Blended evaluation of Phase 2 of the Personalised Integrated Care Programme

Summary report

7th March 2018

About this report

Age UK has adopted a whole-programme, mixed-method approach to evaluating Phase 2, focussing on evaluating the PICP against key outcomes, including formative evaluation and quantitative and qualitative evaluation of the programme's impact.

This report provides an overview of the findings from an independent blended evaluation of Phase 2 undertaken by Yvonne Fullwood (Understanding Value Ltd). The evaluation draws on multiple evaluative evidence sources and performance-management information captured up until the end of September 2017. Full details of the evaluation approach and limitations of the findings are presented in the full evaluation report.

This summary report has been prepared by Yvonne Fullwood.

Acknowledgements
Many people have been involved in capturing and analysing performance and evaluative evidence throughout Phase 2 of the PICP – without their efforts, the blended evaluation would not have been possible. In particular, the author would like to acknowledge the significant contribution that the local Age UKs and older people involved in the programme have made to creating the evidence base, and the time given by local stakeholders (including older people) to participate in evaluation research. Jo-Anna Holmes, Alexander Nobes, Sian Brookes and Phil Hope have provided critical friendship and/or review and comment through various stages of the evaluation, for which the author is grateful. Finally, the author would like to thank Joanne Clay for editing this report.

Key findings (1)

- While the breadth and scale of impact has varied across the sites, the findings provide evidence that Phase 2 of Age UK's Personalised Integrated Care Programme (PICP) has had a proven significant and enduring positive impact on the wellbeing of the older people involved.
- Although not quantified, the support provided by the Personal Independence Coordinators (PICs) has released time from primary care and improved the quality, coordination of and timely access to care. It has also helped to shift conversations away from a purely medical model of care.
- The support provided through the PICs has been effective in answering previously unmet need by filling a gap in existing statutory primary, community and social services. The combined proactive and reactive approach to case finding has also uncovered and responded to unidentified need, supporting 'right care, right place, right time'.
- Whether the programme has been effective in reducing hospital admissions has yet to be confirmed; despite promising early results from two sites, the Nuffield Trust's programme-level evaluation involving a matched control group will need to be taken into consideration. The findings from this evaluation highlight multiple factors likely to influence the PICP's impact on acute care.
- Beyond the Triple Aim, the Age UK Personalised Integrated Care model has:
  - Enabled personalised care for older people – in particular, personalised care and support planning; and
  - Connected people and services in the community through holistic social prescribing – thereby promoting the integration of statutory and non-statutory services and harnessing community assets to improve older peoples' wellbeing.

The findings highlight how the PICP intervention extends beyond 'signposting and care navigation'. While these are important, it is the combination of the shared care planning focused on what's important to the older person, ongoing care coordination and support, and multi-disciplinary working involving the PICs that has been critical to achieving the benefits experienced by older people and primary care.

In particular, the approach to shared, personalised care planning and ongoing support has helped older people regain a sense of control and purpose. In addition, it has boosted their confidence and motivation to not only bring about change to improve their wellbeing but, for many, to also sustain the change they have created.

Key findings (2)

- The service has continued in various forms across all Phase 2 sites. While the journey from the pilot to a commissioned service has varied, at the time of writing, seven of sites have been commissioned to deliver the service in various forms either by the local authority or CCG.
- For all sites, the legacy of their involvement in Phase 2 of the PICP is, on balance, a positive one. For most sites, participation has helped to establish the relationships, skills, knowledge and experience required to design, implement and deliver collaborative approaches to integrated, person-centred care involving the voluntary and community sector (VCS).
- Finally, the Phase 2 pilots have generated transferable learning and insights about how the model works on the ground, including, for example: lessons learned about risk stratification; creating demand; MDT working involving the VCS; involving volunteers; connecting people to community assets; and the time required to stabilise the delivery of new interventions.
- More generally, the learning about delivery of the model and its impact will be of value to other health and care systems as they develop and implement holistic and personalised preventive care models involving the VCS.
- In conclusion, while it is too early to confirm whether the programme has been successful in achieving the Triple Aim impact, the findings from the interim blended evaluation suggest that Phase 2 of Age UK's PICP has generated significant value at a local and national level.

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01 Introduction

Introduction

In 2011 Age UK commenced its ambitious Personalised Integrated Care Programme (PICP), developing an innovative model of person-centred care for older people with multiple long-term conditions who are at the greatest risk of avoidable hospital admissions (see page 2 for PICP model).

Age UK's PICP has adopted a phased approach, evolving iteratively over time in response to learning on the ground and the changing local and national context.

Following the success of the pathfinder in Cornwall, Phase 2 of the programme began in 2015 and involved piloting the model with eight local health and care partnerships across England. The aim of Phase 2 was to test the model in different local contexts to learn key lessons about successfully delivering its core elements.

