rehabilitation ward. Similarly, where individuals indicated that they had attended an outpatient clinic, there were no details as to whether this was a psychiatric appointment or a fracture clinic. To ensure that costs could be appropriately estimated, weighted averages were carried out on the number of admissions of older people within a variety of medical specialisms.

This particular question had its flaws. Respondents were generally able to identify the service(s) they had used, but far fewer responded to the further query concerning frequency of use. For example, within the full sample (n=1,529), a total of 1,267 respondents stated that they had visited their GP, with a mean frequency of 1.62. Yet the average number of GP consultations for those aged 65 and over is seven per annum (Peckham & Exworthy 2003). Even adjusting for a three-month reporting period, there would seem to be an underestimation, given that the POPP sample report poorer health states than the overall population. In presenting this data, it should be remembered that the total increase or reduction in costs found are likely to be underestimated, as only a single use could be counted, where the extent of use was missing.

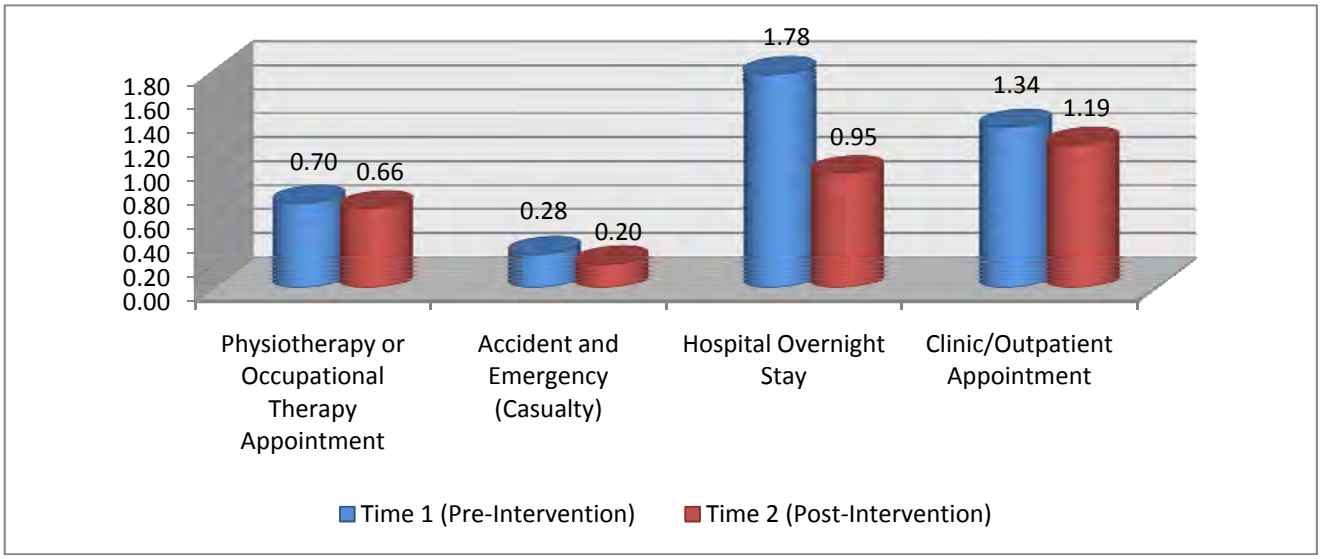
Using the responses to the standardised questionnaire within 23 of the pilot sites, statistically significant changes in usage and costs were found for the overarching sample as well as for the three sub-groups: Project Focus categories, Needs Levels, and Community/Hospital Facing. Care has been taken to ensure that data is reported only where there has been a change in service use at the individual level. For example, it may be that we see a mean reduction in using the GP but what we need to know is whether the individuals who used a service at a certain rate prior to the POPP programme, used the services differently following the POPP programme. If the increase or reduction is not based on individual use, any change is simply a random finding and not reported.

7.5.2 Overarching changes in service use

In exploring the changes in service use for all respondents to the standardised questionnaire (n=1529), a significant change was found in the use of secondary care services. Hospital overnight stays were reduced by almost half (47%) and use of Accident & Emergency appointments by almost

a third (29%). Reductions were also seen in physiotherapy/occupational therapy and clinic or outpatient appointments by almost one in ten. Within the former, an 8% reduction was reported, and in the latter an 11% reduction (see Figure 125)

Figure 125. Self-reported services use within secondary care (mean, numbers)



Such change affects the overall cost of service use, with a total reduction of £328 per person over the median administration period of six months (see Figure 126 and Table 148).

Figure 126. Mean cost of hospital based service use per person

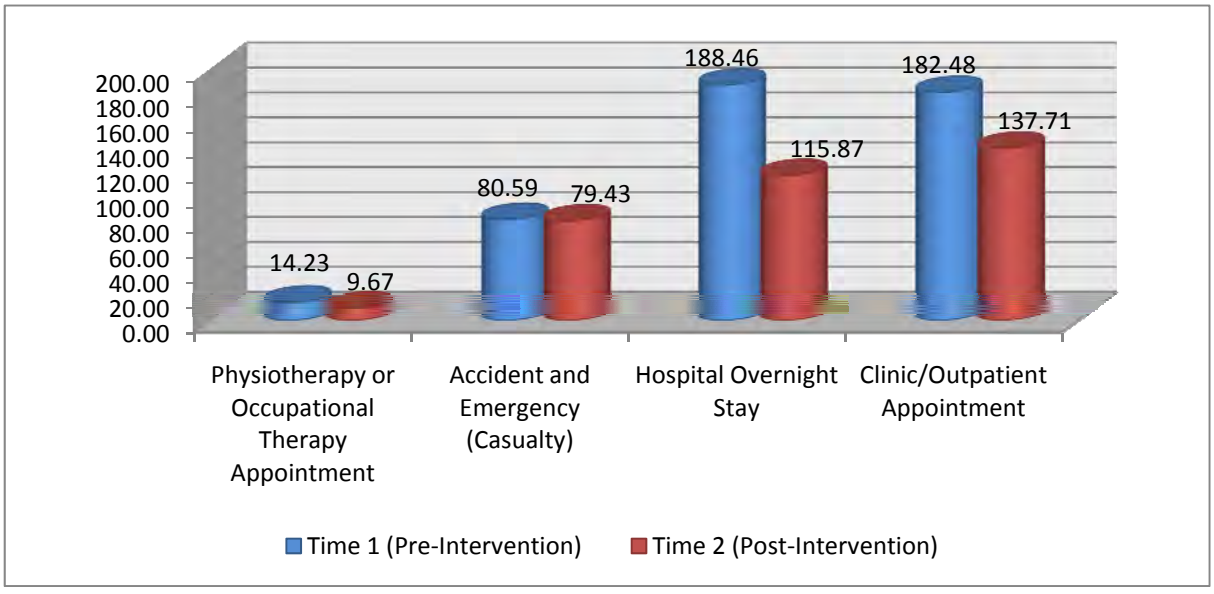


Table 148. Mean cost of change of secondary care service use

Service use	Pre-intervention (t1) mean cost	Post-intervention (t2) mean cost	Mean cost change
Physiotherapy	£14.23	£9.67	£4.56
A & E	£80.59	£79.43	£1.16
Hospital overnight	£188.46	£115.87	£72.59
Outpatient	£182.48	£137.71	£44.77
Totals	**£465.76**	**£342.68**	**-£328.05**

7.5.3 Project categories

Introduction

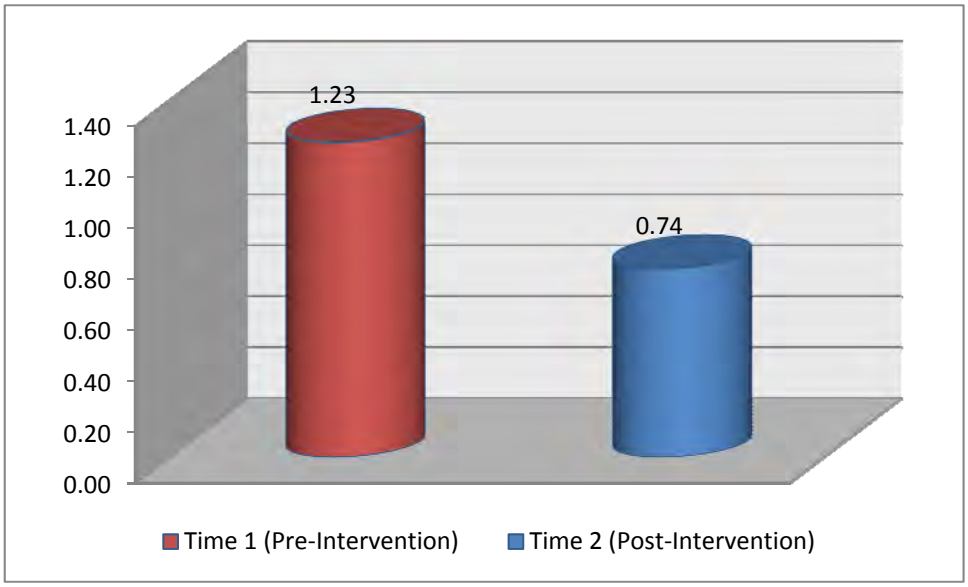
The 62 projects that used the standardised questionnaire were 'coded' into 11 categories, capturing their focus and proposed outcomes. As noted elsewhere, the categories included lower-level 'upstream' initiatives focused on well-being: through practical help (small housing repairs, gardening, shopping), physical health (exercise classes), improving emotional support and reducing social isolation, (lunch-clubs and/or lower level 'talking therapies') and within communities (neighbourhood schemes). A further lower-level yet extremely important group of projects provided information, advice and signposting services. The 'downstream' initiatives were captured within the groups of proactive case co-ordination, long-term conditions and complex care.

In considering such groupings, an intuitive response is that change in service use would be demonstrated only for those more 'formalised' higher level services where the objective was a reduction in hospital admissions. Such an argument does hold true for the categories of Well-being – practical, Information, Signposting and Access services, Involving Older People and the expert patients programme included in the category of Carers Services. However, statistically significant changes in service use were also found in the other categories. Again, these are reported only where the pattern of individual use changed following the POPP programme.

Well-being – Emotional/Social Isolation

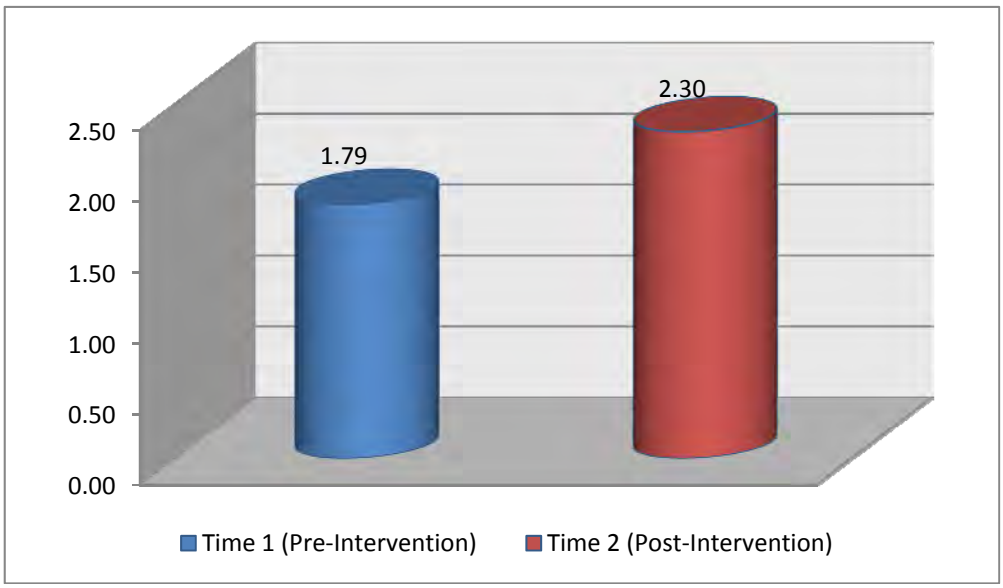
A statically significant reduction was found in respondents' use of clinic or outpatient appointments within secondary care (p=0.04), leading to a decrease in cost of £52.14 (see Table 149).

Figure 127. Self-reported service use within Well-being - emotional/social isolation: reduction in secondary care clinic/outpatient appointments



A corresponding rise in GP visits within their local surgery led to a cost increase of £21.98 (see Table 149).

Figure 128. Self-reported use of GP surgery, pre- and post-intervention (mean)



Taking together these changes in service use, a total saving per person over the administration period was £30.16 (see Table 149).

Table 149. Self reported use of GP surgery pre and post intervention

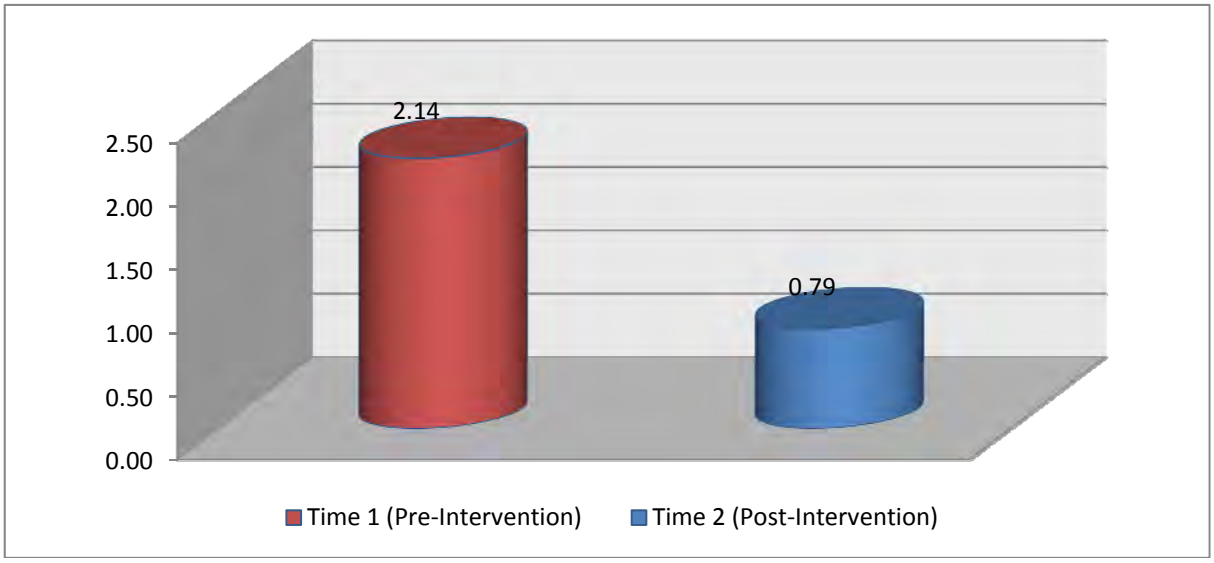
Service use	Pre-intervention T1 mean cost	Post-intervention T2 mean cost	Mean cost change
Outpatient appointment (secondary care)	£141.82	£89.68	**-£52.14**
GP surgery	£45.28	£67.26	**+£21.98**
Total	**£187.10**	**£156.94**	**-£30.16**

Such findings may be due simply to chance, despite the statistically significant change. Individuals are often discharged from secondary care clinic appointments to their local GP. Within this category, there were four interventions providing some form of 'talking therapy' (memory cafes, counselling etc), two aging-well programmes and eight projects that combined lunch-clubs, information and advice and support around community engagement. Individuals may well have received advice from any of these supportive interventions to seek more appropriate and local care.

Well-Being – Physical Health

Within this category, we found a reduction in appointments for secondary care clinics and/or outpatient departments, leading to a decrease in cost of £126.33 (see Figure 129 and Table 150). Again, such findings could be spurious. However, some projects in this category, including home-based exercise courses, T'ai Chi and chiropody,, have been demonstrated to increase balance, strength, reaction time, flexibility (Gardner 2000, Verhagen 2004) and to improve mood (Morey et al 1998). If people were visiting outpatient clinics for depression or muscular-skeletal difficulties, it is likely that a reduction in use would be seen. Such findings are given additional weight by the mean increase in HRQoL (5%) reported by respondents within this group: one particular project increasing participants' HRQoL by 34%, a unit point in EQ-5D.

Figure 129. Self-reported service use at secondary care Clinic/Outpatient Appointment (mean, numbers)



P=0.05 (MHT)

Table 150. Mean cost change of clinic/outpatient appointment

Service use	T1 mean cost	T2 mean cost	Mean cost change
Outpatient appointment (secondary care)	£223.83	£97.50	**-£126.33**

Proactive Case Co-ordination

The overarching concept of case management/co-ordination involves ongoing contact between a client and case worker to ensure receipt of those services appropriate to need (Ferguson 1998, McAlister 2001, Bernabie 1998, Reigal 2002). It would therefore be expected that the projects included within this category (n=8) would involve interventions designed to reduce or divert admissions to secondary care. Following these POPP interventions, visits to Accident & Emergency departments fell by 60%, whilst hospital overnight stays were reduced by almost half (48%) (see Table 151 and Figure 130).

Table 151. Change in self reported service use within secondary care, pre- and post-intervention (mean, numbers)

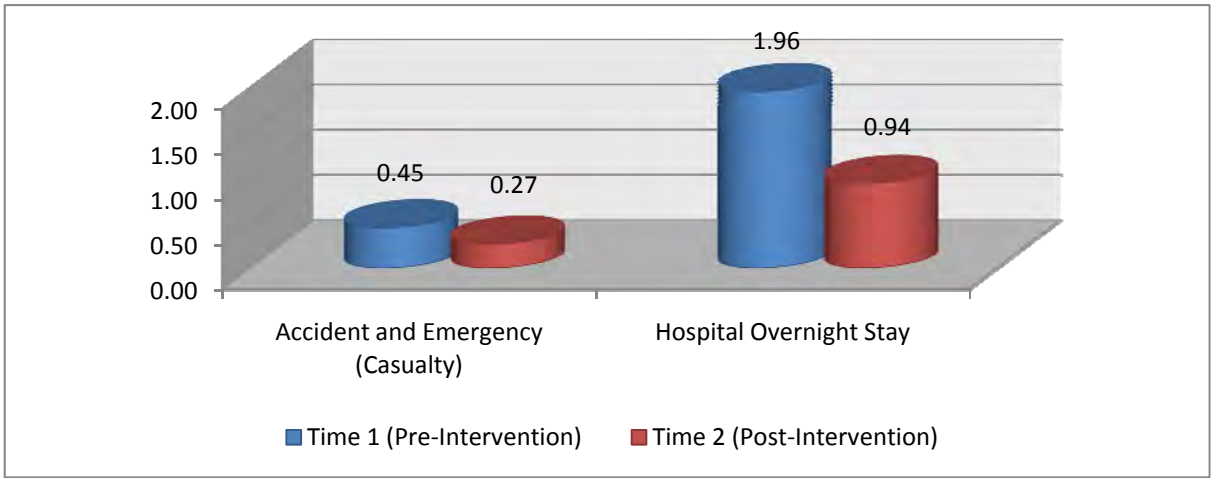
	Time 1 (pre-intervention)	Time 2 (post-intervention)
Accident and emergency (Casualty)	0.45	0.27
Hospital overnight stay	1.96	0.94

Such changes have an impact on costs, with a reported mean reduction of **£235.23** per person across the time-frame of questionnaire administration (seeTable 152).

