The National Evaluation of Partnerships for Older People Projects: 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 an £0.80 to £1.60 saving on emergency bed days for every extra £1 spent on the projects

- Overnight hospital stays were 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 ten 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 at improving health and well-being among older people and reducing social exclusion and isolation. The individual projects were determined according to local priorities. Of the 146 projects, two-thirds were primarily directed at 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, including 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

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older people, working as volunteers, made a significant contribution to the projects

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

over a quarter of a million people used the services of POPP projects over three years

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.

two-thirds of service users were aged 75 and over

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

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

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 was 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 on to 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' 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 found in nine 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 by needs levels and 'community-facing' and 'hospital-facing'. People using community-facing services 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.

POPP services 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 services also had an impact.

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a 12% increase in health-related quality of life was found for those individuals receiving practical help

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, while 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.

> older people using POPP programmes reported increased receipt of state benefits

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 told us the sort of services they wanted the money invested in – and that affected what we spent the money on. The real test to me of engagement is that you have to affect one of the two important things: what you do or what you spend your money on…The involvement of older people in the programme has affected both things directly.'* (Project manager, local pilot site)

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 a POPP programme as a comparison. It was found that POPP projects appeared to have a significant effect on emergency bed days, and this has stabilised 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 overhead 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 the 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 ten 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 ten 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

> within the context of this research, POPP projects can be recommended as a cost-effective policy option

overnight hospital stays reduced by 47% and use of A&E Departments by 29%. There were also fewer physiotherapy/occupational therapy and clinic or outpatient appointments, with a cost reduction of £2166 per person.

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 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 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.

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

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.

> the overwhelming majority of the POPP projects have been sustained, with only 3% closing – either because they did not deliver the intended outcomes or because local strategic priorities 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.

> 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 being entirely sustained through PCT funding. There are a further 14% of projects for which PCTs are providing at least half of the necessary ongoing funding.

Key factors in bringing about continued enthusiasm and funding were the involvement of local councillors and older people as representatives, which raised 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.

older people with high levels of need experienced improved outcomes

if cashable savings are to be released some degree of financial systems reform is likely to be necessary

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. Baseline 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.

FURTHER INFORMATION

The evaluation of the Partnerships for Older People Projects was funded by the Policy Research Programme at the Department of Health. The findings presented and views expressed in this report are those of the researchers and not necessarily those of the Department of Health or any other government department.

Summary and full reports of the evaluation can be downloaded from the PSSRU website, www.pssru.ac.uk.

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