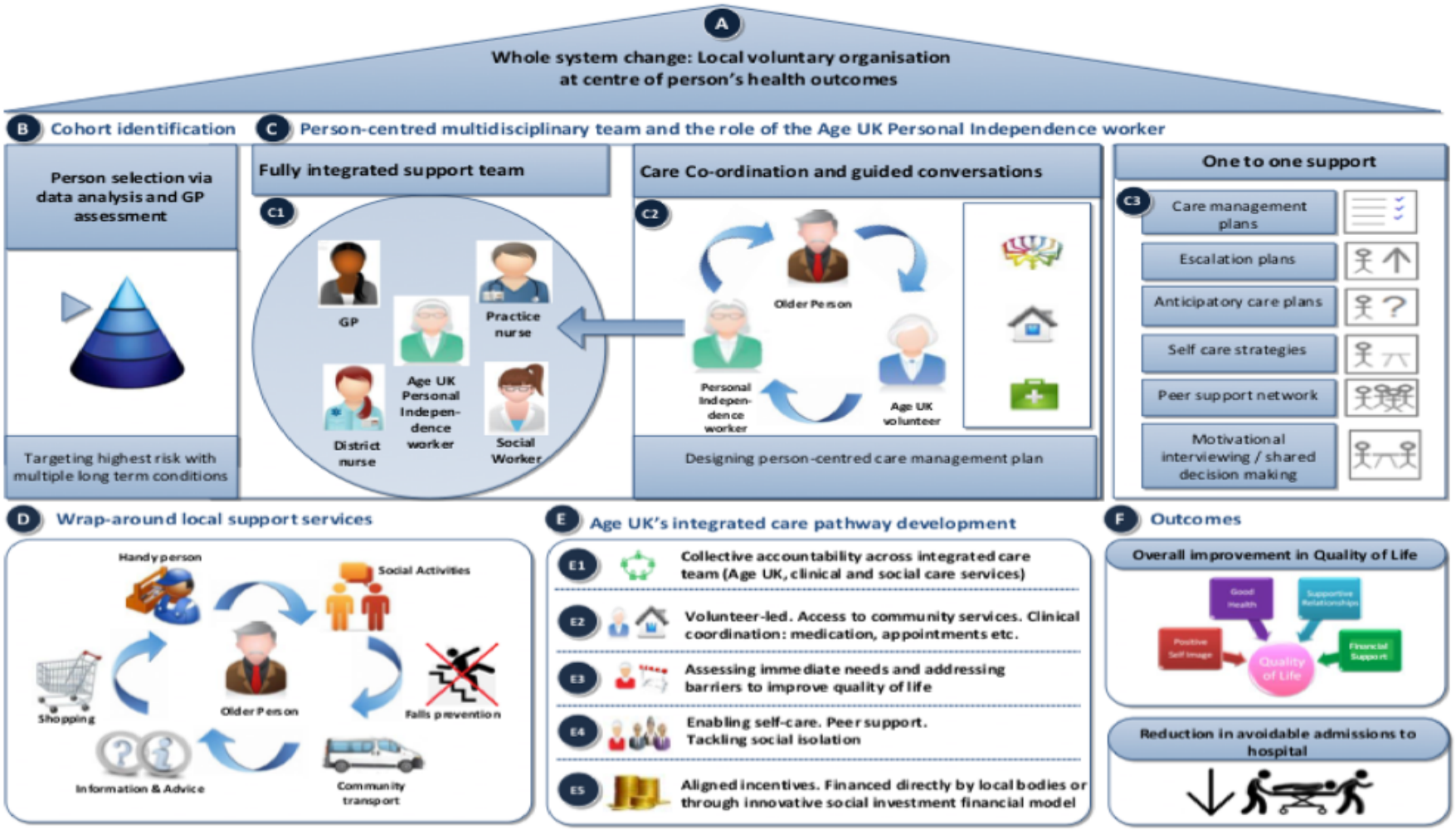
In 2017, Phase 3 of the programme commenced and has involved rolling out the model across five additional local health and care partnerships (Croydon, Northamptonshire, North Kent, South Gloucestershire and South Kent).

The vision and Triple Aim for the Age UK Personalised Integrated Care Programme

Phase 2 local health and care partnerships and delivery models

Site	Delivery model
Ashford and Canterbury; Blackburn with Darwen; East Lancashire; Guildford and Waverly; Portsmouth, Sheffield	Through individual GP practices within the locality
North Tyneside; Redbridge, Barking and Havering	Integrated within an Accountable Care Organisation context

The Age UK Personalised Integrated Care model



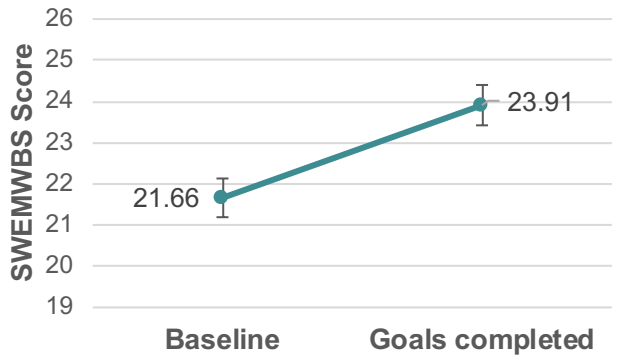
02

The outcomes: What difference has Phase 2 of the PICP made?

Improving older people's wellbeing

A statistically significant improvement in older people's mental wellbeing is observed following involvement in the programme*, with a 10% increase in the sample mean SWEMWBS score from guided conversation to completion of goals (Figure 1).