Table 152. Mean cost change of Secondary Care based service use, pre- and post-intervention (£)

	Time 1 (pre-intervention)	Time 2 (post-intervention)	Mean cost change
Accident and emergency (Casualty)	170.76	104.19	**-£66.57**
Hospital overnight stay	364.52	195.87	**-£168.65**
Total	£535.28	£300.06	**-£235.23**

Figure 130. Self-reported service use within secondary care (mean, numbers) pre- and post-interventions



A&E p=0.027 (MHT)/HO p = 0.021 (MHT)

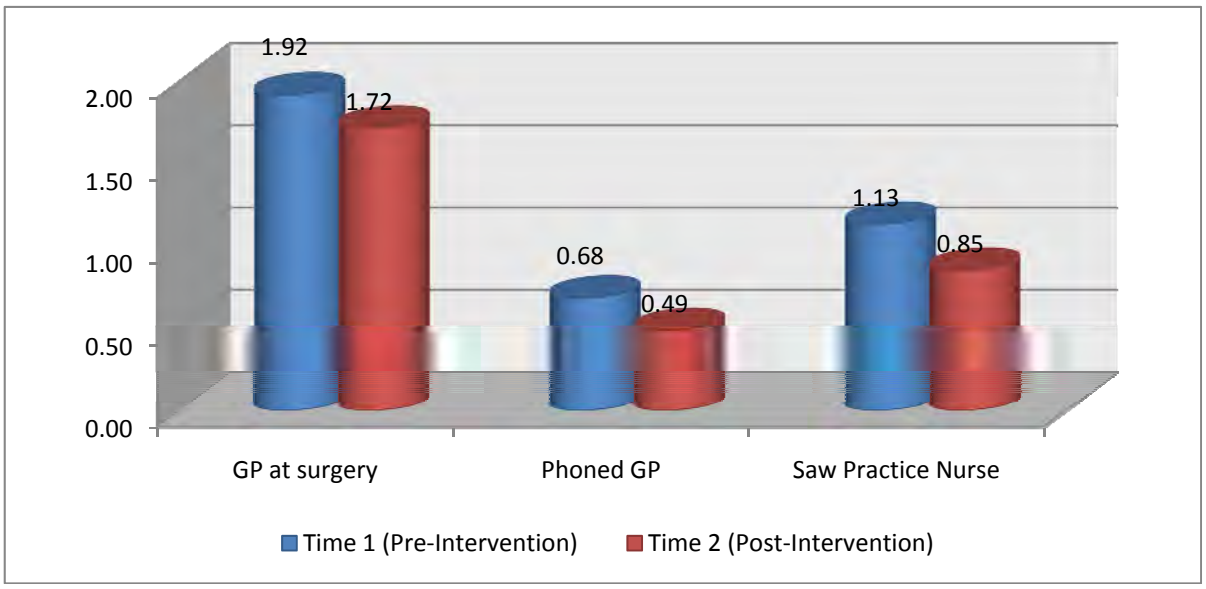
Changes were also found in primary care services. Following the POPP interventions, a 10% reduction was seen in the number of GP appointments, along with a 28% reduction in phone calls with the GP. Visits to the practice nurse reduced by a fifth (25%). Table 153 and Figure 131 detail these findings.

Table 153. Change in self reported service use, pre- to post-intervention

	Time 1 (pre-intervention)	Time 2 (post-intervention)
GP at surgery	1.92	1.72
Phoned GP	0.68	0.49
Saw practice nurse	1.13	0.85

GP Surgery p=0.009 (MHT)/Phoned GP p=0.014 (MHT)/Practice Nurse p=0.05 (MHT)

Figure 131. Change in self-reported service use, pre- to post-intervention



The overall mean cost reduction across these services was £12.88 (see Table 154).

Table 154. Mean cost change of local surgery or health centre service use.

	Time 1 (pre-intervention)	Time 2 (post-intervention)	Mean cost change
GP at surgery	£46.85	£41.63	**-£5.23**
Phoned GP	£20.37	£15.16	**-£5.22**
Saw practice nurse	£11.12	£8.69	**-£2.43**
Totals	£78.35	£65.47	**-£12.88**

If the totals from each area of service use are added together, the total mean cost reduction is **£248.11.**

Hospital Discharge

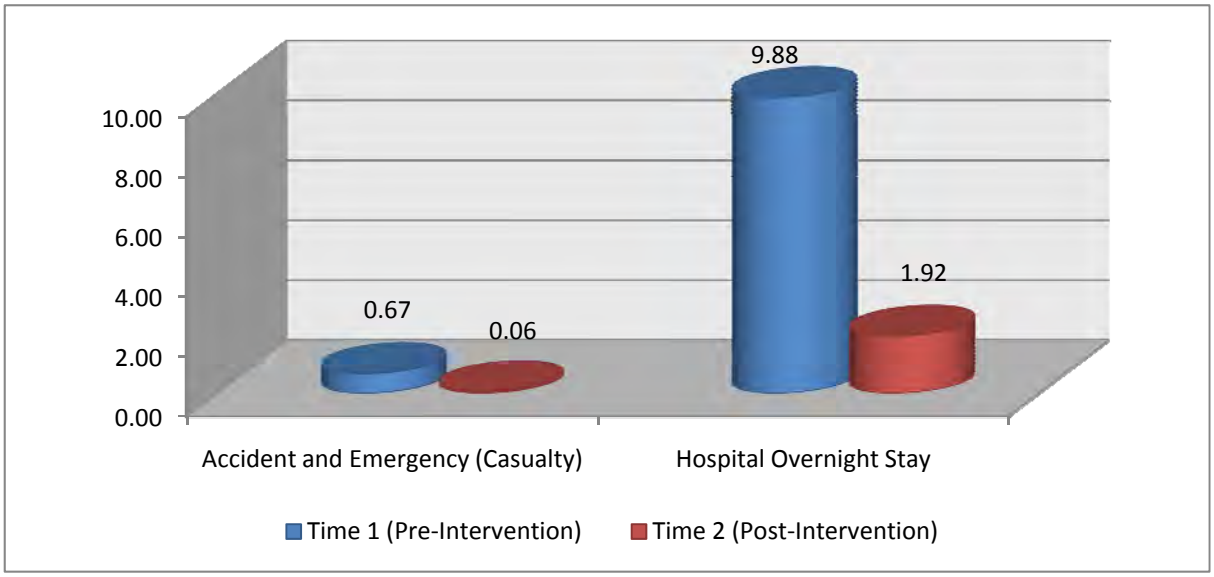
The aim of discharge planning is to reduce the length of hospital stays, reduce unplanned readmission and improve the co-ordination of services following discharge: in short, bridging the gap between hospital and home (Shepperd 2004). Two projects were found to be in this category and, as discussed above, a dichotomous result was found; one project increased HRQoL by 5% while the other reduced it by 16%. Despite such differences, both projects were able to reduce hospital overnight stays (re-admissions) and visits to A&E. Following the intervention, the former reduced by 80% and the latter by 90%, although use of A&E was in any case small (see Table 155 and Figure 132).

Table 155. Change in self reported service use within secondary care pre- to post-intervention (mean, numbers)

	Time 1 (pre-intervention)	Time 2 (post-intervention)
Accident and emergency (Casualty)	0.67	0.06
Hospital overnight stay	9.88	1.92

A&E p=0.000(MHT)/HOS p= 0.02 (MHT)

Figure 132. Change in self reported service use within secondary care pre- to post-intervention (mean, numbers)



Given such changes in use, there is a comparative reduction in service costs (see Table 156).

Table 156. Cost-reduction in secondary care pre and post intervention: Hospital Discharge

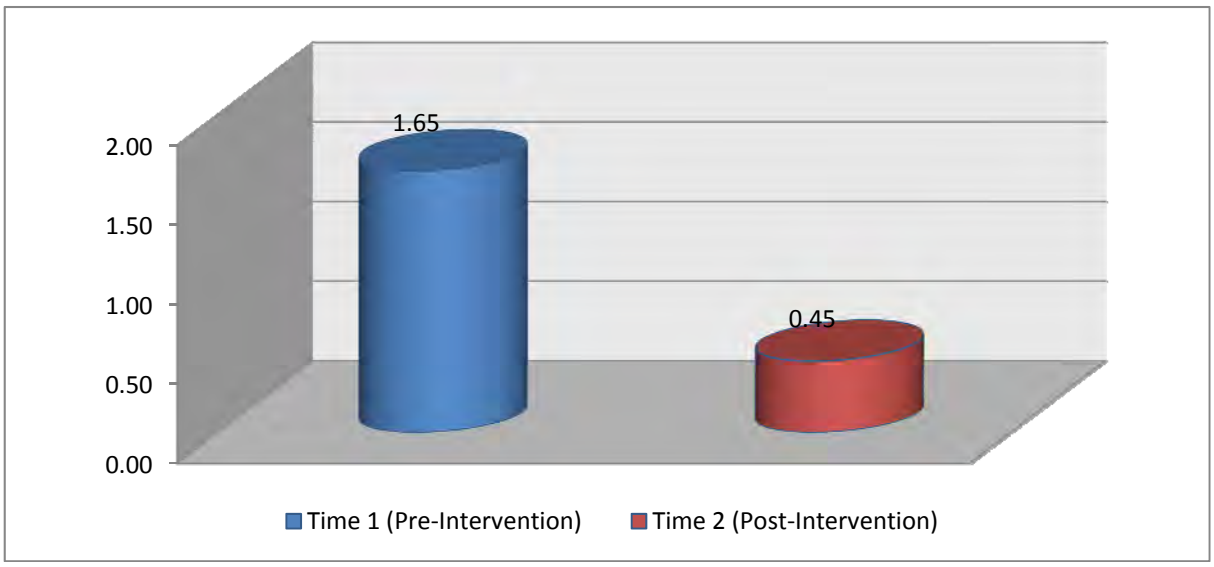
	Time 1 (pre-intervention)	**Time 2 (post-intervention)**	**Mean cost change**
Accident and emergency (Casualty)	£248.57	£47.03	**-£201.54**
Hospital overnight stay	£1904.30	£364.56	**-£1539.75**
Totals	£2152.87	£411.58	**-£1741.29**

It could be argued that what is being seen here is a 'regression to the mean'. That is, such users were involved with the POPP interventions only because they had a specific clinical need and/or fall that required a single admission to hospital for treatment. For such users, no further admission/ readmission would have been required. Therefore, it might be argued that these projects should not claim to have any impact on hospital use, as such a pattern would be equally likely in the absence of the POPP projects. No information is available from the standardised questionnaire to disentangle this issue, as it is not known what type of condition prompted admission. Nevertheless, this particular sample has a number of risk factors that could precipitate re-admission. Almost two-thirds (62%) were aged 75 and over, and admission rates among such older patients have been demonstrated to be three times higher than those aged under 65 (Downing & Wilson 2005). Moreover, three-quarters of this sample (75%, n = 28/37) lived alone and such occupancy impacts on transport to hospital (Clarke et al), repeated attendance at A&E (Caplan et al 1998, McCusker et al 1997) and admission to a hospital ward (Cove et al 2006). However, despite such risk factors, it is not known whether users might have improved in the absence of such services – and the demonstrated reduction in cost needs to be treated with care.

Specialist falls

It is perhaps not surprising to find that services in this particular category demonstrated almost a three-quarter reduction (72%) in secondary care based physiotherapy appointments (see Figure 133), a mean financial saving of **£25.45.**

Figure 133. Reduction in secondary care based physiotherapy appointments: Hospital discharge



P=0.038 (MHT)

In contrast, there was a reported increase in visits to a practice nurse of almost half (51%), a somewhat counter-intuitive finding. The intervention used by the majority of the sample in this category was run by specialist falls nurses and occupational therapists. As the project was based within primary care, it is not known whether the participants confused the specialist falls nurse with a practice nurse and reported their contacts with the actual intervention, rather than any on-going contact within the local surgery. Nevertheless, such increase had a minimal cost impact of a **£4.98** increase.

Summary of the mean cost reduction across the project categories

Table 157 brings together the total mean cost savings per person across the median six months of administration.

Table 157. Summary of the total mean cost reduction per person across the six months administration.

Service area	Total mean cost change
Secondary care	**-£2180.43**
Local surgery or health centre	**+£14.08**
Total cost reduction	**-£2166.35**

7.5.4 Needs Levels

Introduction

As noted elsewhere, the projects were categorised into three Needs Levels, corresponding to Primary, Secondary and Tertiary Prevention respectively.. Among those projects classified as Primary Prevention, there were no statistically significant findings around impact on service use and costs,

perhaps not surprisingly. However, the more downstream projects demonstrated a reduction in use of specific secondary and primary health care services.

Needs Level 2: Secondary Prevention

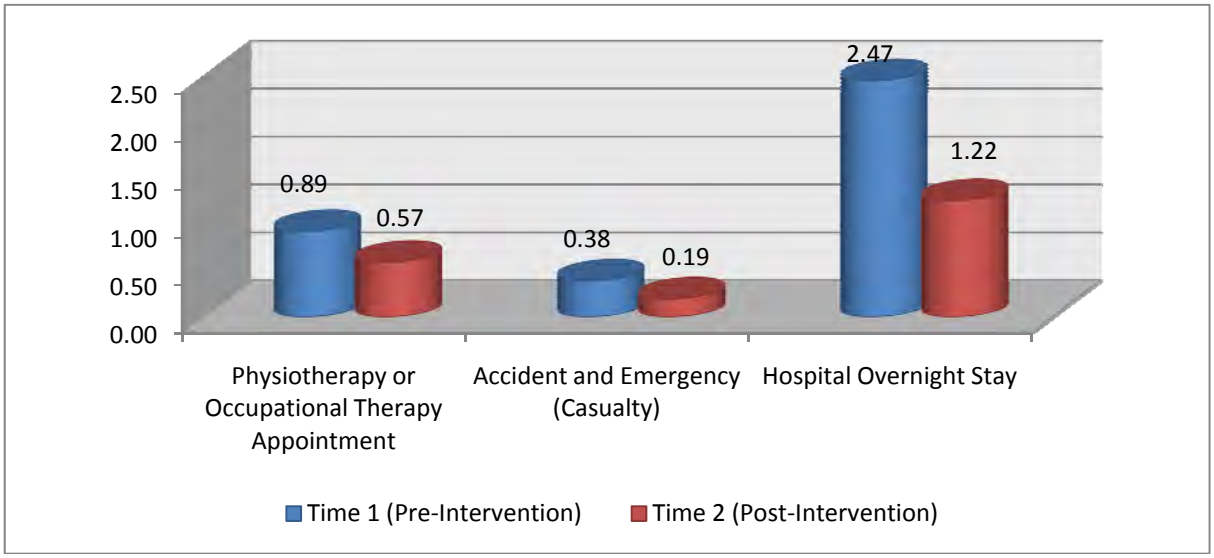
The 21 projects focused toward those individuals at risk of hospital admission achieved a 50% reduction in the number of hospital overnight stays and A&E visits following their intervention. A statistically significant reduction of 44% was found in physiotherapy appointments (see Table 158 and Figure 134).

Table 158. Self-reported service use within secondary care pre- and post-intervention (mean, numbers)

	Time 1 (pre-intervention)	Time 2 (post-intervention)
Physiotherapy or occupational therapy appointment	0.89	0.57
Accident and emergency (Casualty)	0.38	0.19
Hospital overnight stay	2.47	1.22

Physio p=0.016(MHT)/A&E p=.001 (MHT)/HOS p=.002 (MHT)

Figure 134. Self-reported service use within secondary care pre- and post-intervention (mean, numbers)



The mean cost reduction per person was £271.15 (see Table 159).

Table 159: Mean cost reduction: Needs Level 2: Secondary Prevention

	Time 1 (pre-intervention)	Time 2 (post-intervention)	Mean cost change
Physiotherapy or occupational therapy appointment	£26.78	£17.83	**-£8.94**
Accident and emergency (Casualty)	£138.28	£71.77	**-£66.52**
Hospital overnight stay	£422.55	£226.87	**-£195.69**
Totals	**£587.61**	**£316.47**	**-£271.15**

In addition, a mean 15% reduction was found in the use of GP visits, moving from a mean of 1.76 to 1.5 and reducing costs by £6.33 per person (see Figure 135).

Figure 135: Mean reduction in GP visits: Needs Level 2: Secondary Prevention

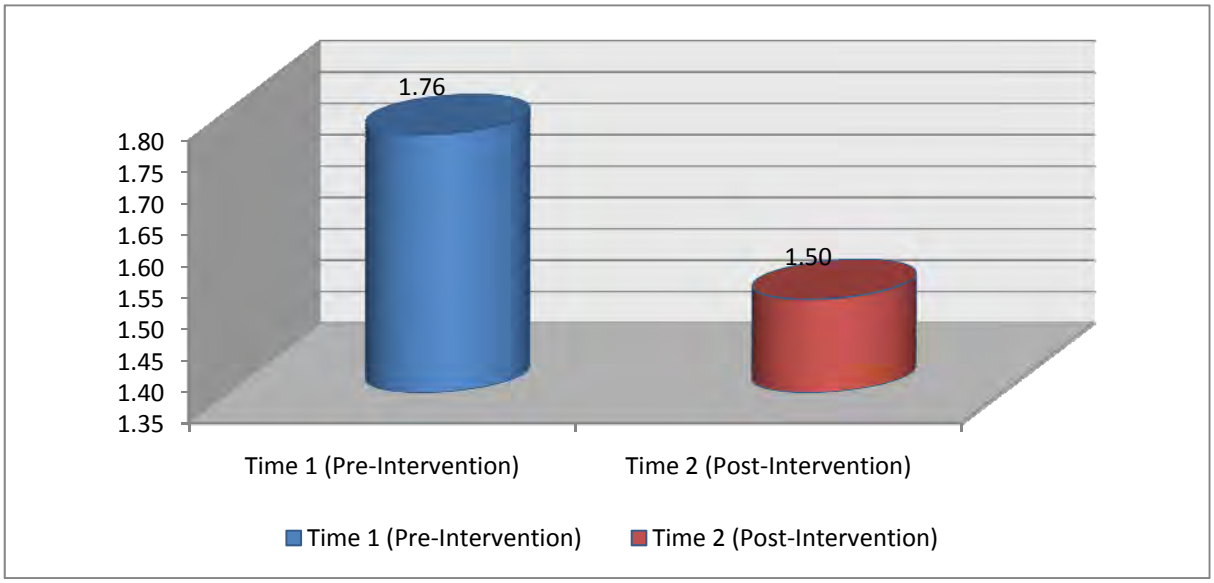


Table 160. Total cost reduction in GP visits T1 &T2

	Time 1 (pre-intervention)	Time 2 (post-intervention)	Mean cost change
GP at surgery	£42.90	£36.57	**-£6.33**

p=0.001 (MHT).