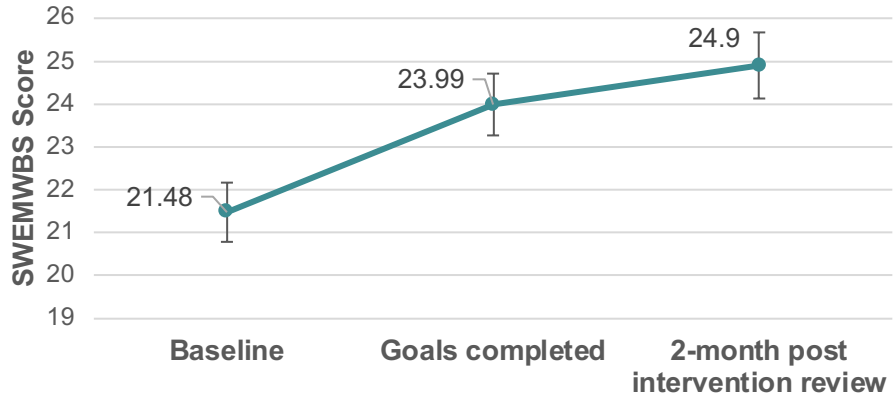
Figure 1 Mean SWEMWBS scores: Sample A (n=932)



- A statistically significant increase in mental wellbeing of **2.25 points** was observed across the sample between guided conversation and completion of goals; p=0.001 (99.90%)
- *(t* (931) = 21.21262, *p* = 0.001)

Analysis of a sub-cohort of sample A **suggests that improvements in mental wellbeing are sustained post involvement in the programme*,** with a 16% increase in wellbeing in the sample mean SWEMWBS score from guided conversation to two months after completion of goals (Figure 2)

Figure 2 Mean SWEMWEBS scores: Sub-cohort of sample A (n=415)



- A statistically significant increase in mental wellbeing of 3.42 points was observed across the sample between guided conversation and two months post involvement in the programme; p=0.001 (99.90%). (t (414) = 17.35750, p = 0.001)
- A statistically significant increase in mental wellbeing of 0.91 points was observed across the sample between goals completed and two months post involvement in the programme; p=0.001 (99.90%). (t (414) = 5.70513, p = 0.001)

**as measured by the Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)*

How does the model enhance wellbeing?

Older people spoke about how their PIC's support had enabled them to explore their own needs, and to discuss them more openly. This greater self-awareness and the help from their PIC then combined to empower older people to make purposeful choices about the steps they could take to bring about changes that were important to them. As a result, clients described regaining a sense of control over their lives.

Older people described how the support they had received to help with practical aspects of their lives (for example home adaptations, greater financial security, access to transport and help around the home) had increased their confidence to go about their day-to-day lives, and given them a sense of independence and peace of mind. In turn , this has improved wellbeing.

Having regular contact, time and trusted relationships with the PICs, and knowing that support is available beyond involvement in the programme, has given older people, in their own words 'an extra arm of support Clients spoke about how this 'lifeline' has helped them to feel more secure and less worried about their circumstances, and, in some cases, less isolated. In turn, it has also improved their confidence and wellbeing.

Many older people described how their ambitions about 'what they could do' had been raised. With their PIC's support, older people spoke about gaining the confidence to re-engage with old interests and develop new ones. They spoke passionately about how pursuing their interests had given them a sense of purpose. For many, it had also enabled them to become more active and widen their social circle and feel less lonely and isolated.

Improving the experience of care and its delivery

Older people and professional stakeholders alike reported that the programme had improved experience of care and/or its delivery by enhancing access to care and support, and facilitating a more person-centred approach to care planning. In some instances, the service has also supported more opportunistic and responsive care. This is a result of the PICs' capacity to maintain regular contact with older people who might otherwise be 'off the radar' of GPs or other healthcare professionals for a period of time.

Improving care coordination and timely access to personalised care and support

Before they had the PICs' support, many older people involved in the research said that they had been unaware of the help available and/or had not known how to access it. Some had, in one client's own words, 'hit a brick wall trying to get things sorted'.

Many older people described being surprised and pleased at how fast their PICs had 'got things moving' – particularly with arranging access to practical and medical support. As a result, older people had been able to benefit from much-needed practical help sooner than they had expected.

Professional stakeholders from the majority of sites also felt that the service had facilitated more responsive and timely coordination of support to meet older people's needs.