Needs Level 3: Tertiary Prevention

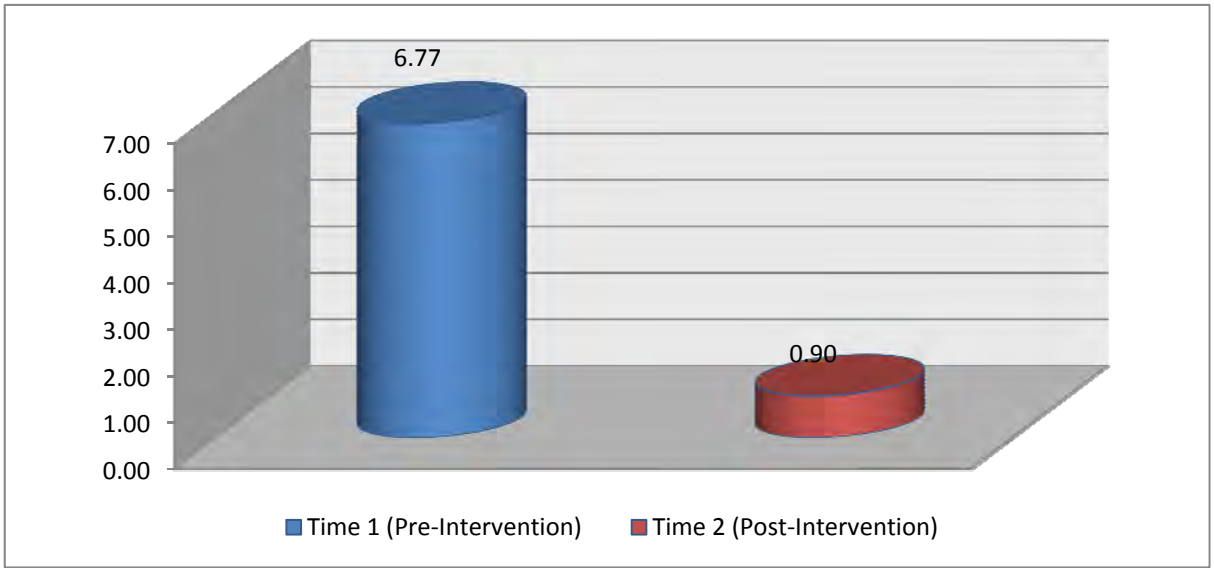
The only change in secondary care service use within this group was within hospital overnight stays: a drop of six times the original usage (see Table 161 and Figure 136)

Table 161: Mean reduction in Hospital overnight stays: Needs Level 3: Tertiary Prevention

	Time 1 (pre-intervention)	Time 2 (post-intervention)
Hospital overnight stay	6.77	0.90

p=0.034 (MHT)

Figure 136. Mean reduction in Hospital overnight stays: Needs Level 3: Tertiary Prevention



The consequent mean cost reduction can be seen in Table 162.

Table 162. Mean cost reduction HOS: Needs Level 3: Tertiary Prevention

	Time 1 (pre-intervention)	Time 2 (post-intervention)	Mean cost change
Hospital overnight stay	£1,329.23	£186.65	**-£1,142.58**

Summary of the mean cost reduction across the needs levels

The higher level projects were able to divert users from admission to hospital and seemingly provided appropriate support to reduce A&E visits. The total mean cost reduction per person within secondary care was **£1,413.73.**

8 Sustainability

Key points

- The overwhelming majority (85%) of POPP projects secured funding to continue in one form or another, in many cases through their local PCT. In addition, the 'transformation agenda' for social care, incorporated in *Our Health, Our care, Our say* (2006), closely mirrored the focus of POPP and was influential on decisions to sustain projects via the Social Care Reform Grant (SCRG).

- Only 3% of the projects 'closed', either because they did not deliver the intended outcomes or because local strategic priorities had changed.

- Sustainability was often achieved through early attention to the issue. Local Area Agreements proved an important mechanism for embedding and sustaining programmes. In many sites, final decisions concerning funding were not made until late in the final year; in contrast, where early agreements were made with agencies regarding their respective responsibilities for sustaining projects – and written into initial bids – the process of ensuring sustainability appeared to be timelier.

- PCTs contributed to the sustainability of the POPP projects within all 29 sites. Moreover, within almost half of the sites one or more projects were entirely sustained through PCT funding – giving a total of 20% of POPP projects entirely sustained through PCT funding. In a number of other projects (14%), PCTs provided at least half the necessary ongoing funding.

- Key factors in bringing about continued enthusiasm and funding were the involvement of local councillors and older people representatives, raising the profile of POPP programmes both among strategic managers and the wider public. Local evaluations were also important, with early findings shaping the development of projects.

- But recognition was necessary of the inherently long-term impact of some of the services, where short-term changes could not be demonstrated. It was particularly difficult to provide robust evidence of service cost-effectiveness within the two year funding period.

8.1 Introduction

Pilot sites received POPP funding on condition that their preventive programmes should '*test and evaluate different models of service delivery, financial and partnership mechanisms, which will create a sustainable shift in resources and culture towards prevention*' (LAC (DH) (2007) 3). The expectation was that by making a strategic shift towards proactive and preventive services – away from more expensive, intensive and reactive services – pilot sites would be able to release funding from across the system to reinvest in those preventive approaches. In this way, a 'virtuous cycle' was to be created. This chapter outlines the national and local contexts in which the process of ensuring the sustainability of POPP programmes and projects took place, the effectiveness of some of the mechanisms used by pilot sites to ensure sustainability, and the outcomes of those sustainability processes within sites.

8.2 Context of sustainability

Particular national and local contextual preconditions needed to be in place to facilitate mechanisms for sustaining the POPP projects. These conditions included the national and local strategic priorities, the structure of the local social and health care economy, and the commitment of local stakeholders. Such contexts were rarely static, however, and over the lifetime of the POPP initiative, pilot sites often found them subject to continuous change:

> '*The strategic and organisational context within which the projects have been created has changed in marked ways since the programme began (e.g. 4 PCTs to 1 PCT, separation of Adults and Children's Services in the LA, Putting People First, the National Dementia Strategy and the development of partnerships including the creation of the Health and Wellbeing Partnership).... it has been important for sustainability for the programme to maintain flexibility in the project portfolio to ensure outputs and outcomes remain relevant, and to ensure a good fit with other emerging system developments*.' FEoY Rpt, p12 (Site 10).

> '*I think probably the architectural context of what's going on around us has changed considerably since what must be four years since the bidding for the first POPPs round even began. So it's an absolutely different world, isn't it?*' Project Manager (Site 73)

8.2.1 The national context: expectations of commissioners

From the outset, there was an expectation from the Department of Health that pilot sites should be in a position to sustain either the projects themselves or their positive outcomes beyond the funding period. Towards the end of the pilot status of POPP programmes, the pilot sites were expected to develop a robust and detailed exit strategy and sustainability plan and to submit this to the DH. These documents were '*to demonstrate how, and ensure that, successful outcomes from the partnerships for older people projects will remain sustainable when the grant funding has ceased, by either mainstreaming funding through releasing and redistributing monies previously used for acute or intensive services and responses or by service redesign, to ensure that service users are not disadvantaged at the end of the pilot process*' (LAC (DH) (2007) 3). The Round 1 POPP sites were required to submit these documents by October 2007, and Round 2 sites by October 2008. The sustainability plan was to be signed off by the Director for Adult Social Services and the Chief Executive of the lead PCT. In keeping with the original application process for the POPP programme and the principle of involving older people, the plan was also to be co-signed by the chair of older people's forums who had been involved with the initial POPP bid.

8.2.2 Local pilot site context: expectations of POPP partners

The original bids submitted by pilot sites for POPP funding all stated at least a general expectation that most of the services developed through the POPP grant would eventually be funded through mainstream funding. In most instances, this was to be facilitated by monies released from a reduction of more expensive and intensive services:

> '*Based on the estimated savings …a continued reduction in activity at similar levels will yield ongoing savings to pay for any revenue costs for the [POPP] project to continue*.' (SSA, p17,Site 73)

Thus, the investment of pump-priming POPP funding in preventive services was expected to enable resources to be freed in subsequent years, which would then be used to maintain those services into the long term. But in keeping with both the iterative nature of much of the overall POPP initiative, and the fact that it was a pilot to test various approaches to prevention, decisions regarding the eventual sources of funding were to be made only once the effectiveness of the new services had been evaluated. It was always accepted as quite possible, therefore, that individual POPP services found to be less effective than expected might not be continued beyond the two-year funding period.

Structure of local social and health care economy

Over the lifetime of the POPP initiative, many pilot sites experienced a restructuring of both their social care and primary health care services. These re-organisations had the potential either to facilitate project sustainability or to represent challenges for that process. In particular, the reconfiguration of the geographical boundaries of PCTs in England, which took place in Autumn 2006, often created challenges for the sustainability of projects:

> '*This workstream was originally planned to encourage care homes to provide short term beds to the PCT for rehabilitation, step up, step down type care...By the time the project had started, the merger of the PCTs had led to a rethink of the strategy around bed provision and the review of capacity as well as pathways...The sustainability of such a service is dependent on the PCT strategy, which is currently under development*.' EoY Rpt. (2008/09) (Site 82)

A recognised need to restructure

There was recognition by all pilot sites within their original funding bids and programme implementation plans (IPs) that there had been an unsustainable rise in the demand for acute health and social care services in recent years, exacerbated by an increasing population of older people and rising costs associated with acute care. Consequently, there was an acceptance that structural shifts needed to take place within local health and social care economies to reduce the use of acute services and institutional care amongst older people. Pilot site bids also recognised a need for restructuring service provision and care pathways in ways that would promote the independence and well-being of older people within their own homes, and reduce the need for reactive acute care and institutional care. In this way, the two-year period of POPP funding was to facilitate the 'kick start' of this whole system change in service delivery.

Provisional commitment of pilot sites to mainstream POPP services

The question arises of what was to be sustained: the specific services developed or the positive outcomes that such services might achieve. Positive outcomes might be sustained through the application of the learning generated within the pilot and through service redesign. It was therefore possible that POPP outcomes might be sustained in a pilot site while the services that had generated them were not. Despite a universal commitment by all pilot sites in their original bids to undertake

sustainable structural change to their service provision, almost all placed caveats on this commitment. The continued funding of particular POPP projects and services would be dependent on their proved effectiveness during the evaluation process:

> *'If the programme elements deliver against stated targets for improved care and optimal cost-effectiveness, the financial partners are committed to future investment in achieving these outcomes.'* (SSA, p22, Site 06)

> '*Decisions on the continuation of funding will be based on both local and national evaluation of what works and what is effective. …Consultation meetings have taken place with PCT Chief Executives and [Locality] County Council's Director of Social Care and Health, and these have achieved commitment to funding on-going service delivery costs where it can be demonstrated that the prevention services are contributing to the health and well-being of older people. This process will continue into year four.'* (SSA, pp13-14, Site 12)

Ongoing stakeholder commitment

Within the two-year funding period, it was often difficult for sites to provide robust evidence of reductions in demand for emergency beds and other expensive services. This was especially the case for those POPP programmes with a focus on developing low level, 'upstream' preventive services, which often also involved capacity building within the voluntary sector. It was necessary for local commissioners to recognise that such projects take time to 'bed in' and to accept that their impact might be long term. Evidence of effectiveness in reducing savings, therefore, might not be realisable before a decision to sustain services or not needed to be taken.

> '*Commissioners recognise the nature of the work requires time and persistence to identify isolated people – who may be self isolating for a number of reasons – and to build trust and rapport in order to engage them in appropriate services*.' EoY Rpt (2008/09) Site 95

Project managers emphasised the importance of an ongoing engagement with senior strategic managers, suggesting that an open and honest relationship with service commissioners was advisable. Indeed, it appeared that sites that began planning for sustainability early on tended to have fewer problems later with securing ongoing funding:

> '*Yes, make sure all your stakeholders are involved at the beginning, What we did quite early, as soon as the sustainability stuff came out, was took that up to the strategic group, so it went to our Executive Leadership Team, it went to the Health and Wellbeing Board. And then what they said is they wanted a sustainability group pulled together and that was chaired by one of the commissioners. So we got all those people engaged, the DPH was on it, our Director of Finance was on it, so we got all those people engaged right at the beginning of the sustainability. So they knew what was coming, you weren't just going knocking on a door and asking for money and they didn't know anything about it, it was on all of their radars which I think definitely helped. If I have any problems or issues, I can just email our Director of Finance myself and get an answer from him*.' Project Manager (Site 11)

> '*I think what was important was having that ongoing relationship with commissioners. Because if they're not involved and then you suddenly appear two years later, I suspect we might have had a different outcome*.' Project Manager (Site 41)

One way to encourage – although not necessarily guarantee – ongoing commitment from POPP partners was to have their respective responsibilities for sustaining projects written into the original

bid. If the future funding of each project is to be the responsibility of one partner, rather than all partners collectively, there may be greater onus on it to achieve:

> *There were three projects that we felt were either time limited or didn't need additional funding, and all of the others have been mainstreamed by either the PCT or ourselves – we did right at the beginning of the programme agree relative responsibility in terms of commissioning the projects*.' Director of Adult Social Care (Site 48)

POPP project managers in several sites stated their belief that future funding constraints were likely to be far more severe than in recent years. This was generally a reflection of the prevailing national economy, but may also have been an anticipation of further constraints from other causes within pilot sites. Thus, as one project manager suggested, their POPP programme may have faced greater challenges securing ongoing funding if it were to be doing so one year hence:

> '*I think the POPP came in at just the right time. If our project had reported next year, I don't think we would have been successful in getting money to sustain, because there's a huge, huge hole emerging in both (PCT and ASC) organisations. And there won't be the money for new projects*.' Project Manager (Site 22)

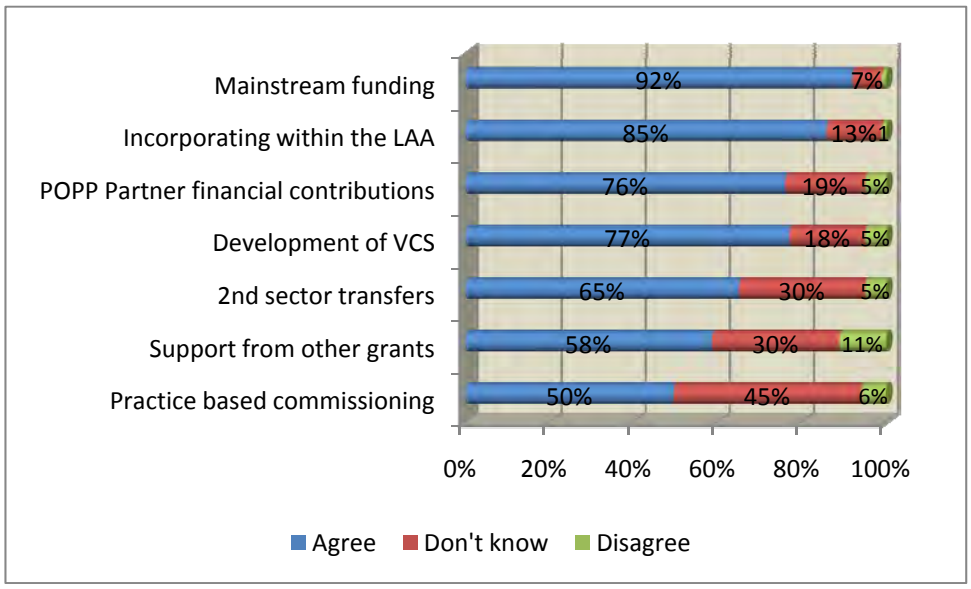
8.3 Mechanisms for sustainability

The data suggest that the particular mechanisms used by sites to ensure sustainability were heavily affected by the local context within which they were being developed. But there is also no doubt that the preparations for sustaining the POPP programmes involved a great deal of uncertainty in many sites and systems were not secured until late into the pilot status of projects. Indeed, when asked to identify what they perceived as the key challenges to the success of their programmes, 61% (n=291) of KIQ respondents identified it to be the process of establishing arrangements to secure sustainability.

8.3.1 Potential sustainability mechanisms

The KIQ, administered in each pilot site one year after the start of their programmes, sought to understand the principal factors determining whether POPP projects would be sustained into the long term. As can be seen in Figure 137, respondents overwhelmingly (92%, n=376) accepted that mainstream funding would be required, and three quarters (76%, n=208) acknowledged that this would necessarily involve both statutory and non-statutory partner agencies contributing from their own budgets. Two thirds (65%, n=263) also agreed that to facilitate these ongoing financial commitments, it would be necessary for monies to be saved through a reduction in the costs of acute care, with such savings transferred to social and primary care agencies from the secondary health care sector. As noted below, such retrieving of 'cashable' savings in fact turned out to be one of the most difficult aspects of the sustainability process.

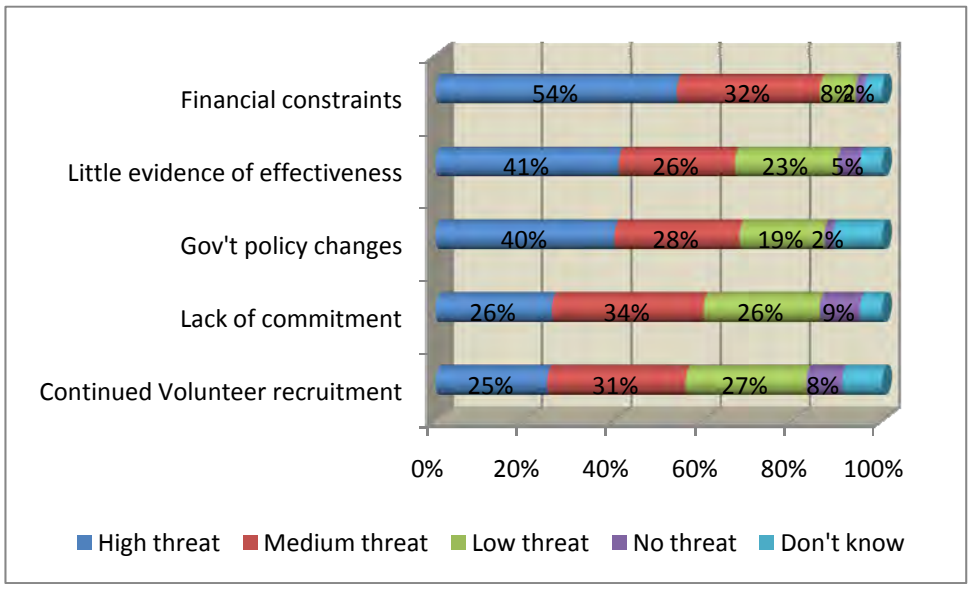
Figure 137. Factors important for sustainability



With regard to the actual mechanisms used to sustain projects, 85% (n=346) of KIQ respondents felt it was important that their target outcomes should be incorporated within the Local Area Agreement (LAA), and 50% (n=198) believed that the development of practice based commissioning (PBC) could facilitate sustainability. These mechanisms are discussed further below. Finally, almost a third (31%, n=9) of the pilot sites sought to develop capacity within the community and voluntary sector, reflected in the views of over three quarters (77%, n=312) of KIQ respondents who agreed this was necessary for the POPP programme to be sustained into the long term. Such VCS development was necessary so that local VCOs would be able to provide self-sustaining projects to older people in their area.

A further question within the KIQ asked participants to indicate the level of threat that certain potential barriers might pose to the sustainability of their pilot projects. As Figure 138 indicates, the challenge that most respondents (54%, n=219) agreed would threaten this process was ongoing financial constraints facing managers and commissioners within primary health and social care. There also appeared to be a high level of doubt amongst respondents (67%, n=274) about the ability of local evaluation teams to provide sufficiently robust evidence of the effectiveness of POPP projects in meeting their targets to convince commissioners of the need to sustain them. There were also concerns that changes in central government policy direction would distract attention from the need to sustain the projects (68%, n=281). These issues are discussed further below.

Figure 138. Potential barriers to sustainability



National policies

One facilitating factor for ensuring the sustainability of POPP projects was their alignment with other national and wider local strategic priorities within social and health care. The processes of negotiating sustainability between project management teams and local commissioners often meant ensuring that the business case for services could be understood to contribute towards those wider concerns:

> '*I think the key learning for me would be translating the POPPs project's view of what needs to be sustained, making sure that it coincides with the language of other strategic directions*.' Project Manager (Site 73)

> '*In terms of the historical and recent policy context and from the emergent national and local policy drivers in respect of prevention, independence, health improvement and well being, the POPP initiative has shown itself to be an extremely well placed and cost effective, platform to take us forward beyond the Department of Health funding commitment to March 2009*.' Site 29 EoY Rpt (2008/09)

Indeed, ensuring POPP service models coincided with wider strategic imperatives seemed to enable at least one pilot site to justify the mainstreaming of low level preventive services, even when robust evidence of their effectiveness in reducing demand for acute services was as yet unavailable:

> '*The general national policy emphasis on preventative services has also made it easier to justify mainstreaming services*.' FEoY Rpt, 2008/09, Site 41

Local area agreements (LAAs)

LAAs were rolled out to all areas in 2007 and required local authorities and their key partners to co-ordinate the improvement of services within their area. A majority of pilot sites cited the use of LAAs as mechanisms for embedding and sustaining POPP projects, and the KIQ found that 85% (n=346) of respondents believed that ensuring that the objectives of POPP projects coincided with those of the LAA was important for their sustainability:

'*Our POPP is helping us to meet some of our LAA targets. That's what we found we had to do, tried to say to the people that mattered, who had the money, "this will help you tick your boxes" – to be blunt, this will contribute to your national indicators, your PIs, your PSA targets. So there was a kind of win/win situation from that point of view*.' Project Manager (Site 67)

'*Our POPPs partnership model, which engages with the voluntary sector and empowers older people, has been embraced by all agencies, and is understood to make a significant contribution to the LAA*.' EoY Rpt (2008/09) Site 22

However, Round 1 POPP programmes were often already in the process of being implemented within pilot sites at the time that LAAs were being developed. As a consequence, the two pieces of work could become closely related, and in at least one pilot site the existing POPP pilot influenced the emerging LAA:

'*The LAA didn't drive it. There was a reporting connection to the LAA. If anything, I think the POPP initiative and the localism emerging agenda drove the LAA as opposed to the other way around. And there might be discussions there as to whether that's the right way around or not*. ...*The POPP targets on reducing emergency bed days was an LAA target. I think that was one which was "Oh! What can we put in that [LAA] box? – Oh! There's a POPP programme, they've got an EBD target reduction, let's put that in the LAA box kind of thing*." Project Manager (Site 13)

Practice based commissioning (PBC)

As part of the *NHS Improvement Plan* (2004a) and *Creating a Patient-Led NHS* (2005a), joint commissioning mechanisms were extended through partnership boards to enable a strategic approach to service development, incorporating agreed priorities for social and health care partners. The KIQ found that half (50%, n=198) of respondents agreed that PBC was an important factor in determining the sustainability of projects. However, within most POPP pilot sites, PBC arrangements appeared to be in the process of development and very limited qualitative data were available to analyse the impact they had on POPP sustainability. It might be argued that the pilot sites in which PBC would have had most influence as a factor in sustainability would be those that had developed health focused services that addressed higher levels of need. However, the following two quotes are from project managers in just such sites:

'*GP locality groups are the forerunners to PBC. Commissioning hasn't matured here in the same way as it might have done in a number of other areas. Aligning GPs into locality groups is preparation for when the money will flow from the PCT into the practices to do PBC*.' Project Manager (Site 13)

'*We are now making more efforts to get into discussions with practice based commissioners and trying to get World Class Commissioning, but we're still at an early stage*.' Project Manager (Site 47)

Transforming social care

This emerging policy was signalled in the Green Paper *Independence, well-being and choice* (DH 2005b) and the White Paper *Our health, our care, our say* (2006a), and involves the development of an increasingly personalised approach to the delivery of adult social care incorporating choice and control for users. The policy represents a further strategic shift towards early intervention and prevention, and requires councils to redesign and reshape their social care services in ways that assist people to maintain their independence, health and well-being. The transformation closely

mirrors the focus of the POPP initiative agenda and has been greatly influential upon the decision-making processes around the sustainability of POPP projects within several pilot sites:

> '*I don't know whether it's by luck or judgement, but our [POPP programme] model fits very nicely with Putting People First in terms of universal services, certainly in terms of early intervention and prevention, universal services, social capital, choice and control. We fit very nicely in there and we can provide good evidence as to how we are ticking all those boxes*.' Project Manager (Site 38)

> '*Aligning the successful third sector POPP schemes to the agenda for transformation - personalisation and early intervention, universal services, low level preventative services, flexible individualised approach providing choice and control and realising local potential to build social capital, has been key in securing their future funding*.' EoY Rpt (2008/09) Site 95

> '*The sustainability plan has presented the rationale for supporting the continuation of selected projects within POPPs. These are all ones which demonstrate best fit with personalisation and promoting independence, and can demonstrate improved outcomes for older people. They also extend the care pathways for older people's health and care services into community based prevention, which is where POPPs has built capacity*.' EoY Rpt (2008/09) Site 22

The transformation agenda has been supported with a ring-fenced Social Care Reform Grant (SCRG) to assist councils to restructure their services over the next three years. Within a number of sites this SCRG was cited as an important source of funding with which to ensure the sustainability of POPP projects:

> '*We have established from the Social Care Reform Grant dedicated funding to continue the services that have proved successful from the POPPs projects, to underpin their mainstreaming*.' FEoY Rept, p5,Site 06

> '*If we didn't have the SCRG, it would have been more difficult to work out where we were going to get the funding to support the older people's involvement in an ongoing way*.' Director of Community and Adult Care (Site 82)

> '*Adult services would have had trouble picking up the four services that it did without that extra [SCRG] grant*.' Project Manager (Site 04)

However, the SCRG was not necessary to ensure sustainability in most sites, particularly where sustainability planning had been initiated early on in the POPP programme. Moreover, where possible, pilot sites wished to use the SCRG to develop further the prevention and personalisation agenda and build on what was achieved through the POPP programme:

> '*We've got a sustainability plan for POPP, we've diverted resources, they're mainstream resources, I wouldn't want to be substituting them for the social care reform grant. So if we use that money, I'd want us to be achieving different things, building in what we've already done here*.' Director of Adult Social Care (Site 56)

There may also have been reluctance on the part of some local authorities to invest the SCRG into POPP services that appeared to be achieving savings mainly within the primary care sector, rather than social care. Such services were likely to be those targeting higher levels of need amongst clients:

'*[The SCRG] has not been used for the POPP schemes, because we wanted to deliver those in partnership with health – because the majority of the savings are delivered to the health system not into the social care system*.' Project Manager (Site 47)

Links between local strategic aims and those of the POPP pilot

If POPP projects were to be sustained there needed to be clear understandings not only of the clear link between the aims, objectives and expected outcomes of the projects, but also a robust understanding of how these connected with the other local strategic aims of health and social care agencies within a pilot site. In this way, it was possible for a minority of sites to build sustainability into the programme design. Moreover, if pilot projects were viewed by commissioners as carrying forward wider strategic aims, there was often less emphasis on them generating robust evidence of effectiveness in the short term:

'*There needs to be a clear link between the local strategic aims and the project concerned*.' EoY Rpt (2008/09) Site 03

'*I think a bit of the learning was that it was important to look at the work within a strategic context and to look at overall what we were trying to achieve. That meant that when we were not on target with the cashable benefit but still showing the potential that helped us to make the case really'.* Project Manager (Site 10)

Some sites underwent structural reorganisations within adult care services, with the development of Health and Well-being teams, and the objectives of POPP programmes could then be written into the new strategic frameworks. These then became important mechanisms around which sustainability plans could be developed:

The strategic framework created in 2008 was a key lever in developing the sustainability plan, with [POPP] pilots being embedded within a whole system service model. FEoY, p6 Site 10

Nevertheless, it should be noted that given the speed with which both national policies and local priorities may change over the lifetime of a pilot study, it is possible that such links between project and wider objectives may become obsolete.

National Dementia Strategy

The POPP programmes of four pilot sites focused principally upon providing services for older people with both organic and functional mental health problems, and four further site programmes included services dedicated to mental health problems. The National Dementia Strategy was launched in February 2009, aimed to improve the quality of care for older people with dementia and to ensure early diagnosis and intervention. This strategy mirrors many of the services developed within POPP programmes, and it has had an impact on the decision making processes that have sustained them:

'*The important message, 14 months after the end of the POPPs-funded period, and in difficult financial circumstances, is that the Council and PCT have identified resources to mainstream the POPPs-funded projects and sees them as key elements of delivering our joint strategy for Older People's Mental Health, including the National Dementia Strategy*.' FEoY Rpt, Site 10.

'*The services that were previously funded by POPP are all now commissioned by the [Mental Health Care for Older People] Strategic Commissioner. This post also project managed the*

POPP programme, and will ensure that there is a consistent preventative theme to the delivery of MHCOP services. ...The aim of the MHCOP strategy is to improve the well being of older people with mental health needs, and ensure that it leads in the implementation of the national agenda, of POPP.' FEoY Rpt,Site 19.

National Carers Strategy

The National Carers Strategy was launched in 2008, setting out a vision for greater recognition and support for family and other carers, including the provision of integrated and personalised services to help them continue in their role. There are also grants available to support these new services. Within the POPP initiative, six pilot sites provided services directly aimed at supporting carers, and the national strategy has provided support to the sustaining of some of these services:

'*The National Carers Strategy has assisted to raise the profile of carers and supported continued investment in the [carers project]. The strategy includes a number of drivers to improve support for informal carers including: carers to have access to the services they need to support them in caring role, carers able to have a life of their own and support to stay mentally and physically well*.' EoY Rpt (2008/09) Site 95

Renegotiating existing contracts with the voluntary sector

Almost a quarter (24%, n=97) of respondents to the KIQ agreed that existing contracts for services 'tied up' funds in their areas and represented a high threat to POPP project sustainability. Without restructuring these contractual arrangements, monies would not be available for investing in POPP. Thus, one route to ensuring future sustainability, particularly for projects involving the third sector, often required a review of the way that the existing contracts between them and the local authority could be reshaped:

'The intention is to look at our current contracts with the VCOs. We have legions of little contracts and day care contracts and community support contracts and so on with a number of organisations that need some sort of rationalisation, so some of our existing day care service contracts could be re-engineered to incorporate this type of role within it – I think it's that re-engineering that will make it sustainable. And also we used a bit of a blunt instrument by saying that each team would get 8 hours of community rep time, when some of the smaller teams didn't need that and some of the bigger teams want more than that.' Project Manager (Site 79)

Publicity/raising project profiles

The importance of ongoing publicity for pilot projects has been touched on earlier in this report. To secure funds to sustain projects in the long term, it is as necessary to promote projects' image as it is to encourage initial public take up of those services, as well as to encourage other agencies and professionals to refer clients to them. Most sites reportedly sought to raise and maintain a wider awareness of the potential benefits of the pilot projects among senior managers:

'*The projects were very well publicised, promoted and championed by senior members of all of the statutory agencies and many of those from the Third Sector in our area. Undoubtedly this added to their success*.' EoY Rpt (2008/09) Site 88

'*The strong partnership approach and the clear identity for our area's POPP have led to strong, shared ownership of the project. As a result of the commitment to POPP, the projects have achieved recognition by partners of the benefits of low level support for quality of life*

and potential cost savings and secured joint commitment to further investment.' EoY Rpt (2008/09) Site 95

Supporting People

The Supporting People initiative was launched in 2003 to help provide housing-related services to maintain the independence of vulnerable and older people. Together with several housing associations, the Supporting People infrastructure were partners within at least four POPP partnership programmes and assisted with the provision of benefit advice services, community alarms, home visiting and a range of other services. The Supporting People programme also contributed financially to the ongoing sustainability of POPP projects within at least three pilot sites:

> '*In partnership with Supporting People, over the next two years the initiative will also have access to £150k Communities and Local Government funding to increase the capacity, accessibility and role of minor repairs and adaptations services to people using the CORA Check and Support service*.' FEoY Rpt (2008/09) Site 29

Reinvestment of savings around the local social and health care system

One of the principal aims of the POPP initiative was to determine the ways in which monies could be moved around local social and health care economies. It is clear from the qualitative data that monies have been moved within organisations, especially where the development of new services was accompanied by a wider service redesign. Thus, monies have been moved from residential care to preventive services:

> '*Money has moved within organisations – the biggest shift of money has been within the county council. We've shifted probably about half a million pounds from fairly traditional day care services of various types, be they in day centres or residential homes. We've shifted that into prevention, and that includes staffing resource, because one of the things we've done now is taken a team that was providing social care and relocated it as a community development team. But there's been a big shift there*.' Director of Adult Social Care

However, within only a minority of pilot sites was it reported that any direct movement of monies from acute to primary care organisations had been achieved, whether from health to social care organisations or vice versa. Where these transfers were achieved, there appear to have been agreements already in place at executive managerial level that such movement of monies should take place:

> '*We did make some savings and there were two areas where we moved some money. One was where there was an initial agreement by the Chief Executive of the PCT, the Mental Health Trust and the Director of the local authority that savings made in continuing care for the older people with mental health needs would be redirected into prevention services – we did actually realise that in 2008/9, so the savings will be coming out in 2009/10. So we have actually used that money to partly fund some of the prevention services that were running before and to fund some other areas that were identified through the pilot*'. Project Manager (Site 19)

There seems to be little scope for money transfers to take place where no such prior agreements had been made between organisations. Savings achieved within primary health, as a consequence of interventions developed in social care, are not likely to be repatriated in the absence of any formal requirement that this be done:

'*I think without a directive from the centre, [transfers of monies] aren't going to happen. Bottom line. Locally PCTs are under enormous pressures to deliver their priorities across a broad agenda. Any efficiency savings benefits that it accrues, 'over my dead body' would I let go of it if I were them. ...Without a clear directive, x amount of your budget goes into social care; it won't be offered up voluntarily*.' Director of Adult Social Care (Site 29)

Movement of monies from the secondary health care sector to either primary care or social care was found to be more difficult. Many pilot sites had hoped to be in a position to sustain preventive projects, developed in partnership between social and primary health care agencies, by repatriating to them some of the savings from reducing emergency bed days. Indeed, as noted above, almost two-thirds (65%, n=263) of KIQ respondents had agreed that to sustain their POPP projects, such transfers would be necessary. Nevertheless, the overwhelming message from the interviews with project managers and other key informants was that such system-wide transfers had not been possible:

'The other issue that is very real for us is the fact that a lot of the work that we've done in POPP, particularly around early intervention, has created capacity for both the acute trusts that we work with. And the data that we're looking at clearly shows that. But there's no easy mechanism to transfer funding from the acute hospitals into these pathways – in terms of government agendas around, moving acute activity into the community, there needs to be a mechanism to support that' KITI Participant (026)

8.3.2 Wider relationships that assisted sustainability

There were wider relationships, beyond the local statutory and non-statutory partners, which pilot sites could use in the process of securing future funding, just as there had been for the implementation of those projects. These included the Department of Health project management team, local elected politicians, and older people themselves. The ongoing partnerships with these three groups could be used by pilot sites as levers to help raise the profile of services and encourage sustainability.