Supporting personalised care planning

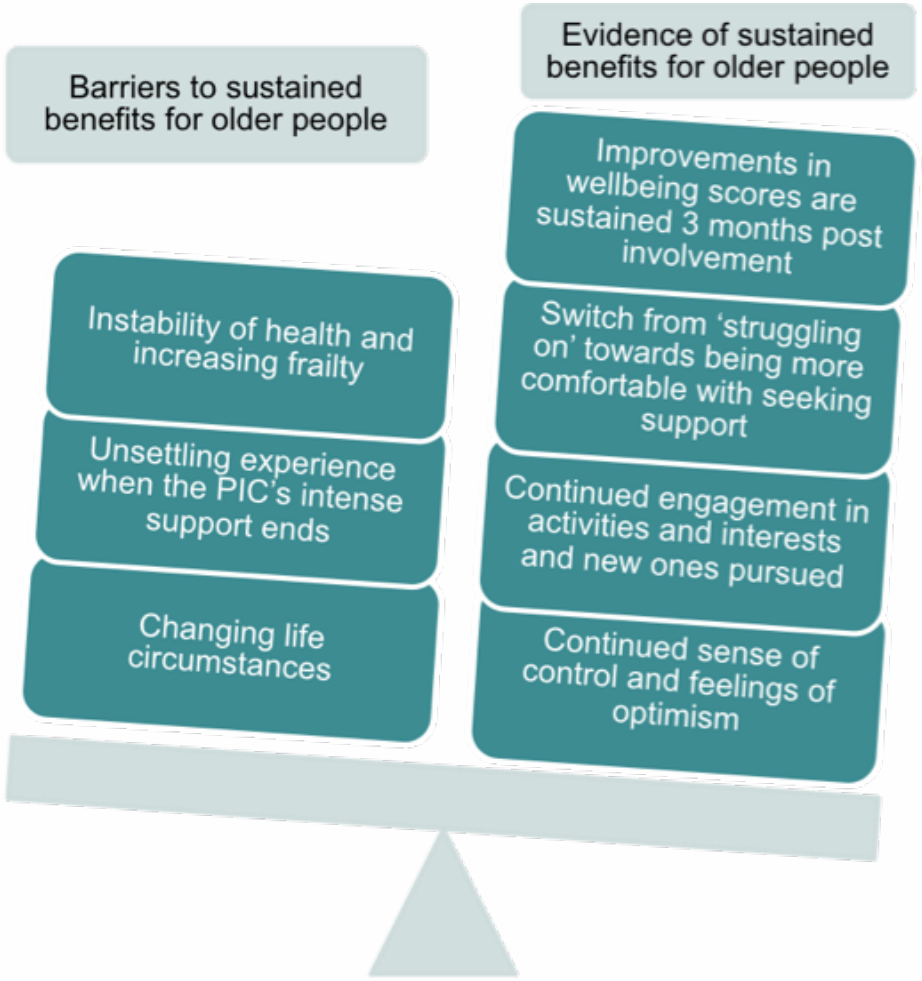
Across most sites, professional stakeholders described how the PICP has promoted a more holistic, person-centred model of care by improving understanding of the wider needs and preferences of older people.

Multi-disciplinary working has played a key role in this change. Stakeholders from several sites explained how the sharing of insights captured by the PICs has enhanced healthcare professionals' knowledge of their patients and helped to shift the conversation from a medical model to more holistic care planning for older people.

Sustainability of the benefits experienced by older people

Across all sites older people involved in the qualitative research reported that the benefits of participating in the PICP had continued after the PIC's intensive support ended. Additionally, older people noted that being involved in the programme had 'opened their eyes' to the various types of support available. Many reported that they would no longer wait for a crisis, or 'struggle on coping' if their circumstances changed.

Nonetheless, professional stakeholders expressed some anxiety about whether the benefits would be sustained in the longer term. Many professional stakeholders (including the PICs) acknowledged the challenges of doing so, particularly for people with a high level of frailty. They noted that a continued focus on creating sustainable networks of support in the community will be key to helping older people to maintain improvements in wellbeing – including exploring opportunities to create networks that draw on older people's own assets, albeit it that they recognised the challenges of creating such networks in the context of a pilot.



Reducing the cost and demand pressure on the health and care system

Whether the programme has been effective in **reducing hospital admissions** has yet to be confirmed (see section 5 for a discussion of factors likely influence the programme's impact on hospital activity).

"From a primary care perspective, we've seen better outcomes for those patients, our high-intensity users. We've observed reductions in telephone appointments, we've seen a reduction in actual GP appointments and the need for home visits as a result of Age UK. I think a lot of that is down to the fact that they've got that PIC that they can contact." Clinician

"It's about the right services at the right time – and using the NHS effectively. Many older people will start to feel unwell and turn to hospital or go to the GP for a while and then go to hospital. We now have a pathway where older people are being engaged out of hospital to make sure that they are comfortable, taking their medicine, they are involved in activities that are supporting them, reducing the likelihood of moving into the hospital trap." Commissioner

Releasing GPs' and practice staff's time for care

Qualitative evidence suggests that for the majority of sites the PICP has had a positive impact on the workload of GP practice staff by supporting those older people who would otherwise have sought help from their GP or other healthcare professionals.

Responding to unmet need and supporting right care, right time, right place

The support provided through the PICs has been effective in answering previously unmet need by filling a gap in existing statutory primary, community and social services, and older people's wider support networks. The programme has also uncovered and responded to unidentified need, supporting 'right care, right time, right place'. In some instances, responding to unmet need will lead to an increased use of statutory healthcare services resources.

Longitudinal evaluation of impact is required to understand whether this earlier intervention leads to more effective use of resources in different parts of the system in the long term.