Involvement of the Department of Health as a lever

The DH POPP project management team had encouraged pilot sites to reflect on the processes by which they would ensure the sustainability of their programmes early on, both in their reporting requirements and through the quarterly PLEN meetings. At a PLEN towards the end of the programme, a sustainability exercise was arranged, along the lines of *Dragon's Den*, where project managers were asked to present and defend the business case for their programme's sustainability before a panel of experts, who acted the part of local commissioners. Project management teams were then provided with feedback and advice. Most project managers reported that they found this exercise very helpful:

'*The Dragon's Den – I'm an absolute convert to it. Really helpful and just at the right time, because I was just about to go to a series of meetings with PCT and public health, and it was really helpful for people to say "I don't quite understand that bit of it, you need to be more robust about that, and don't be apologetic about not having the evidence yet." I had initial reservations*.' Project Manager (Site 67)

'*People were really fearful of the Dragon's Den. But actually it was quite interesting, because it came at the right stage for stage one POPP pilots to begin to think about how you would pitch what you had actually achieved through the POPP pilots to other partners who would potentially fund. So it did make you focus on what your strong selling points were*.' Project Manager (Site 56)

Another way in which the DH project management team took a leading role in promoting the sustainability of projects was by arranging for meetings within pilot sites between themselves, the local POPP project managers, the CEOs of the PCT and adult social care, and the lead commissioners. Again, almost all project managers felt that this had been helpful:

> '*Really, really influential in making the PCT commit. Before that, they were a little shaky. They'd never made a firm commitment before, but at that point the commitment was made. And we were very grateful because the Department of Health actually ...made that happen*.' Project Manager (Site 04)

Influence of local elected politicians/councillors

Project managers in several sites reported that local elected politicians had played a role in lobbying for the continuation of popular POPP projects beyond their pilot site status. Councillors represented a link with the wider public and were at the same time often members of various committees and joint partnership boards, so that their voices carried great weight:

> '*We had from the beginning the portfolio holder [for older people], the councillor, who was from the very beginning working with the programme, and who sponsored and lobbied for it*' POPP Project Manager (Site 22)

> '*Nothing other than excellent support from politicians, and then they were able to use that in the health and security committees, and they were able to influence the health agenda*.' POPP Project Manager (Site 13)

Older people's involvement

Although service user and citizen involvement can take time to develop, it has the potential to be a strong driver for change once it has been established. Several pilot sites reportedly engaged older people's forums in the sustainability exercise and encouraged them to lobby senior managers. Allowing older people themselves to convey the potential benefits of popular services to commissioners, and reasons for their continuation, provided greater subjective weight to the case for sustainability:

> '*Discussions around sustainability have included older people and they have been encouraged to voice their thoughts and views about the services at a number of forums, including the older people's champions group. This has helped raise the profile of the successful schemes and has undoubtedly supported the case for continued funding*.' Site 95 EoY Rpt (2008/09)

> '*We had made up a couple of professional DVDs. Showing those at partnership meetings had more success than probably reams and reams of reports. Older people were interviewed [on the DVDs] to say what difference [the POPP programme] had made to them and people were won over by that right away. Managers and commissioners get so much information. The DVDs were able to give an immediate impact –e were able to bring the older people closer to the senior managers ...to get them in the room]*.' Project Manager (Site 52)

Managing fears and expectations

In several of the projects, a major issue was said to be managing the expectations and fears of various partners. Operational staff were concerned about the future of their jobs if projects were not sustained, and third sector organisations providing services were anxious that their contracts

might not be renewed. However, several sites had encouraged older people's community involvement as part of the development of the voluntary sector. Many of these older people invested much of their time and effort to these projects and identified closely with them. Although this did much to provide weight to arguments for sustainability, the delays that often occurred before final funding decisions created a difficult period. Project management teams had therefore to allay fears as best as they could:

> '*One of the main difficulties wasn't obtaining the funding, it was trying to alleviate the fears from the Expert Elders themselves that the funding was going to be stopped. They got really concerned at one stage because things weren't happening quickly enough. We kept saying we're 99% sure [of further mainstream funding], but at this stage it's not definite. And that didn't placate them at all – they wanted it in writing, they wanted it cast-iron guaranteed ...Some of them had had experience of working in local communities where things had been grant funded and then the funding disappeared*.' Project Manager (Site 04)

8.4 Issues around local evaluation

In most pilot sites, the local evaluation was an essential element of the sustainability process. Commissioners often required evidence of projects' effectiveness prior to committing investment. Local evaluators were commissioned to measure that effectiveness in a number of ways: a reduction in emergency bed days; evidence of cashable savings; the promotion of service users' quality of life; increased efficiency with which resources were utilised; or evidence that projects were achieving other national or local priorities. But there were nevertheless several generic issues concerning the type of evaluation that would provide appropriate evidence for sustainability.

8.4.1 Internal or external evaluations

Most pilot sites commissioned external evaluations, primarily from universities and academic research units, but also from private consultancy firms. A minority of sites undertook internal or in-house evaluations from within the social services department. At least one pilot site stated that external evaluations tended to be perceived by commissioners as more objective and impartial, because they were independent from the organisations delivering the services:

> '*External evaluation helps to add "weight" to the case for continuation of services, if outcomes have been successful*.' EoY Rpt (2008/09) Site 95

Moreover, sites that engaged internal evaluations sometimes found that the teams lacked the resources necessary to provide sufficiently robust evidence of the effectiveness of POPP programmes:

> '*The person didn't have the expertise to come up with things like cost-benefit analysis – we didn't have anyone that could provide us with that. We were fortunate that the PCT didn't want that to persuade them, but if they had done, I think we would have fallen down*.' Project Manager (Site 52)

This was not the case for all internal evaluations, and even those that commissioned academic institutions sometimes found that the approach taken did not provide the evidence required:

> '*The intention was to achieve savings through reduced admissions – however, the evaluation found that, with the research design which they were using, there was no clear evidence of that outcome*.' FEoY Rpt, p6, Site 41

Within most sites, the working relationship between the project management teams, service delivery staff and local evaluation teams was collegial and mutually supportive, and the early findings of local evaluations often helped shape the focus of developing pilot projects:

> '*Because we had [a Local Evaluator] working on the project with us, he was full time and so he spent a lot of time on the ground with the teams. So we did a lot of action learning stuff as well, so there was a constant flow of information coming from the evaluation about what was working and what was not. We used that to inform some of the direction*.' Project Manager (Site 11)

Nevertheless, within a small minority of pilot sites, relations between the project management teams and the local evaluation teams were sometimes strained. This may have been due partly to a lack of communication between them, but there were also other problems. Some project managers were unused to having their work evaluated by independent and external academics and, while pilot sites naturally wished to present their programmes as favourably as possible, independent evaluators, working as 'critical friends', would sometimes question that portrayal:

> '*I think as organisations you're so different – that does affect the relationship. Some of what you do on a daily basis, when you're delivering health and social care, and [the] style of working is very different and a different type of activity than an academic approach, so the kind of information and datasets that we use on a daily basis is very different from the approach that an academic would have*. Project Manager (Site 79)

> '*We're evaluated to death. It's just a different kind of evaluation. We've had CSCI regulation for years and years and years, and there was an inspection unit before that, so we're old hands at it. So I think what's interesting are the different styles of evaluation*. *I don't think it's that we've not had experience at being evaluated, I think the style and the focus and the type of evaluation is different*.' Project Manager (Site 79)

> '*Our local evaluators did not have an easy time. I'd be the first to acknowledge that. Some of that is because POPPs introduced the whole thing of independent evaluations for a social services initiative. I've been in the social services for years – for many of us, that would have been our first real exposure of an independent evaluation, so the whole question of having a critical evaluation or critical friend was new to us. I think too much from our side, we took the challenges, too much criticism, because in a sense when you have a pilot, of course you want it to succeed. There is a danger that you talk everything up and for you to be talking it up, get the [local] politicians on your side, for them to talk it up, in order to do the business with the PCT, so that you win the money. So you're always talking it up, and then along come the independent local evaluators, who are not social service employees, and say 'Ah but!' – and then we say "Push off" kind of thing. So that's born of a background of traditionally social services rarely had independent evaluations, so we are not used to that culture of that kind of critical challenge*.' Project Manager (Site 13)

Nevertheless, almost all project managers acknowledged that their attitudes towards the need for – and value of – objective and independent evaluations of the pilot projects played a vital role. Many also had much stronger views by the end of the pilots of the sort of evaluations that were necessary. In particular, it was almost universally acknowledged that the local evaluation should be in place right from the beginning of a pilot project:

'*The POPP project has made me realise the importance of evaluation now, particularly given the present economic climate. There's absolutely no way I'd be starting any project now without a very very firm evaluation written in at the very beginning. But I know much better now how important it is and how it should be structured. It has to be based around the needs of commissioners*.' Project Manager (Site 22)

'*I think we would look at the evaluation aspect from the beginning because they were very much things that were tagged on at the end*'. Project Manager (Site 19)

Project managers also often argued that the expected outcomes of the pilot should have been agreed with evaluators much earlier in the process. . There should also have been greater clarity about the sort of evidence the evaluation might be able to deliver, and the resources necessary to provide it:

'*I would do it differently, I'd tighten it up. I would have had a much better understanding myself in terms of what we needed from the evaluation. ...We needed to be much firmer from the very beginning about OK, how we were going to get evidence of impact and outcomes for older people? What difference has that made to them? – that should have been written in earlier I think. But that's because we hadn't done it before, and we've learnt a lot from that*.' Project Manager (Site 22)

'*Be really clear before you start of what it is you are trying to demonstrate, in order that you can show that what you are trying to demonstrate is what makes a difference*'. Project Manager (Site 03)

8.4.2 Types of evidence necessary

The evidence necessary for pilot sites to provide for commissioners depended heavily on the context in which their projects were being developed. Pilot sites with serious financial constraints were expected to provide robust evidence of impact and outcomes for individuals and across the whole system, and that POPP services were achieving direct savings:

'*In other [pilot site] areas, there may be a mutual faith between PCT and the local authority that this would deliver long term savings. We had to demonstrate to a turn- around team in our PCT that there were savings – otherwise there'd be no investment. So we had a much higher benchmark to jump over. You had to prove that by doing that, that and that, the patient would not go into hospital*.' Project Manager (Site 47)

In contrast, other pilot sites with fewer constraints, or for which the POPP programme linked closely with the local strategic priorities, had less rigid requirements made on them:

'*It always felt like I, over the course of those two years while we were making those arguments, that the argument was already won before I sat in the meeting. I never felt like I had to really convince a group of people to do something that they didn't want to do in the first place. It was always just about "giving you the reasons why you can justify why you're doing this, because I know you want to do it anyway".*' Project Manager (Site 15)

In some pilot areas, financial savings were shown to be accruing and the evaluations could successfully credit those savings to the POPP programme itself:

'*Evidence from local evaluation which proved that the project was successful and that financial savings were being made against predictions*.' EoY Rpt (2008/09) Site 33

In many other sites, especially those whose programmes comprised low level 'upstream' services, it was not possible to identify clear evidence of the economic impact of the programme within the two years of POPP funding:

> '*The short term funding for these projects, and the long term expected benefits, has made it difficult to ascertain impacts on high intensity care for many of these services. ... It is anticipated that savings from the mainstreamed low level services ... will not be realised in the next five years.*' Site 19 EoY Rpt (2008/09)

In some cases, savings were not found to be accruing in the short term and, in others, it was not possible for the evaluation to prove that savings or reductions in bed days were the consequence of POPP programmes. Even where changes were detected, there were often many other variables that might have brought them about them, and distinguishing key factors was not always possible:

> '*There were a number of issues about the [local evaluation's] research design which made it impossible to pick out the impact of [the POPP programme] from other changes taking place in local systems. Other problems in evaluation include predicting whether a hospital or care home admission would have definitely occurred without the low level intervention; the difficulty of excluding external effects on service use caused by aging populations; working out the "conversion" rate from activity to a prevention (e.g. how many prevented falls would have converted into fractures that would require admission).*' EoY Rpt (2008/09) Site 41

> '*Reliably measuring the number of people who take up universal and sub-threshold services as a consequence of information advice and support provided by the CORA Check and Support service has proved challenging*.' EoY Rpt (2008/09) Site 29

But some sites gave a priority to improving = the quality of life of service users. In these, as well as sites where it had not been possible to demonstrate economic savings, qualitative data from the case studies, questionnaires and interviews with older people attributing improvements in quality of life to the POPP projects were sufficient to convince commissioners to maintain their ongoing funding:

> '*It's obvious, but for NHS [Site 56] it was really important to show how this relates to the health agenda and how you could show it was making a difference. You needed to be able to show that. Bit frustrating really – I suppose they're driven by facts and figures and it is notoriously difficult to provide that kind of very hard evidence of prevention making a difference. So we relied heavily on case studies, and we let people tell their stories, and that helped to persuade partners and show particularly health partners that it was useful*.' Director of Adult Social Care (Site 56)

> '*Whilst we do not yet have robust cost-benefit data, we have gathered extensive evidence of improved health and quality of life which has contributed to securing ongoing funding*.' EoY Rpt (2008/09) Site 22

> '*The use of case studies and satisfaction questionnaires have played a vital part in our sustainability decisions, particularly since it has not been possible to quantify the savings from the acute end of the health and social care economy*.' EoY Rpt (2008/09) Site 88

> *For many of the lower level services, we are not anticipating significant savings to impact on the system, but have instead relied upon evidence of effectiveness and impact on Quality of Life for ongoing financial decisions.* EoY Rpt (2008/09) Site 19

In at least one instance, the lack of robust evidence to prove a connection between a POPP project and either bed day reductions or economic savings was compensated for sufficiently to justify continued funding, by appealing to evidence from previous initiatives that had been used to inform policy:

> '*The core elements of the programme were based on "gold standard" evidence from research elsewhere; this made it easier to convince NHS commissioners of the case for funding continuation*.' EoY Rpt (2008/09) Site 41

Nevertheless, where it was not possible to provide evidence for the effectiveness of POPP services within the two-year pilot period, there was often a continued commitment to do so in the longer term:

> '*Partners recognise the importance of evidencing the financial impact of services and work will continue to progress this approach for the low level "preventive" services*.' EoY Rpt (2008/09) Site 41

8.5 Types of sustainability

There were a number of different forms in which programmes, projects, and/or their outcomes were sustained within pilot sites. Indeed, even within a single pilot site, the separate projects that comprised a programme were sometimes sustained in very different ways, while some may not have been sustained at all. Thus, projects that previously sat together under a POPP management team may have been separated and mainstreamed within different agency departments:

> '*[Project 1] has been sustained and the hosting of that has been transferred into the workforce development team. [Project 2] is being sustained by transferring it into adult services commissioning team and in the future we are forming a health and well-being team so it will become part of that. [Project 3] teams are being sustained, but the specifications are being revised based on our learning and the external evaluation and that will be going out for tender for a new provider. [Project 4] is not being sustained, but we will be looking at pathways within the overall strategic framework and will be picked up again'.* Project Manager (Site 10)

> '*Instead of POPP being seen as one separate discrete service, the individual projects have now been inserted into the newly developed Older People's Joint Commissioning Strategy under their separate themes: falls, mental health, information/advice, advocacy, transport, community engagement, access to leisure and learning etc. This will ensure that preventive community based POPP services are included as part of the care pathway (for falls, older people's mental health etc) in future strategic planning and developments*.' EoY Rpt (2008/09) Site 22

Many projects were sustained as discreet services into the long term, but with different levels of staffing than the pilot stage. While many service delivery teams were reduced in size once they were mainstreamed, there were also those that were to be expanded:

'*[Project 1] will be mainstreamed, or the way of working will be mainstreamed. It's not necessarily in the same format as it currently is, but in terms of having the dedicated social worker resource as well as a dedicated health adviser as well as the community link worker who's responsible for actually plugging people into the services. That whole concept will remain, it might be just that the numbers within the teams changes, and actually in some areas it may be that we need to extend the teams further*.' Project Manager (Site 38)

'*All aspects within the project will continue in one form or another, it's just the numbers that sit behind that, in terms of the posts that need to be looked at – and that will obviously be done from lessons we've learned throughout the pilot phase*.' Project Manager (Site 38)

Some roles within multi-agency teams were not sustained because the funding agency was not in a position to continue that funding post-pilot status and other partners were not able to pick up the extra expense. Alternatively, service roles may not have provided sufficiently robust evidence of their effectiveness:

'*The voluntary sector representative role was more difficult, because they found it difficult to perform within the context enough of the way for us to get good evaluation material out of it*.' Project Manager (Site 79)

Although projects may have been sustained in a more limited form than when they were pilot projects, it was nevertheless argued that the outcomes would continue to be sustained. Such outcomes might involve better relationships between statutory and non-statutory agencies, and more efficient referral processes between them:

'*Ours was one big idea, rather than lots of little projects, and it was a service with a number of elements to it. What is going to be sustained is increased on what existed before and decreased on what was there during the pilot. So there will be more care co-ordinators than what we had before. So we started out with five and ended up with eight, although we had 10 during the period. But the links with various voluntary sector and other teams – for instance, we had a mental health nurse within the team and we had various other bits of input – are not being sustained, unfortunately. But I think what we have done is developed relationships through the project which have to some extent facilitated better referral processes and better links with some of those services. So though it is not sustained as such, it has improved the quality of relationships and therefore the quality of services and joined-upness*'. Project Manager (Site 03)

There was agreement between the partners of several pilot sites to continue to fund certain projects as pilots for a further year to allow evaluations to accumulate a greater evidence base of their effectiveness. In these instances, therefore, the decision to mainstream such services was therefore delayed for a further year:

'*[Project 1] is being sustained for this year from the social care transformation fund. And this relates to the short time scale, because we've been doing some heavyweight evaluation on it. At the moment, I'm not feeling absolutely convinced I know what's going to come out of that. So that's a bit of an issue for us. All of our management information is screaming that this is producing excellent results, and we've had people writing to ministers demanding that it continue*.' Project Manager (Site 79)

Several POPP programmes that focused on the development of the third sector and on the capacity of VCOs to provide low level services to older people, expected those services to then become

wholly or partly self-funding following the initial investment of pump-priming monies. However, even if such low level projects do become self-funding, they may nevertheless require ongoing infrastructure support from statutory agencies in order to be sustained:

> '*It depends what you mean by self-sustaining. We've got groups that are self-sustaining in the sense that we don't provide them with any finance – they run themselves, they deliver their own programmes, they deliver their own volunteers, and for the most part they are self-sustaining, but that's not to say they don't need that community development officer who is providing that link into other preventative services. So in some senses you'll always need some sort of community development resource to provide those links and provide that support. And sometimes the nature of community development is that groups do come, flourish, and then go away again, and they need to keep recreating themselves. So sometimes we'll be putting in community development time quite intensively, because that's the point in the cycle, and other times we'll be standing back, and just being on the end of a phone, a presence if we're needed. But I can't envisage a time where we wouldn't need any community development resource*.' Director of Adult Social Care (Site 56)

8.6 Outcomes of sustainability process

The overwhelming majority (85%, n=124) of the projects secured funding beyond their pilot status in one form or another, with only 5% (n=8) being closed either because they did not deliver the intended outcomes or because local strategic priorities had changed. However, between the pilot sites themselves there was variable success within the sustainability process, and although most sites were able to successfully sustain the projects that comprised their POPP programmes, there were sites that struggled with the process:

> '*Everything that it was suggested [in the IP] might be commissioned in the future was*.' Project Manager (Site 82)

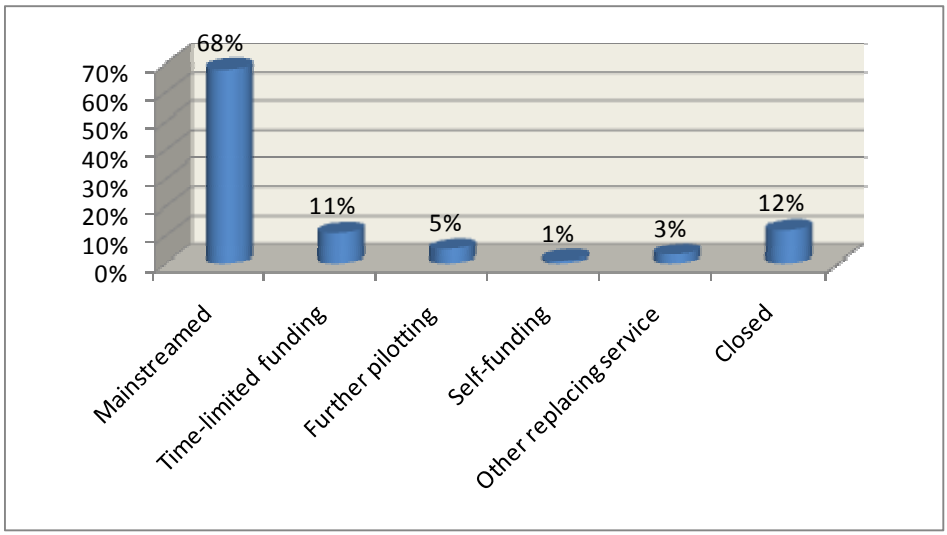
> '*There was disappointment that we were not more successful with some of our projects, and by successful I mean that they actually worked in their own terms and then we sustained them all*.' Project Manager (Site 47)

As Figure 139 indicates, the majority 68% (n=83) of POPP projects were reportedly either sustained into the long term as discrete services or were integrated into other existing mainstream services. Ongoing funding was provided mainly by the local authorities and PCTs. Eight sites acknowledged that the Social Care Reform Grant (SCRG) would be used in part to sustain POPP projects, and PCTs are contributing to the sustainability of POPP projects within all pilot sites. PCTs are providing at least half the necessary ongoing funding for 35% (n=51) of projects, and within almost half of pilot sites (n=14) one or more projects are being entirely sustained through PCT funding. Other sources of ongoing funding included Supporting People, which supported the sustainability of projects within three sites, and the Carers Grant, which in part sustained projects within two sites.

It is often the norm that ongoing funding for discrete statutory services is dependent on competing local priorities and spending requirements, and subject to annual negotiation. Thus, in addition to those POPP projects mainstreamed into the foreseeable future, it was stated by pilot sites that 11% (n=16) of projects were to receive time-limited funding for either one or two years, at the end of which further agreements regarding ongoing funding would be reached. Some 5% (n=7) of projects have secured status as pilots for a further year, being funded by their local authority and/or PCT. This is to allow an evaluation to further strengthen the evidence of the effectiveness of those

projects. Another 11% (n=17) projects have been closed, although there are several reasons why this may have occurred, which are discussed below.

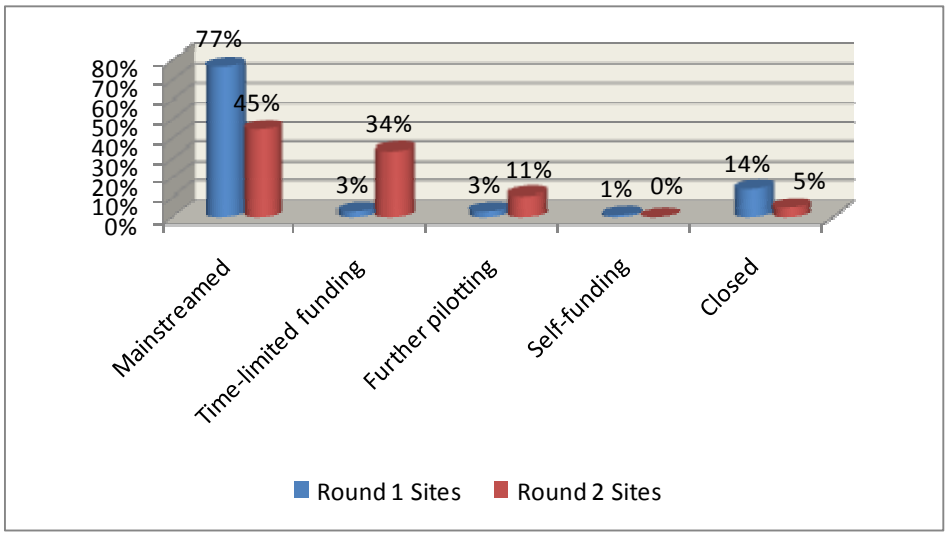
Figure 139. Outcomes for sustainability process for POPP projects



In addition to the types of sustainability listed, four pilot sites indicated that the outcomes or activities of 3% (n=5) of projects were to be carried forward by other mainstream services that were to replace the POPP services. For instance, when describing the future of a community development project, one site stated that although the community development worker (CDW) posts were not to be sustained '*some elements of these posts have been absorbed into a new service user and carer involvement framework*' (Site 41, Sustainability Plan, p5). However, it was not always clear to what degree those outcomes or activities would in fact be maintained. Thus, another pilot programme stated within its final End of Year report (2008/09) that the VCO providing a particular service had gone into receivership mid-project, but that the work had been picked up within other mainstream activity. However, elsewhere within the same report it was stated that: '*This element of the project has not been very successful for a number of reasons and whilst elements such as individual volunteering opportunities, leadership and involvement through [named VCO] activities and some work in hubs, may have opportunities for sustainability, there is no other strand of work going forward beyond the project*.' (End of Year Report 2008/09, p59-60, Site 82).

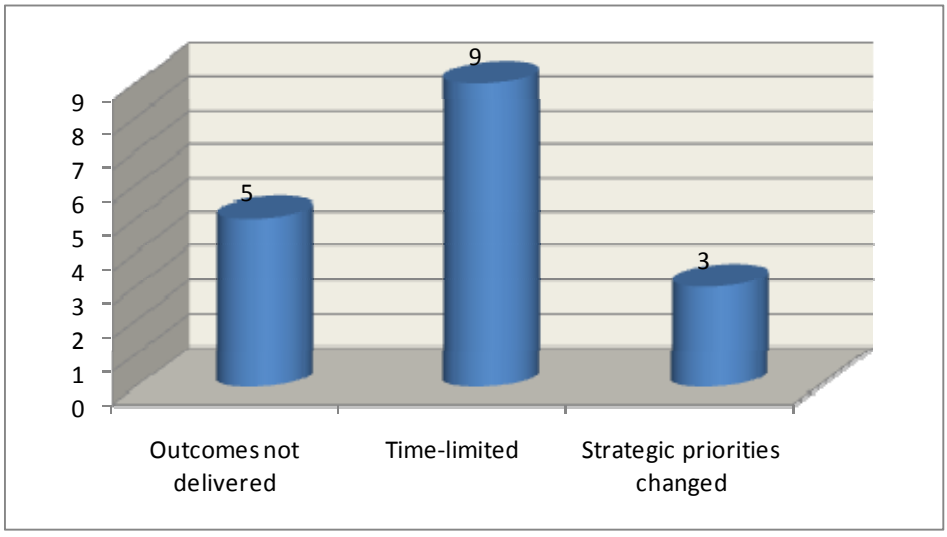
There are some differences concerning the outcomes of the sustainability process between the two pilot site rounds, and to some degree this may be explained by the duration of the funding period each round has enjoyed (see Figure 140). Among Round 1 sites, well over three quarters (77%, n=83) of pilot projects have now secured long-term mainstream funding, while among Round 2 sites, less than half (45%, n=17) the projects have done so. Nevertheless, a far larger proportion (34%, n=13) of Round 2 pilot projects have secured time-limited funding for one or two years, when further arrangements will need to be made.

Figure 140. Outcomes for sustainability process: Round 1 and 2 compared



Pilot sites reported several reasons why pilot projects were not sustained. As Figure 141 shows, 3% (n=5) of projects were closed because the outcomes they were designed to achieve were not being delivered. Another 2% (n=3) were closed because it became clear that they no longer reflected the strategic priorities of the pilot site (e.g. when a merger of two or more PCTs altered the context in which the project had been designed). A further 6% (n=9) had intentionally been established as time-limited initiatives and had been due to close at the end of the POPP funding period.

Figure 141. Reasons for POPP projects closed

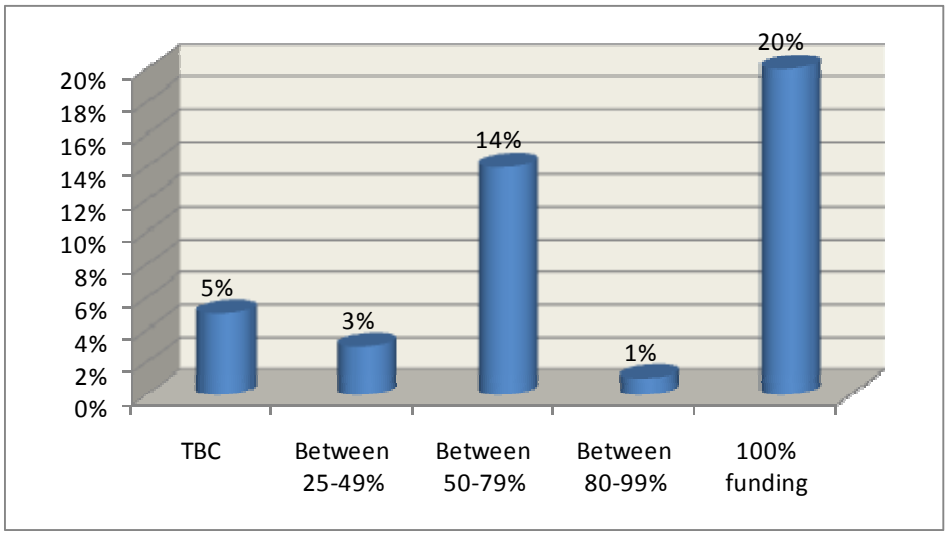


PCT involvement in POPP project sustainability

PCTs are contributing to the sustainability of POPP projects within all pilot sites. Moreover, within almost half of pilot sites (n=14) one or more projects are being entirely sustained through PCT funding. Altogether, as Figure 142 indicates, one fifth (20%, n=29) of all POPP projects have been entirely sustained through PCT funding (i.e. PCTs are providing 100% of project funding). There are

also 14% (n=22) of projects for which PCTs are providing at least half the necessary ongoing funding, and a smaller PCT contribution is taking place within four (3%) projects. A further 5% (n=8) of projects are due to be partially sustained with PCT contributions although the exact proportion has yet to be determined.

Figure 142. Proportion of sustained POPP projects receiving PCT funding



9 Discussion

Key points

Achieving desired outcomes

- The POPP programme demonstrated that prevention and early intervention can 'work' for older people. Local authority-led partnerships, working within the context of Local Strategic Partnership and Local Area Agreements, can help to reduce demand on secondary services, providing they are appropriately funded and performance managed.

- The programme has also shown that small services providing practical help and emotional support to older people can significantly affect their health and well-being, alongside more sizeable services expressly directed to avoiding their need for hospital. Most of the older people using POPP services had relatively high levels of need, but they nonetheless experienced improved outcomes and reported greater satisfaction than the comparison group, as a result of using these services.

- It is possible that the evaluation results understate the benefits which might be derived from such a programme. The POPP projects were new and largely untested and some were necessarily more effective than others. If those seeking to introduce similar programmes were to focus solely on those projects found to be most effective and those older people found to be most likely to benefit from them, the returns from similar levels of investment is likely to be greater.

- Moreover, the POPP projects took time both to bed in and to become embedded within local health and social care systems. It is possible that even greater value could be secured over the longer term, as new projects learn from their experience, and general expertise and confidence grow.

- These gains were secured by pump-priming prevention and early intervention projects. Their cost-effectiveness gains cannot be fully realised unless cashable savings can be released and re-invested in such projects. Initially, only marginal savings may be identified. Some degree of financial systems reform is likely to be necessary to support the decommissioning of services in one part of the health and local government system alongside the re-investment of resources elsewhere.

- From the results of this evaluation, it can be argued that the approach piloted by the POPP programme should be sustained, using the programme's learning to target investment to maximise individual and systems benefits. The realisation of the cost-effectiveness gains will be dependent, however, on the introduction of systems to support decommissioning and reinvestment.

Improving processes and management arrangements

- Complex new programmes are inherently challenging to get off the ground, especially where they involve a range of agencies. Because it can be difficult to anticipate the particular problems likely to arise, time and resources for the implementation period should be built in from the start. Both commissioners and programme managers need to recognise that recruitment, training and staff preparation is likely to take at least six months and local project managers should be in place to ensure appropriate implementation.

- It should be expected that both project structures and processes will, quite rightly, evolve over time. Such changes will need to be mirrored by changes in project targets and monitoring tools. Good staff supervision should be ensured to support staff through such changes.

- Multi-disciplinary projects benefit from the co-location of staff from different agencies and professions in one place, rather than seeking to develop a 'virtual' team, as well as from single line management. Co-located teams enable people to work more effectively together and achieve better outcomes, although they do not function without difficulties.

- Where large programmes involve tendering for projects, attention should be given to the development of flexible commissioning processes appropriate to the scale of the exercise. Tendering must be arranged to assure an equitable process, particularly where small voluntary organisations are involved. Support and assistance with capacity-building should be available early on, together with clear information concerning requirements for monitoring and targets.

- Where there is to be a programme evaluation, project leads should work with all stakeholders (providers, commissioners, programme clients) to think through their desired *outcomes* from the programme, rather than simple *outputs*. These outcomes should be used to develop a framework for evaluation, prior to commissioning external evaluators. Monitoring and measurement should then be embedded in any project recording systems prior to the start of any project. Base-line measurements must be established early on.

- Involving consumers effectively in the design and direction of programmes is well known to be difficult and may be particularly problematic in the case of older people. Time and resources to assist this process must be built into the implementation programme, including for the provision of appropriate training and the establishment of systems for such practical issues as payment arrangements and transport. There also needs to be a balance of understanding between the necessary 'safe-guarding' procedures (through criminal records bureau checks) and the level of support older people are provided. Management of risk may need to be undertaken and underwritten across the authority if the contribution of volunteers and representatives is to be optimised.

9.1 Introduction

This chapter summarises some of the key findings from the research and discusses some implications for policy. These issues are preceded by a discussion of issues for the National Evaluation itself.

9.1.1 The national policy context

The POPP initiative was designed to achieve three aims for older people: the provision of person-centred and integrated services; the encouragement of investment in approaches that promote their health, well-being and independence; and the prevention or delay in the need for higher intensity or institutional care. To achieve these objectives, there needed to be strong and effective partnerships in place between key stakeholders. Indeed, in order to produce a real shift towards preventive community care, partnerships needed to extend beyond health and social care agencies to include other statutory organisations, such as police and fire services, housing associations and libraries, and both national and very local voluntary and community organisations (VCOs). Furthermore, to the extent that more services were to be provided by the third sector, this might bring in its wake the development of more sustainable communities and the encouragement of greater engagement of service users and their carers in the design, provision and governance of local services.

The government's drive towards the development of more person-centred care and higher quality services for older people was reflected in the *NHS Plan* (2000a) and the *National Service Framework for Older People* (DH 2001a). This was later followed with an overarching national strategy for older people, set out in '*Opportunity Age – Meeting the challenges of ageing in the 21st century*' (DWP 2005). Together, these documents are drivers for 'active ageing', where older people have the opportunity to play a full active role in society and where services are aimed at promoting independence, choice and control. Moreover, to enable older people to live full, healthy and independent lives, social and health care services needed to focus on preventing older people's illness and crisis situations by providing services that promote health and well-being.

The boundaries between health and social care have long been regarded as problematic for older people who require community based support. Over the last decade, however, the government has sought to integrate service delivery and promote joint working to improve health and well-being through, for example, the White Paper *Saving Lives: Our Healthier Nation* (DH 1999a), the Green Paper *Independence, Well-being and Choice* (2005b) and the White Paper *Our health, our care, our say* (2006a). Financial levers have also been developed to facilitate partnerships between social and health care agencies including: pooled budgets (Section 31 of the *Health Act* (DH 1999)) and joint commissioning.

9.1.2 The POPP programme

The POPP programme was one of a number of recent government policy initiatives to improve the quality of life of older people by testing new approaches to shift towards prevention and personalisation. POPP was central to this approach, with its £60m of ring-fenced central government funding for CSSRs to develop innovative pilots. CSSRs were invited in March 2005 to submit bids to develop council-led partnership pilots that would demonstrate ways of supporting older people to lead active and healthy independent lives. Bids were selected to test a range of different approaches.

9.1.3 The National Evaluation of POPP

There was a two-level evaluation process within POPP. Each pilot site was required to commission their own local evaluation to respond to specific locality needs and to assist in the provision of key information to a National Evaluation team (NET). The roles of the National Evaluation were to ensure

that the specific core and subsidiary data from each pilot site could be centralised, to ensure a robust overview of the progress of each site, and to provide an overarching and comparative analysis of the progress of all pilot sites in the achievement of the programme's aims.

The Department of Health (DH) called for proposals for a national evaluation of the POPP initiative in September 2005. Although it was left open for applicants to propose additional or alternative questions, the following indicative research areas were to be addressed:

- The effectiveness of partnership and financial arrangements within pilot sites
- The effectiveness of the preventive model of care
- The effectiveness of processes supporting pilot sites with monitoring and evaluation
- The integration of POPP with other policy directives
- The effectiveness of pilot sites to mainstream services beyond the POPP funding period
- The evidence that POPP programmes were cost-effective

There were no fixed assumptions or requirements regarding the methodology of proposed bids, but the NET would be expected to work closely with local evaluation teams.

9.1.4 National Evaluation response

The proposed National Evaluation protocol involved a flexible case study approach (Yin 1994, 1993) that incorporated multiple methodologies, both qualitative and quantitative. It was proposed that the research design would have three phases, incorporating both formative and summative elements. The first 'exploratory' phase was to be carried out within each pilot site, collecting and analysing data to ensure adequate information on the structures, processes and outcomes of the pilots. From these data, a minimum core data set (MCDS) was to be established, which would include data to support the Public Service Agreement (PSA) targets, and quality of life and well-being data that could be used to assess the impact of the POPP intervention on the well-being of older people.

On the basis of the interim findings of this first phase, a second 'explanatory' phase was designed to take place within five selected sites. This involved a more in-depth summative exploration to demonstrate comparative demographic, partnership/financial models, operational interventions and outcomes. Within the third phase, the empirical work was to be brought together to develop a partnership/financial model that could be transferred to other care groups. Two stakeholder consensus workshops were to be undertaken to facilitate this 'framework development'. Due to the innovative and iterative nature of the POPP programme, it was an underlying assumption that there should be ongoing flexibility with both research design and methods.

9.1.5 Challenges to the evaluation structure and methods

The need for flexibility within the research design and the methodologies to be used was emphasised early on in the POPP programme, when it became apparent that there were several unexpected challenges facing the National Evaluation. First, there was an altered emphasis in what the DH wanted from the evaluation. Less concern was to be placed on an examination of the process of project implementation and the theoretical modelling of partnership and financial frameworks, and greater emphasis to be given to an analysis of the cost-effectiveness of the programmes. This meant the NE design also changed, and the theoretical framework element of the research protocol was dropped.

The second challenge emerged when wide differences became apparent in the working methods of project management and local evaluation teams. Project management teams worked at different rates and there were delays in the recruitment of key personnel, which slowed down the

implementation process. In addition, many project managers were unused to external national evaluations, and their provision of data to the NE Team also varied, with some sites providing whatever was requested within the suggested timeframes, but others proving less successful in doing so. Moreover, there was a range of local evaluation teams, some drawn from local universities, some from private consultancy firms, and still others from 'in-house' local government performance management teams. Negotiation and compromise were thus necessary from a very early stage within the evaluation, regarding the types of data that could be provided by sites and included within the evaluation.