03

The critical elements of the model

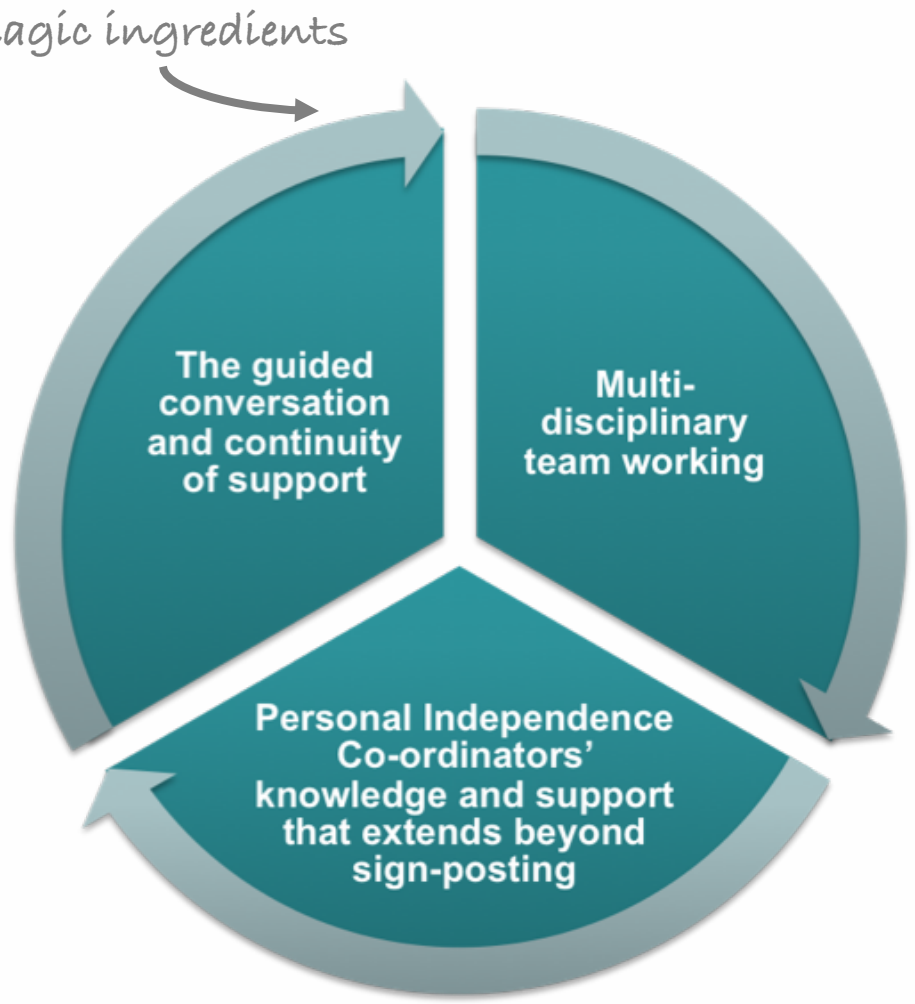
Which elements contribute the most to improved outcomes?

Perceived added value: which elements contribute the most to improved outcomes?

Several elements of the model have proved to be critical in improving the planning and delivery of integrated, holistic, person-centred care. These elements have delivered real benefits to older people and added value, especially to primary care.

While the model is effective in its own right, when combined these 'magic ingredients' have created a cycle of positive action that have helped older people move towards and achieve their goals for living well.

How each of these elements works, and the change it creates is discussed on pages 9 –11.



The guided conversation and continuity of support

"She cared about the situation we were in. That was the first time, really, that we had anyone who was genuinely concerned and interested, and who helped us to work out what we could do and supported us to do it." Client

"I feel she is not undermining me and she gives me respect. That's really important because once you have trust and respect you can open up, and once you do that you can start to regain some control about what you can do." Client

"It feels like you are talking to someone who understands you. That's important. Someone who listens and listens to what's important to you, and helps to make it happen. It's the personal approach that makes a difference; he took the time find out what I really wanted and needed. He made me feel like I wasn't a burden." Client

How does it work?

- A conversation, not an assessment
- Trusting relationships are built over several home visits, enabling the older person to express their desires and needs freely
- Goes beyond asking *'What do you need?'*, by seeking to discover what the older person can do for themselves, with a little help
- Makes it possible for PICs to understand and work with clients to address the barriers they face to making change

What change does it create?

- ✓ **Older people are treated as equal partners in a discussion that empowers them to identify their preferences and goals – and to recognise their own strengths**
- ✓ **Care planning focuses on how services and support can help ensure that older people's preferences are met and their goals are achieved**

Multi-disciplinary working

"By being at the MDT and the offer of the services, they [the PICs] give us an opportunity to think more holistically about the patient. When those things aren't aligned, it's much more challenging. It's much easier to have a discussion with someone in a room or a discussion about what might be achieved than it is to have to actually activate the process of referring or trying to track down a service or whatever." Clinician

"We have social services at our MDT and we bandy around the term MDT, but it does tend to mean health. But having someone in the room who keeps referring to people as clients rather than patients is quite a positive thing, and it makes you think in a slightly different way. [The PICs] have the ability to think outside the box, and even when they are in the box, they are in a different box to me, so they bring a different perspective to care planning." Clinician

"[The PICs] have helped to reframe the discussions in the MDT so that they are able to be more holistic. We start to think outside of the box about the things we can do to improve people's overall health and wellbeing and not just the conditions they are suffering from." Clinician

How does it work?