Thirdly, a further methodological problem arose concerning the way in which the wide variances between the targets set by sites were to be measured within a standardised data collection. The POPP programmes were inherently innovative and iterative, and driven by local needs. The programme designs and what they were aiming to achieve were thus greatly variable, as were the ways in which they were to be measured. For example, many of the local performance indicators (LPIs) set by pilot sites were measurements of output rather than outcome, and data were to be collected by various methods. Thus, there was an issue for the NE Team regarding the best way to manage the variance between sites, a question that was only partially solved.

9.1.6 Key research questions

In response to the challenges faced by the NE Team, the initial research questions were adapted slightly, but nevertheless kept faith with the indicative questions suggested by the DH in their tender document. The key research questions finally determined by the NE Team concentrated on exploring the structure, process and outcomes of the pilot site programmes comprising the POPP initiative.

Research questions relating to process:

- What were the opportunities and challenges to the implementation of the POPP programme?
- Did the POPP programme change partnership working and practices within the pilot sites?
- What was the level of older people's involvement in their local POPP programme?

Research questions relating to outcomes:

- Did the interventions improve quality of life for older people, compared with normal care?
- Are the projects/interventions cost-effective?
- Do the projects/interventions reduce use of high cost services?
- To what level were projects sustained beyond the POPP funding?

In the sections below, the NE findings are discussed with respect to these broad research questions in turn.

9.2 Process issues

9.2.1 Barriers/facilitators to implementation

The process of project implementation covers the initial design of services and planning of service delivery teams, the recruitment of staff, and the direct provision and 'bedding in' of a service. During this process, pilot sites faced both opportunities and challenges.

To achieve the development of more integrated social and health care services requires high levels of trust and communication between operational staff of different organisations. This necessarily entails the development of a greater understanding of one another's professional roles. The structure of a service delivery team therefore has a fundamental impact on the degree to which it

can function in this collaborative way. The majority of pilot sites developed services that involved staff employed by more than one agency, and several adopted multi-agency teams to deliver them. Across the POPP initiative, such teams ranged from those that were 'virtually' integrated to those that were fully co-located with a single line management.

Within all multi-agency teams, closer working practices between professionals allowed advice to be sought and referrals to be made in a more timely fashion and with greater benefits for patients. Indeed, such joint working practices often revealed the extent of existing problems facing some older people, such as incompatible or over-medication, which had been created by a previous lack of communication between organisations. However, a feature of 'virtual' multi-agency teams is that there remained a physical distance between the staff of the different agencies that comprise them. This can compound the pre-existing cultural and professional distance between agencies, and it was found that very often staff failed to identify fully with the virtual team of which they were members. What seems to be necessary to maintain good working relationships over the longer term is regular day-to-day contact.

Even where teams are co-located, the strong cultural boundaries separating professions and organisations can mean that a single line management is necessary to facilitate optimal effectiveness and efficiency. Such management presents challenges, however, both to the team leaders, who must manage different conditions of employment among the members of their team, and to the staff who comprise the teams, who can find themselves answerable to more than one manager. Some sites that developed these forms of multi-agency teams did not initially take into account the necessary administrative support, creating greater workloads for team leaders.

Another approach to developing more collaborative working practices between organisations, and providing seamless care for patients, has been the development of new roles to link organisations more closely. Such roles include excess bed day workers, working within hospitals but employed by social care, and community link workers, working closely with local networks of VCOs and charged with overcoming potential problems for the timely discharge of older patients from hospital. Again, such links between agencies allow decisions to be made regarding appropriate care in individual cases more quickly.

The challenges to project implementation were particularly acute and widespread in the recruitment of key project personnel. This arose primarily because of the length of time necessary to recruit staff, often far longer than had been anticipated and allowed for within the bid and pilot site Implementation Plan. A consequence of the inherent delays was a slowing down of the whole process of project implementation. It was often voiced by research participants that the recruitment processes for project personnel should have been initiated earlier. Similar recruitment problems were experienced with respect to the volunteers necessary to provide many of the low level prevention services.

Moreover, the implementation of new and innovative services often required specific training for newly recruited or seconded staff, who might be undertaking different roles from those they had been used to. Very often, the exact roles of staff were still evolving after the initiation of the service, and service specifications were frequently vague. It therefore took time for staff members to 'find their feet' and become comfortable with those new roles. A particular problem also existed regarding the use of volunteers, in that once they were recruited an ongoing effort was required to retain them. This process of retention could be exacerbated where other elements of a project were delayed.

There needs to be a recognition within initiatives such as POPP that recruitment, training and preparation of project management and service delivery staff take time. This should be factored into project implementation plans. Such recognition was acknowledged during the POPP initiative in several ways by the DH. For example, Round 2 sites were awarded a part of their funding in January rather than May 2007, three months earlier than Round 1 sites, to allow them to recruit their project management team before the pilot stage commenced. In addition, Round 1 sites were also allowed to 'roll over' funding into a third year.

Many of the difficulties identified around recruitment, time and training were mirrored within voluntary sector partners commissioned to provide services in local programmes. There was often a cultural dissonance between what the statutory commissioning agencies expected and what VCOs were able to provide. For example, many of the local voluntary organisations had little experience with tendering processes. In some instances, VCOs commissioned to provide services found that they had underestimated the costs of both setting up and delivery. Some sites found it necessary, therefore, to build in the development of the capacity of small VCOs to participate in tendering and commissioning processes. Such support helps to increase their opportunities for securing future funding, and ensure the sustainability of their schemes. Nevertheless, commissioning processes sometimes remained too bureaucratic for many of the smaller charitable organisations and older people's groups.

POPP projects were new, innovative and often evolved iteratively. Unsurprisingly, therefore, they encountered unanticipated challenges. For example, there was a consensus among respondents that local programmes did not exactly reflect their original bid, service specification or programme plan, because some flexibility was required to allow for adaptation and change in the face of unexpected challenges to the original specification.

Both statutory agencies and VCOs often initially underestimated the level of resources needed to plan and implement POPP services. In particular, many reported an unexpected level of administrative support was required and its absence produced heavy burdens for project managers. Perceptions of 'overload' caused by insufficient administrative support for responsibilities additional to existing roles may reduce staff morale, efficiency of service delivery and, ultimately, reduce the chances of justifying sustainability.

Many research participants cited the sharing of electronic data as a major obstacle to the effectiveness of multi-agency working. There were both practical and logistical problems involved, such as different agencies using different e-mail and data storage systems, as well as ethical problems relating to patient confidentiality and data protection. These problems need to be resolved as early as possible between agencies during the implementation stage of a project.

It takes time for new services to become established and embedded within social and health care economies and for professionals from other referring pathways and organisations to be fully aware of what those services can provide for their clients. These professionals, including GPs, community matrons, district nurses and hospital discharge teams, need also to be assured of the effectiveness of these services. It became necessary, therefore, for the POPP services in many sites to maintain an ongoing publicity exercise to raise and maintain their profile locally. Again it was found that insufficient resources were initially made available for this function in several sites, which meant that the project budget had to be re-balanced and staff members, initially dedicated to service provision, needed to take on additional publicity roles.

GPs were particularly important to the success of POPP programmes in terms of referrals, whether into 'upstream' or 'downstream' services. However, in the majority of sites the engagement of GPs

proved challenging, especially in the early stages of project implementation. The reasons appeared to be twofold. First, GPs often required robust evidence of the effectiveness of new services, and of the benefits they offered, before they would routinely refer patients to them. Such evidence was generally unavailable at first, but once GPs began to recognise the value of the POPP services, their referral rates tended to increase. A second reason for slow GP engagement may have been a concern that the short-term funding of pilots and uncertainty about their sustainability meant they might not be able to provide continuity of care for their patients.

Pilot sites developed relationships beyond the local statutory and non-statutory partners to deliver the programme, including the DH project management team, local elected politicians, and older people themselves. These three separate groups of individuals could be used to help raise the profile of services and encourage both strategic and operational partnerships.

9.2.2 Changes to partnership working

It was a condition of POPP funding that pilot sites were to include a broad range of partners and that partnerships should include older people. Sites needed to secure the formal support of at least one local forum of older people for their funding application to be considered. Nevertheless, membership of each partnership was to be determined locally and dictated by the focus of each programme.

There was, therefore, some necessity for close partnership working. There was wide variance among the 29 pilot sites in the extent to which such relationships were embedded prior to the development of the POPP programme. Overall, it was found that POPP programme greatly strengthened partnership working in the majority of pilot sites. However, even where good partnership working existed beforehand, an investment of time and effort was necessary to build and maintain those relationships, often greater than initially expected.

Difficulties arose within some social and health care partnerships as a consequence of the PCT reconfiguration in October 2006, and the serious financial constraints that some were experiencing. Uncertainty amongst PCT managers about their future roles and subsequent personnel changes was sometimes reflected in poor attendance at multi-agency and steering group meetings. However, where objectives were shared by the partners and commitment was strong at both an executive and operational level, the difficulties were addressed and eventually overcome. It should also be noted that there was significantly less impact from the reconfiguration on Round 2 sites, which initiated their pilots shortly after it had taken place.

The partnerships that appear to have been most strengthened during the POPP programmes were those between local authorities and voluntary and community organisations (VCOs). Two thirds of partner organisations across the pilot sites were VCOs, ranging from national charities such as Age Concern and the Alzheimer's Society, to very local community and older people's groups. Many sites focused their POPP programmes on developing capacity within the voluntary sector, and a wide range of such groups were commissioned to provide services. Within the concept of partnership, there is the presumption of a degree of equality of influence upon decision-making. While there appeared to be fairly equal relations between the statutory social and health care agencies, it was less evidently so between those organisations and VCOs. Nevertheless, the disparity of power was not seemingly perceived by VCOs as an obstacle to effective partnership, and some degree of inequality was accepted by most of those involved. What was more important from the perspective of the VCOs was that there should be transparency around decision-making processes, and that their views, concerns and suggestions be taken seriously by statutory commissioners. Difficulties arose from these unequal partnerships only where commissioning bodies were perceived as inflexible and

domineering. Moreover, the domineering attitude of some agencies may have been mainly unconscious, and with negotiation and compromise could be altered to the benefit of all parties.

Secondary health care trusts were more likely to be partners in POPP programmes if the projects that comprised them addressed higher 'downstream' levels of need, which involved hospital in-reach, discharge teams or intermediate care. One third of POPP projects were categorised as Hospital Facing, rather than Community Facing, and across the 29 sites, 61 acute and community health trusts were partners. Where secondary trusts were involved with POPP programmes, the collaboration between them and other agencies appeared to be strengthened. Nevertheless, there remains an apparent conflict of interests between social care services and the PCTs as commissioners of acute care, and the secondary sector as providers. While a principal aim of POPP programmes was a reduction in emergency bed days, this aim ran counter to the interests of managers within the acute sector. Such a dichotomy of interests remains fundamental to the commissioning/provider split within health and social care.

9.2.3 Involvement of older people

Underpinning the main aims of the POPP programme was the demand that older people be involved within the structure and process of the POPP pilot sites from design to dissemination. To help with the analysis of such involvement, the NE Team categorised it into five types: the design of services; the recruitment of POPP staff to manage and deliver services; project governance; service delivery as volunteers; and the evaluation of services. Overall, the involvement of older people across the POPP initiative was mixed, although this may be understandable. The pilot sites were working under tight timescales to deliver evidence as to the effectiveness (or otherwise) of the interventions. Ensuring that older people outside the structure of innovative services can have a real voice inevitably takes time (Hogg 1999, Beresford 2005), which was not always available to the sites if they were to meet necessary external targets. Nevertheless, most sites made genuine efforts to go beyond tokenism and to fully involve older people, not simply to 'tick a box', but in recognition that such involvement could bring real benefits to the innovative services being provided. Similarly, many sites were honest enough to admit that they had found it a struggle to appropriately engage and 'hand over power' to older people. A number stated that the starting point of any discussions had been limited by internal and external constraints, for example the LA strategy, the need for appropriate criminal record checks, the tight time-frame of the POPP programme and so forth.

The area with most reported involvement from older people was programme or project governance. All but two pilot sites had involvement at this level. Very often, a steering group was created to oversee the overall programme within a pilot site, with a number of local older people invited to join it. The invitees often had previous experience within VCOs or of working as representatives of older people on similar local authority initiatives. They were often personally invited by local project management staff or invitations were sent to established local older people's groups, who would then nominate a representative. There was, therefore, a sense in which the 'usual suspects' were drawn into the POPP governance process, which can lend a sense of exclusivity to such involvement.

There were also high levels of involvement of older people reported in the design and evaluation of POPP services. Nevertheless, there may have been some over-reporting of involvement in these categories, and there was sometimes a perception among the sites that older people had been involved if a voluntary organisation *representing the interests of older people* had been included. Thus, to avoid a simple stratification, the forms of involvement were further analysed to indicate increasingly degrees of involvement within these areas. For example, older people's involvement in the design of POPP programmes was used to mean that they had some form of decision-making role in determining the type and focus of projects to be included. To that end, almost one third (31%, n=49) of project sites carried out a public consultation exercise; more than a quarter (26%, n=41)

used existing older people's forums and advisory groups; and almost a quarter (23%, n=36) set up specific POPP advisory or reference groups. Specific advisory groups were themselves constituted from representatives from existing forums, which, as noted above, might be perceived as exclusive. But where undertaken well, public consultations can draw on a wide range of views across the local older population, and include individuals who are have not taken part in the committee process. On the other hand, consultations can sometimes be shaped by the priorities of the agencies that set them up, and participants have no guarantee that any notice will be taken of what they say (Carter & Beresford 2000). By the time the National Evaluation had been set up, such consultations had almost all already taken place, which meant it was difficult to assess the level of openness involved.

The involvement of older people in evaluating POPP projects seemed to be toward the passive end of the continuum. Most reported forms of involvement comprised evaluation reference groups, which provided feedback on evaluative tools, such as questionnaires, or the layout of information leaflets and service user feedback. These forms of involvement could include involving older people as research subjects. Indeed, 16% (n=25) of the projects, within eight pilot sites, provided training to prepare older people as peer evaluators. Older evaluators usually did not evaluate all the projects comprising a site's programme, but such user involvement nevertheless represents a high level of participation and empowerment for older people (Poulton 1997). More than a third (36%, n=53) of projects had older people involved in the recruitment process of POPP staff, and ten pilot sites reportedly had older people included on recruitment panels for programme managers and management staff, with older people in at least one site involved with the recruitment of the local evaluation team. Again, such involvement indicates a high degree of real inclusion within decision-making processes.

Finally, a little less than one third (29%, n=42) of projects were partially provided by older volunteers. Older people who volunteer to help to provide services and activities, such as well-being cafes, active living centres and so on, tend to vary in their interests, depending on the level of commitment and the nature of the involvement. Many will be willing to be involved in an informal and ad hoc way, but fewer are prepared to go through any formal recruitment process with large national VCOs or local councils. In this case, such people were found to be motivated by several aims. Many were personally committed to improving the circumstances in which older people live or, more generally, wished to do something for others in their community. For others, it provided a great deal of satisfaction to be constructively involved with organising and networking in their community. While there may be numerous older people willing to provide a little help towards services, it is much more difficult to recruit older volunteers to the co-ordinating roles required by many preventive services, involving greater long-term commitment and greater responsibility in the day-to-day running of services. Such roles were often perceived by older volunteers as 'unpaid jobs'. Recruitment of older people was also necessarily found to be an ongoing process, because older volunteers could experience increasing or sudden periods of ill health and periods when they lacked motivation, and as they age they could find themselves able to do less. Sufficient resources are therefore necessary to facilitate this ongoing recruitment.

The older people involved within the POPP programmes were not a homogenous group. Rather, there appeared to be certain types of individuals that sought different types of involvement, although within all roles they were usually the 'younger' old and more physically fit. Those involved in POPP governance bodies and undertaking co-ordinating roles within service delivery tended to be confident and articulate, and often well-educated and recently retired professionals. This has some advantages for projects in securing input from people who are familiar with the issues and operating cultures. Similarly, such 'experts' are able to negotiate the very real barrier to involvement: the committee structures.

There was relatively little difference in the involvement of older people between services that addressed Needs Levels 1 and 2, but there was markedly less involvement within projects targeting Level 3 needs. The levels of involvement in personnel recruitment and service delivery were also much lower within services addressing Level 3 needs. This finding is unsurprising, given the higher level of expertise required from staff to deliver these services. There was also a greater degree of involvement in all five categories within Round 2 sites than in Round 1 sites, which may be explained by the fact that there were more projects in the latter addressing higher, or tertiary prevention, needs. Nevertheless, there was no simple divide between levels of involvement and the needs levels addressed within projects. Even among those sites that aimed at 'upstream' interventions, there was a minority that found it difficult to engage with older people and to find meaningful roles for them within their POPP programmes.

The number of older people recruited to be involved in one way or another varied between sites and even between localities within sites. Unsurprisingly, areas with a low number of community voluntary groups found recruiting older people more difficult, while areas with established networks of such local groups found it less so. It must be recognised that many older people who would be willing to volunteer are also carers for partners who may be physically infirm or suffering from mental health problems. Older people willing to become involved with projects, such as those developed within POPP, tend to be very active individuals, often with a number of interests and volunteering responsibilities elsewhere. The incentive for them to continue being involved with the POPP projects in their areas must therefore be maintained by project staff. If volunteers do not perceive their time and effort to be valued, they may cease to participate.

There are several practical considerations regarding older volunteers, and the degree to which they were addressed was often reflected in a site's ability to retain them. First, consideration must be given to the timing of meetings, because older people are often reluctant to go out after dark, both due to safety concerns and because they may tire more easily. Secondly, if volunteering and involvement within projects require a lot of bureaucracy, paperwork and administrative commitments, it seems that older people will be less inclined to become and remain involved. Thirdly, transport was a recurring issue within all POPP pilot site programmes. Older people are less likely to own a car or to drive, so either the provision of transport is necessary, which may be costly, or consideration should be given to ensure that venues are easily accessible through public transport, and at times when public transport is available. There have also been difficulties in many sites with recruitment of older volunteers from BME communities, either to governance roles or for the delivery of services. One particular issue has been with securing CRB checks on volunteers.

The involvement of older people within many pilot sites helped to bring about a 'culture change' amongst older people in the community. The notion that older people are necessarily passive recipients of social and health care services was replaced with recognition that they had the capacity to be involved with their direction and delivery. This is especially the case in site programmes that aimed to build sustainable local communities supported by stronger networks of VCOs. Where older people were directly involved with the design and implementation of POPP projects, their involvement and influence 'snow-balled', as their role became progressively more embedded. Moreover, all pilot sites reported a commitment to continuing and building on the engagement of older people developed within their POPP programmes. The experience and learning from the programmes will reportedly be used to further deepen and broaden the involvement of local older people. There has been an expressed intention to include a broader population of individuals and to devise alternative ways in which older people can feed their views into the policy process.

9.3 Outcome issues

9.3.1 Improving quality of life – for whom?

From data drawn from the strategic and operational staff in the POPP interventions, users of POPP services and users of non-POPP services, it was demonstrated that service users benefited in some way from the POPP interventions.