- Provides an effective mechanism to:
  - establish and maintain trusting relationships and understanding of ways of working between various disciplines
  - improve understanding of the value the programme offers
- Facilitates timely access to coordinated care
- Shifts the discussion and solutions away from a medical model

What change does it create?

- ✓ **Establishes a shared understanding of the contribution that different practitioners can make to improving the care and the health and wellbeing of older people**
- ✓ **Older people receive coordinated care and support that responds to their holistic needs and preferences**

PICs' knowledge and support that extends beyond signposting

"They have got their finger on the button, and have the know-all and ability to point you in the direction of where you want to be. They are, in my opinion, the best link to help you with your future as well as present problems. In my experience, Age UK are the only people who have been able to get things done for us. We may not be able to do it ourselves initially. But they pointed us in the right direction, and came along and helped us, rather than just telling us to telephone someone. It makes me think all the other organisations are playing about it." Client

"The added value is not just to focus on social needs, it's the PICs' local knowledge. They have a big knowledge base of what is happening locally. That knowledge is traditionally disjointed from the clinical care, so the PICs have bridged that." Clinician

"You need a bit of encouragement and extra support sometimes to take the next step. When you are on your own, it's difficult to just jump up and do new things, even if you really want to. It's got a lot to do with confidence, as well. It's that extra help that made a difference. She [the PIC] came with me the first time I went [to a crochet group]. She called me in the following weeks to encourage me to keep going, which I did and still do." Client

How does it work?

- Tacit knowledge which extends beyond 'what's on paper or a directory'
- Follow-through support helps to address the barriers to accessing care and support:
  - for GPs and healthcare professionals: follow-up support to chase other statutory services
  - for clients: support consists of 'doing' and enabling connections in a way that signposting alone does not achieve

What change does it create?

- ✓ **Creates a single and trusted point of contact to access diverse care and support**
- ✓ **Older people are motivated and supported to develop their confidence and to take action to achieve their goals**
- ✓ **Makes visible the community offer**
- ✓ **People and services are connected in the community**

04

The challenges and lessons learned

The challenges

Risk stratification criteria

Reflecting the limited use of predictive risk stratification tools in each locality during the inception of Phase 2, all sites adopted a threshold (criteria-based) approach to identifying older people who were at risk of having a high need and cost of care. Focusing solely on older people who meet the Two Plus Two risk stratification criteria* proved unworkable for all sites. Post implementation, the criteria were broadened to better reflect local context, demand and need.

Engaging GPs

Consistently securing genuine GP involvement, crucial as it is, has been challenging for sites delivering the service through individual practices. While the breadth and efficacy of the action taken across the sites has varied, all have taken steps to support GP engagement. For most, it has increased during the pilot, yet further embedding the PICP within primary care will be critical to its sustainability.

Tracking outcomes for the health system locally

Problems accessing NHS Hospital Episode Statistics data have limited sites' ability to track and evidence outcomes (creating a dependency on the programme-level impact evaluation being undertaken by the Nuffield Trust to demonstrate impact on acute care). These barriers, which have largely been due to national and local Information Governance protocols and NHS capacity issues, have also led to a reliance on GPs to create the risk stratified lists of eligible older people.

Involving volunteers

For all local Age UKs, recruiting volunteers, and having a timely pool of volunteers who match clients' needs has been difficult. Only four sites have used dedicated PICP volunteers. The findings highlight the need to invest time and resources in recruiting enough volunteers and in enhancing their effective training, management and support. Workforce models to address the challenges associated with involving volunteers in the programme have been explored.

Addressing gaps in the community offer

All sites have invested significant time in mapping and continually exploring community assets throughout all phases of the pilot. Yet, given the pilot's duration, few sites have attempted to address mismatches between the community offer and clients' needs. However, stakeholders from several sites encouraged a greater focus on exploring the feasibility of establishing new, sustainable community offers to better meet some clients' needs.

**Older people who have two or more long-term ambulatory sensitive conditions,* and *have experienced two or more unplanned hospital admissions in the previous 18 months, and are therefore at high risk of becoming a frequent user of hospital services*

The lessons learned

- ✓ **The co-design work streams,** when embraced by all partners, have helped to ensure that the 'right' infrastructure and a collaborative culture are in place to support successful strategic and operational delivery.
- ✓ **A combination of proactive and reactive case finding** has been necessary to create sufficient demand. This dual approach has also made it possible to identify older people who are not currently 'on the radar' of GPs and other healthcare professionals.
- ✓ To create demand, it has been important to **target more older people than the programme aims to reach**, as not all those invited to participate choose to do so. It is also crucial to **address the barriers** older people could face to becoming involved.
- ✓ **MDT working** has been identified by most sites as an important and particularly effective element of the model that has worked well. However, the extent to which Age UK PICs have become embedded within MDTs has varied across and within sites.
- ✓ The pilots have focussed on facilitating and enabling **personalised shared care and support planning**, rather than on creating a single, holistic care plan. However, shared care planning and case review involving a MDT has not taken place for all clients.
- ✓ **A partnership approach to day-to-day strategic and operational programme and team management** has been critical to success, blending the skills, expertise and experience of managers from the VCS and the statutory healthcare system.
- ✓ **The PIC role is challenging** and involves ways of working with older people and healthcare professionals that are relatively new; developing confidence in the role has, therefore, necessarily taken time.
- ✓ **To facilitate programme-level performance management**, time and resources have been invested in defining, reviewing and analysing performance data. Yet, if the **data collected at a national level** is to drive continuous improvement, it **needs to be both fit for purpose and used.** This has not always been the case.
- ✓ Additional **resources and time are needed to help local teams make the most of data they capture** through the programme's performance framework.
- ✓ It is not just about measurement. **Opportunities for reflective learning and strong feedback loops** have been effective in supporting continuous improvement and have helped to maximise success.
- ✓ **One year's operation is insufficient to 'stabilise' delivery**. Longitudinal evaluation is therefore essential to capture more than merely the impact of implementation.

Variables in the target cohort's profile and programme delivery are likely to influence the support provided and the level of outcomes achieved

- The profile and needs of the cohort of older people involved in the programme have been diverse (see page 15 for variables in the client profile). While the evaluative evidence strongly suggests that all the older people involved, irrespective of their profile, can benefit from the service, **levels of frailty and loneliness and isolation** are likely to be important variables to consider when defining the target cohort for the programme.

- Reflecting the diversity of the cohort, not all older people involved in the programme have 'fitted' into the full model of intensive support over a three-month period. The extent to which this observation is symptomatic of the broadened risk stratification criteria, the approaches used for case finding and/ or an inherent facet of the personalised approach to goal setting is uncertain. However, there may well be implications for the workforce and delivery models (and associated costs) if the balance between low and high need (in terms of both the duration and types of support needed) is tipped towards the former.

- In addition to shaping the duration and type of support provided, the findings indicate that the variables in the client profile can influence the scale at which the model impacts positively on levels of wellbeing, experience of care, and the use of health and care resources.

- Beyond the profile of the client cohort, the findings from this evaluation suggest that variables in how the elements of the model have been implemented in practice are also likely to influence the scale of the outcomes achieved (see page 15). However, gaps in the quality and consistency of the programme's existing evaluative evidence prevents any firm conclusions regarding how such variables as approaches to case finding, case review involving a MDT and the extent to which clients are supported beyond 'signposting' to achieve their social goals influence the scale of outcomes achieved.

Variables which are likely to influence the outcomes

Variation in the different elements of the approach to case finding results in ...

- Risk stratification criteria
- Proactive case finding using data and clinical judgement
- MDT meetings (reactive)
- Other referral routes (reactive and proactive)
- Client choice

.... a diverse client profile across the achieved cohort

Variables in the client profile

- Levels of help needed with daily living and personal activities
- Levels of mobility
- Levels of loneliness and isolation
- Existing support networks (including social networks)
- Appetite and desire to make changes to improve their own health and wellbeing
- The medical stability of their LTCs

.... which influences the support provided. Together with other variables in delivery, this, in turn, is likely to influence the scale of outcomes achieved.

- Type, intensity and duration of support
- Shared care planning involving a MDT
- Existing community offer
- Delivery model: signposting vs supported signposting to help clients engage with interests / social activity

Improved wellbeing, improved experience of care and reduced cost pressures in the local health and social care economy

05

Discussion: Achieving the Triple Aim and beyond

Achieving the programme's Triple Aim

The blended evaluation provides evidence that Phase 2 of the PICP has brought about positive change for those who have been involved. In particular, the findings provide:

- Strong quantitative and qualitative evidence of a significant **positive impact on the wellbeing of older people**, irrespective of their profile
- Qualitative evidence of the **positive impact** the programme has had on **primary care workload** by supporting those older people who would otherwise have sought help from their GP for underlying non-medical needs

Whether this positive change is sufficient to reduce hospital activity across the cohort is still uncertain. Evidence of reductions in hospital activity from several sites is promising. However, the findings from the Nuffield Trust's programme-level evaluation involving a matched control group will need to be considered in order to confirm and understand this aspect of the PICP's impact.

Success in preventing avoidable hospital activity is likely to be dependent on a combination of the following factors (discussed further on page 17):

- Wider system change and capacity to support integrated care and proactive case management
- Targeting the 'right' cohort for whom future hospital admissions can be avoided
- Changes in client behaviours

Finally, given the lesson learned about the time taken to stabilise delivery of the model (see page 13), whether changes in hospital activity will be observable after 12 months' operation remains uncertain.

Beyond the Triple Aim: supporting shifts in care and its delivery locally

While not a panacea, the findings highlight that the model itself, and/or elements of it provide an approach that is effective in enabling:

- **Personalised care for older people** – in particular in ensuring that older people are equal partners in care planning and that their holistic needs and preferences are met
- **Connecting people and services in the community through holistic social prescribing*** – thereby promoting the integration of statutory and non-statutory services and harnessing community assets to improve older peoples' wellbeing.

*Kimberlee (2015) categorized signposting/social prescribing models as basic, light, medium and holistic (Kimberlee R. (2015) *What is social prescribing*? Advances in Social Sciences Research Journal, Volume 2, No 1.