Pilot sites argued that their local programme had made a wider range of services available to older people, facilitating choice and access, and that older people were more aware of such availability. It could be argued that with £2,051,877 (the average grant provided to POPP sites), any site should be able to provide a wider range of services. Nevertheless, the POPP sites seemed to demonstrate far more fundamental developments in the profile of their services, in changes in attitude regarding how such services should be delivered and in their attitudes to older people themselves. Many sites argued that POPP had for the first time put older people's needs to the top of the agenda:
'I think what has really been a success - and in years to come we'll realise that even more - is the way it's helped to push older people up the agenda, right across the council, right across the borough, right across a whole range of agencies and it's been done in such a way that there is now very much a positive view around what it is to be older in [locality]' (Exit Interview; Project Manager)

This cultural change was facilitated by the national profile of the programme and its very strong requirement to deliver outcomes. We have argued that such external demands were in part a 'double-edged sword', putting delivery pressures on sites when time taken to involve older people further, for example, might have been more valuable. Nevertheless, without such external demands to demonstrate changes in quality of life, cost reductions and sustainability, the incentives to ensure success might not have been so apparent or influential across so many organisational boundaries. Similarly, the cultural understanding that older people's services should include prevention, personalisation and be driven by users themselves might not have begun to be embedded so widely.

Interviews were held with users of POPP services and non-POPP services, exploring their satisfaction levels as to service use, opportunities around choice, timeliness of delivery and impact on their quality of life. The difficulty in separating out any 'value-added' nature of POPP is that users perceived that they were simply receiving a service. They did not distinguish between POPP 'branded' services and those received within 'usual care'. All users reported that services were helpful, but there were some slight differences with POPP services, which were reported as providing more time to discuss difficulties and problems and leaving less unmet need. Slightly more users in the POPP sample also reported feeling 'listened to'. However, there were few POPP services which users were able to distinguish clearlyfrom 'usual care'.

The 'value added' by the POPP projects was demonstrated by the analysis of user responses to the standardised questionnaire, although it must be stressed that any findings cannot be extrapolated to the full POPP programme, given the differences in sample. Nevertheless, not only did users report that their health related quality of life was maintained (a success in itself, given the high levels of frailty and need), but they reported a 3% to 12% improvement in nine of the eleven project categories. When measured against the quasi-control group, users of POPP services showed far higher improvements in health related quality of life. However, any recommendations around roll-out and extrapolation of such findings are affected by the huge number of projects that were developed across the POPP programme. Sites were not tasked to 'test' specific models of preventive services. Rather, the choice was left to local partnerships and the resulting programme consisted of 146 core projects and 530 VSO-led 'upstream' services. This wide range, together with the lack of any local control group, meant that the variance could only be controlled by coding and categorising the projects in different ways, based on the development of key criteria (e.g. staffing levels, line-

management organisation, objectives, written outcomes etc). Such higher level analysis does, to a certain extent, 'hide' the very real differences in success. We cannot say, for example, that an 85 year old woman with mobility problems would report a 5% increase in her health related quality of life if she were provided with an eight-week home-based exercise programme. To fully identify those projects that did improve quality of life, it would be necessary to analyse each project at a micro-level. For example, there were indications (reported above) that the type of structure (multi-disciplinary, co-located) and the type of staff involved improved the health related quality of life for users.

We have reported here the effects of both more and less successful outcomes at an aggregated level. However, instead of seeking to smooth out the variances (the 'synergy' of data being the core brief of any national evaluation team), there is also a need to treat these variances as a finding from the evaluation. In short, further analysis needs to be undertaken at the micro-project level to understand more fully how and if such variations have an impact on users' reported quality of life. Since the aggregated data show positive changes in health related quality of life, even higher outcomes could be expected if investment were to be focused on the more successful services.

9.3.2 Overarching cost-effectiveness

We 'measured' outcomes in four areas: the cost per user; the difference between POPP pilot sites and those areas without a POPP programme in the use and consequent cost of emergency beds; whether the health-related quality of life benefits to users seemingly provided by the projects were being delivered in a cost-effective way; and whether there was a change in the type and extent of services used by individuals before and after the POPP projects. The findings demonstrated that a £1 investment in POPP services would produce more than a £1 saving in emergency bed-days, that there was a high probability that the overarching POPP programme was cost-effective if compared with usual care, and that there were demonstrable savings from the changes in service use in secondary and primary care, amounting to £2,166 per person.

As a programme set up to pilot innovations in prevention, POPP was necessarily implementing untested projects. That it has demonstrated that such projects can significantly reduce demand on secondary care services is, itself, a success. It has also provided the learning and confidence across 29 local authorities that such services, appropriately funded and project-managed, are capable of changing the pattern of demand. However, the question remains as to whether a wider roll-out would be justified and, perhaps even more importantly, how such a roll out should be targeted. In addressing such questions, two important issues are the extent and type of future investment. The first addresses 'economies of scale': the optimum number of users to achieve the optimum user and cost benefits. From the analysis of emergency bed-days, there was some indication that as the Community Facing projects took on more service users , they demonstrated higher savings, whilst conversely Hospital Facing projects demonstrated immediate effect, but a reduction in impact across the longer term. What this evaluation cannot answer is the optimum number of individuals within any project – the 'tipping point' at which economies of scale are optimised. In studying project activities, we were limited to what the pilot sites would report and, despite strong encouragement, the data were not always accurate, nor provided by all projects. Similarly, as the Community Facing projects became mainstreamed (and higher numbers of users potentially came forward), the pilot sites no longer had the infrastructure in place to provide the necessary activity returns. The necessary focus of the evaluation on higher level 'synergy', rather than project-level (micro) analysis, limits how far we can answer the question as to how many users in which projects would produce the most optimum outcomes.

The limitations of such aggregate data similarly affect how far it is possible to identify which services justify further investment (and in which combinations). For example, funding concentrated on

substituting lower level prevention services for the categories of higher level services (secondary and tertiary prevention) may provide greater financial savings. Funding services to promote Well-being – practical, Well-being - physical health, Information and Signposting – will provide better outcomes in terms of health-related quality of life compared to higher level services, but will provide fewer immediate cost reductions. (Indeed, a longitudinal study would be needed to demonstrate the longer-term impact on demand of such lower level services). The evaluation did not find any of the lower level projects to be affecting emergency bed-days, although there was evidence suggesting that they were associated with reducing demand for secondary care clinic and outpatient appointments. However, these findings do not explain the greater success in some projects than others. For example, if we explore the category of Well-being physical health, one of the projects had a far greater effect (by over a third) on health-related quality of life than others, but the National Evaluation did not have the data to judge whether this was achieved at less cost and for the optimum number of individuals.

We would therefore argue that the question for policy makers is not whether the same level of benefit could be derived from replicating the POPP programme, but whether even greater value might be obtained from a similar sized programme targeted on service users whose needs have a good fit with the characteristics of the services offered.

9.3.3 Sustainability

Particular contextual preconditions need to be in place nationally and locally to facilitate sustainability. These conditions include national and local strategic priorities, the structure of the local social and health care economy and the commitment of local stakeholders. Such contexts were rarely static over the lifetime of POPP.

From the beginning, both the DH and pilot sites had expected to sustain those POPP services that proved to be effective and cost-effective. However, in many of the sites, local evaluators found that the two-year period was insufficient to provide robust evidence that projects, particularly 'upstream' services, led to reduced use of more intensive social and health care services, or that any local reduction in emergency bed days was the result of the POPP projects. It has therefore been necessary for local commissioners and strategic managers to recognise that such projects take time to 'bed in' and accept that their impact may be long term. An ongoing engagement between the POPP project managers and commissioners usually facilitated a better understanding in this respect. However, some sites had written agreements into their original project plans specifying their respective responsibilities for sustaining specific projects after the pilot stage.

The local context often changed within pilot sites as a consequence of organisational restructuring. The PCT reconfiguration of 2006 led to a lack of PCT engagement in some pilot sites, so delaying the development of their POPP programmes, and this often presented challenges to the sustainability process. In contrast, where pilot sites underwent structural reorganisations of adult social care services during the pilot stage of POPP, this often facilitated sustainability as it allowed POPP objectives to be written into the new organisations' strategic frameworks.

Local Area Agreements (LAAs) were found to be a particularly important mechanism for the sustainability of projects. If the objectives and output targets of the POPP projects were aligned with those of the LAA, the rationale for their continued funding was apparent. Indeed, an important facilitating factor for ensuring the sustainability of any projects was their links with other national and wider local strategic priorities within social and health care. If pilot projects were viewed by commissioners as not advancing core aims, there was often less emphasis on project managers and local evaluations generating robust evidence of effectiveness at their pilot stage. Examples of relevant national priorities are the National Dementia Strategy, the National Carers Strategy and

Supporting People. However, another apparently relevant national initiative - practice based commissioning (PBC) – had little impact on sustainability and remained underdeveloped.

The transformation agenda for social care closely mirrors the focus of POPP and was found to be greatly influential on decision-making about sustaining projects, in part because managers and commissioners could see a good fit between POPP projects and national expectations of the social care sector. The ring-fenced Social Care Reform Grant (SCRG) was also influential: eight sites acknowledged that it had been used in part to sustain POPP projects. However, many social care managers were reluctant to use SCRG this way. First, they hoped that POPP projects could be sustained, as had been the original intention, by mainstream funding, generated by service redesigns and/or changes in service use by older people. The SCRG could then be used to further develop early prevention services in the area. A second reason for reluctance to use the SCRG to sustain POPP was that, very often, it was perceived that any savings achieved by the programme were mainly realised within the primary health sector. Social care managers often did not wish to see what they perceived as a social care grant being spent to save money for the PCT.

While quantifiable savings were achieved within most sites, moving those monies around the local social and health care economies, specifically between agencies, was found to be very difficult. It was possible to transfer savings from one part of an organisation's budget to another, but rarely between the budgets of partner organisations. There were, for example, transfers of monies from residential care to preventive services within social care, but more rarely from PCTs to social care agencies or vice versa. Where such inter-agency transfers did take place, they were generally the result of prior agreements at senior level. Nevertheless, PCTs were involved with the ongoing funding of POPP projects within all pilot sites, and are providing at least half the necessary ongoing funding for 35% (n=51) of projects.

The most difficult movement of monies appeared to be their transfer from the secondary sector back to primary or social care agencies. Many pilot sites had expected to be in a position to sustain preventive projects, developed in partnership between social and primary health care agencies, by transferring to them some of the savings from reducing emergency bed days. The overwhelming message from interviews with key informants was, however, that such system-level transfers had not been possible.

There were also wider relationships, beyond the local statutory and non-statutory partners, that sites could utilise to secure future funding, just as there had been for the initial project development. The DH project management team and the regional CSIP leads encouraged pilot sites to reflect on their sustainability plans early on during the initiative, both in their quarterly reporting requirements and within the PLENs. A *Dragons Den* exercise towards the end of the programme was universally praised by project managers as an effective way to prepare them for negotiations with commissioners. Moreover, the meetings arranged between the DH project management team, social services and PCT executive managers were reportedly decisive in some sites.

Local councillors and other elected leaders played an important role in raising the profile of POPP locally through their links with the wider public, and lobbied effectively for it within various committees and joint partnership boards. Older people were also effectively engaged in the sustainability process, often as part of the local evaluations that were taking place. Service user and citizen involvement can potentially be a strong driver for change once established. Allowing older people themselves to convey the potential benefits of popular services to commissioners provided greater weight to the case for sustainability.

Final decisions about sustainability were often delayed until late into the funding period, even though mainstream funding would almost certainly be forthcoming. This is unsurprising in an environment of financial constraints and many competing funding demands. Nevertheless, the trust that had been built within many sites between the statutory agencies and networks of both older people's groups and VCOs was to some extent put under stress by a period of uncertainty. Project managers within several pilot sites reported that allaying the fears of these groups, as well as those of operational staff on fixed-term contracts, had been one of their most demanding tasks during the final months of the pilot.

Projects have been sustained in a number of different ways. Although projects had sat together within a POPP programme, they were often separated and mainstreamed under different funding channels, often with changes in personnel, staff mix and staffing levels. Such projects were likely to lose their POPP identity quickly. The overwhelming majority of pilot projects secured funding beyond the pilot stage in one form or another, and very few were discontinued as a result of not having achieved the desired outcomes. Moreover, as noted above, there was a high degree of involvement from PCTs in the future funding of POPP projects, with a fifth of the projects being wholly financed by them. This is a testament both to the strength of the POPP partnerships between the local social service and PCT partners, and to the effectiveness of the projects themselves. Nevertheless, it should be noted that future funding decisions will be determined annually and will be subject to national and local strategic priorities of the time and competing funding demands.

9.4 Recommendations for policy and practice

9.4.1 Lessons from the study for future policy research

Throughout the course of this study, as noted above, the National Evaluation Team (NET) have had to address several important challenges: a changing emphasis on the part of the DH concerning the type of evidence they required of the evaluation; problems of ensuring consistency of standardised data across the varied programmes of 29 pilot sites; and a high level of negotiation necessarily undertaken by the NET with pilot site project management and local evaluation teams. These difficulties were exacerbated by the short term nature of the initiative, which has had several ambitious aims. Together these challenges required the POPP evaluation design, including the research questions, to necessarily remain very flexible and adaptive. However, there are several key lessons that can be drawn from the experience of the POPP NET for future evaluations.

Firstly, the terms of the POPP evaluation were similar to several other large scale national evaluations of policy programmes, which have been instigated by national government in recent years, in that the evaluation teams started work after the initiative was already underway (Barnes et al. 2005; ODPM 2003; Sullivan et al. 2002). Nevertheless, to ensure the eventual evidence is optimally robust, it is necessary that the design of the research protocol and research questions are agreed between the national evaluators, the commissioners and the local project management teams at the very start of the programme. This means involving the national evaluation team at an earlier stage than has been recent custom, perhaps at the point of the development of the policy initiative itself. Appropriate data sets can then be developed early on, including the types of standardised data to be collected and collection methods, and these can then be agreed upon across the programmes. Such early agreements should greatly reduce the levels of missing data. Moreover, once research questions have been agreed, and methodologies designed to address them, these should then be maintained over the course of the project where possible.

Secondly, the innovative and iterative nature of the POPP initiative meant a high degree of variance between the pilot sites in terms of project designs, target populations and numbers of users able to access the new POPP services. In such circumstances it must be recognised by commissioners that

there may be great variance between the sites being evaluated, and that this may reduce the generalisability of findings. Thirdly, as with some previous national evaluations, there were rigid time constraints imposed on sites and the evaluation, which meant that processes evolved rapidly during the course of the evaluation (Glendinning 2008). This increases variance between sites, but also introduces the possibility that some outcomes may reflect early implementation experiences within pilot sites that lead to outliers within data sets, and these experiences would not necessarily be replicated in a mature roll out of particular interventions. Finally, given the innovation and variance inherent within such an initiative, it should be accepted by commissioners that it may not be possible for perfect evidence to be produced that incontrovertibly proves its effectiveness, or that failure to produce such data necessarily detracts from the robustness of the evaluation. It must be understood that research in the real world will sometimes produce 'messy' and ambiguous results.

9.4.2 Achieving desired outcomes

The POPP programme, set up to test preventive approaches, demonstrated that prevention and early intervention can 'work' for older people. Local authority-led partnerships, working within context of the Local Strategic Partnership and Local Area Agreements, can help to reduce demand on secondary services, providing they are appropriately funded and performance managed. Moreover, it has shown that small services providing practical help and emotional support to older people can significantly affect their health and well-being, alongside more sizeable services expressly directed to avoiding their need for hospital. Most of the older people using POPP services had relatively high levels of need, but they nonetheless experienced improved outcomes and reported greater satisfaction than the comparison group, as a result of using these services.

Indeed, it is possible that the evaluation results understate the benefits which can potentially be derived from such a programme. The POPP projects were, by definition, largely untested and some were necessarily more effective than others. If those seeking to introduce similar programmes were to focus on those projects found to be most effective and those older people found most likely to benefit from them, the returns from similar levels of investment are likely to be greater. Moreover, the POPP projects took time both to bed in and to become embedded within local health and social care systems. It is possible that even greater value could be secured over the longer term, as new projects learn from their experience, and general expertise and confidence grow.

These gains were secured by pump-priming prevention and early intervention projects. Their cost-effectiveness gains cannot be fully realised unless cashable savings can be released and re-invested in such projects. Initially, only marginal savings may be identified. The majority of sites reported that any direct transfer of monies from secondary to primary health and social care had not been a possibility. Some degree of financial systems reform is likely to be necessary to support the decommissioning of services in one part of the health and local government system alongside the re-investment of resources elsewhere.

From the results of this evaluation, it can be argued that the approach piloted by the POPP programme should be sustained, using the programme's learning to target investment to maximise individual and systems benefits. The realisation of the cost-effectiveness gains will depend, however, on the introduction of systems to support decommissioning and reinvestment.

9.4.3 Improving processes and management arrangements

Complex new programmes are inherently challenging to get off the ground, especially where they involve a range of agencies. Because it can be difficult to anticipate the particular problems likely to arise, time and resources for the implementation period should be built in from the start. It needs to be recognised – by both commissioners and programme managers alike – that recruitment, training

and staff preparation are likely to take at least six months, and local project managers should be in place to ensure appropriate implementation.

It should be expected that both project structures and processes will, quite rightly, evolve over time. Such changes will need to be mirrored by changes in project targets and monitoring tools. Good staff supervision should be ensured to support staff through such changes.

Multi-disciplinary projects benefit from locating staff from different agencies and professions in one place, rather than seeking to develop a 'virtual' team, as well as from single line management. Co-located teams enable people to work more effectively together and achieve better outcomes, although they do not function without difficulties.

Where large programmes involve tendering for projects, attention should be given to the development of flexible commissioning processes appropriate to the scale of the exercise. Tendering must be arranged to ensure an equitable process, particularly where small voluntary organisations are involved. Support and assistance with capacity-building should be available early on, together with clear information concerning requirements for monitoring and targets.

Where there is to be a programme evaluation, project leads should work with all stakeholders (providers, commissioners, programme clients) to think through their desired outcomes from the programme, rather than simple outputs. These outcomes should be used to develop a framework for evaluation, prior to commissioning external evaluators. Monitoring and measurement should then be embedded in any project-recording systems prior to the start of any project. Base-line measurements must be established early on.

Involving consumers effectively in the design and direction of programmes is known to be difficult and may be particularly problematic in the case of older people. Time and resources to assist this process must be built into the implementation programme, including provision for appropriate training and the establishment of systems for such practical issues as payment arrangements and transport. There also needs to be a balance of understanding between the necessary 'safe-guarding' procedures (through Criminal Records Bureau checks) and the level of support older people are providing. Management of risk may need to be undertaken and underwritten across the authority if the contribution of volunteers and representatives is to be optimised.

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