Factors likely to influence the programme's impact on hospital admissions

Wider system change and capacity to support integrated care and proactive case management

- During Phase 2 the PICP has focused on influencing and supporting positive change at the primary care level. Many of the older people involved in the programme, given their profile, will require ongoing medical care after the PICs' intensive support has ended. Preventing or reducing hospital activity for these clients will, in many instances, be dependent on wider system change beyond the level of the primary care.
- Integrating the PICP into a pathway of care that enables both ongoing proactive case management and preventive care for older people after their involvement in the programme has ended is likely to be critical to maximising its impact on acute care.

Targeting the cohort for whom future hospital admissions can be avoided

- By using risk stratification, the PICP aims to target those older people within the 2-5% band of the 'Kaiser Triangle of Need' who are deemed to be 'not too fit and not too frail' to achieve programme's aims.
- Reflecting the limited maturity of the use of predictive risk stratification tools in each Phase 2 site, a threshold (criteria-based) approach to identifying the target cohort was adopted instead. Wider literature indicates that this approach is susceptible to regression to mean and of limited effectiveness in identifying those at risk of a hospital admission*.
- Nonetheless, the findings from this evaluation suggest that there will be merit in refining the Two Plus Two criteria further, to include levels of frailty and loneliness and isolation.

Changes in patients' behaviour and self management of LTCs

- Changing patterns of statutory healthcare services increasingly place an onus on 'patients' to play an active role in managing their own health and wellbeing. Involvement in the PICP has supported such behavioural change. The PICs have helped older people to recognise and develop their own strengths and abilities, and have supported clients to take action that enables them to lead lives that are as independent and fulfilling as possible.
- The PICP has helped older people to self manage their LTCs' practical and emotional impact. However, self management could be enhanced by further supporting clients to improve their knowledge, skills and confidence with also managing the physical / medical aspects of their LTCs.

*Lewis G, Curry N, Bardsley M (2011) *Choosing a predictive risk model: a guide for commissioners in England*. Nuffield Trust; Operational Research and Evaluation Unit (2017) *Risk Stratification: Learning and Impact Study*, NHS England.

06

Conclusions and focus for continuous improvement

Conclusions

- Phase 2 of the PICP has made a positive and sustainable difference to older people's wellbeing and experience of care, as well as releasing time from primary care and improving the quality of care.
- The findings reveal that, for most sites, involvement in the programme has also helped to establish the relationships, skills, knowledge and experience required to design, implement and deliver collaborative approaches to integrated, person-centred care involving the voluntary and community sector.
- More generally, the learning about delivery of the model and its impact will be of value to other health and care systems as they develop and implement holistic and personalised preventive care models involving the VCS.
- In conclusion, while it is too early to confirm whether the programme has been successful in achieving its Triple Aim, the findings from the interim blended evaluation suggest that Phase 2 of Age UK's PICP has generated significant value at a local and national level.

"It would be a regressive step if [the PICP] wasn't available. We've seen some progress: we feel there is an improvement in the care of our patients, we feel that we know them better for it. And I think our patients feel special because they know there is a service there for them, and they know we are trying to help, even with the non-medical issues." Clinician

" They [the PICs] have helped us to understand something more about our patients' needs and wants, and demedicalised some of the issues people have. It has helped us get to grips with what the non-medical issues are, rather than just trying to solve everything through a medical model." Clinician

"I felt supported, I was at all sixes and sevens and there [the PIC] was offering me all this help, understanding, kindness and friendship. I couldn't have done without her; I was frightened, depressed and unwell. She treated me with respect, and that was important to me at a time when I felt like I was losing everything around me. My garden was getting overgrown and my house was a muddle, and I couldn't get out to shop so I wasn't eating properly. I now feel more in control, and that I have choices. She motivated me to get out. Before, it was like I had a brick wall in front of me. She cracked a bit of that wall and then, with her help, I made that crack bigger and bigger until it became an open door." Client

Focus for continuous improvement

Throughout Phase 2 of the PICP programme, Age UK has captured and reflected evidence of how the model and its design and implementation have unfolded on the ground in different contexts. Age UK has responded to lessons learned, being careful to strike a balance between the need to flex and adapt the model locally with that of ensuring the implementation of the core elements of the model that it is seeking to test. In doing so, Age UK, together with its local partners, has already made numerous improvements to the programme's design and operation, as well as to its own ways of working with and supporting the local health and care partnerships involved.

Building on the improvements already made and on work in track to enhance spread, scale and sustainability, 13 recommendations to support continuous improvement are made in the full report. These recommendations are focused on the following challenges and risks requiring attention at a national and local level to further strengthen the development and delivery of the Age UK Personalised Integrated Care model:

- Understanding the target cohort for the programme
- Creating and maintaining sufficient demand from primary care and from potential clients who can gain the most from the service
- Exploring further the workforce model and workforce development – including examining opportunities to optimise volunteer involvement in the programme
- Enhancing the programme's impact on self management by motivating and supporting clients to deal with the medical/physical aspects of their LTCs
- Reviewing the quality and consistency of the data/evidence collected and ensuring its timely use at a national level to support continuous improvement and evaluation
- Addressing barriers to active performance management and evaluation locally, including overcoming the challenges associated with accessing local healthcare data
- Creating sustainable networks of support for older people – including pathways of care that will endure beyond their involvement in the programme