# Blended evaluation of Phase 2 of the Age UK Personalised Integrated Care Programme

**Final evaluation report**

**23rd March 2018**

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# Executive Summary

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. The programme's three primary aims (known as the Triple Aim) are to:

- **Improve the health and wellbeing outcomes for older people** with long-term conditions who experience high numbers of avoidable hospital admissions

- **Improve older people's experience and quality of care and support** by tailoring services to meet their needs

- **Reduce cost pressures** in the local health and social care economy, with a particular focus on acute care

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. Phase 2 began in 2015, piloting the model across England with eight local health and care partnerships. Each partnership, together with Age UK, tailored the model to its local context through a structured co-design phase while seeking to retain the fidelity of the core elements of model.

## Evaluation of Phase 2 of the PICP

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 details the findings from the blended analysis of multiple evaluative evidence sources and performance-management information captured up until the end of September 2017.

## Evaluation findings

### Achieving the programme's Triple Aim

#### *Improving older people's wellbeing*

Changes in the Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS) and qualitative research findings demonstrate that the programme has had a proven significant and enduring positive impact on the mental and overall wellbeing of the older people involved. The support provided through the PICP has improved older people's wellbeing by:

- Helping older people to become aware of their own needs and fostering agency

- Enabling independence and wellbeing through practical support

- Reducing isolation and raising ambition by empowering clients to re-engage with interests and become more socially connected

- Providing an 'extra arm' of support for older people that endures beyond involvement in the programme

The evaluation findings suggest that involvement in the programme can also deliver multiple benefits for carers. In particular, carers of spouses have been supported and empowered to accept help and take action to improve their own wellbeing.

#### *Improving the quality and experience of care and its delivery*

The PICP has improved the quality and experience of care and its delivery by:

- **Improving care coordination and facilitating timely access** to more responsive, and, sometimes, opportunistic care and support to meet older people's needs and preferences

- **Facilitating a more holistic, person-centred approach to care planning** and helping to shift the conversation from a purely medical model

The programme has reduced cost pressures on the health and care system by:

- **Freeing up GPs and practice staff to focus on primary tasks** through the support provided by Age UK Personal Independence Coordinators (PICs)

Whether the programme has been effective in **reducing hospital admissions** has yet to be confirmed. The results from the two sites able to access local healthcare data are 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. Factors that are likely to influence the programme's impact on hospital admissions are considered within the report.

*A bonus: responding to unmet and unidentified need*

- 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 programme has also **uncovered and responded to unidentified need**, supporting 'right care, right time, right place'

## The magic ingredients

Several elements of the model have been critical in adding value to the local service offer, and in improving the planning and delivery of integrated, holistic, person-centred care:

- **The guided conversation with older people, and the continuity and duration of the support** has been effective in enabling:
  - Older people to become equal partners in a discussion that empowers them to identify their preferences and goals
  - More personalised, holistic care planning focusing on how services and support can help ensure that older people's preferences are met and their goals are achieved
- **Multi-disciplinary working involving Age UK PICs** has been effective in:
  - Building a shared understanding of the contribution that different practitioners can make to improving the care and the health and wellbeing of older people
  - Shifting the conversation from a medical model to more holistic care planning for older people
  - Facilitating coordinated care and support that recognise older people's holistic needs
- **PICs' local knowledge and support that extends beyond 'signposting'** has:
  - Created a single and trusted point of contact for older people, GPs and other health and care professionals to access diverse care and support
  - Motivated and supported older people to take action to achieve their goals, including removing the barriers to improving their health and wellbeing, in a way that signposting alone does not
  - Connected people and services in the community

## Common challenges associated with delivering the model

The research highlights some common challenges experienced across the pilot sites:

- All Phase 2 sites have adopted a threshold (criteria) approach to risk stratification. Focusing solely on older people who met **the Two Plus Two risk stratification criteria** presented difficulties. Post implementation, the risk stratification criteria were broadened in all sites 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. Further embedding the PICP within primary care will be critical to its sustainability.

- **Accessing local health data and active performance management.** Problems accessing HES data have limited sites' ability to track and evidence outcomes and have increased dependency 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. It is essential to invest time and resources in recruiting enough volunteers and in enhancing their effective training, management and support.

- **Addressing mismatches between existing community offers and clients' interests.** Given the pilot's duration, few sites have tried to address gaps in the local community offer. However, stakeholders from several sites recommended exploring the feasibility of establishing new, sustainable community offers to better meet some clients' needs.

## Lessons learned about delivering the model in practice

- ✓ **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 key element of delivery has been **the creation of sufficient demand for the programme and equality of access,** achieved through a combination of proactive and reactive case finding. 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 potential clients 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. 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 performance management** at a national level, time and resources have been invested in defining, reviewing and analysing local **performance data**. Yet, if the data collected is to support continuous improvement, it **needs to be both fit for purpose and put to use**. This has not always been the case. Additional resources and time are also 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 supported continuous improvement and 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.

- ✓ The profile and needs of the cohort of older people involved in the programme have been diverse. While all older people, irrespective of their profile, have benefited 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.

## Sustainability

- **Sustainability of the benefits to older people:** Across all sites clients reported that the benefits of participating in the PICP had continued after the PICs' intensive support ended. Nonetheless, professional stakeholders noted that creating sustainable support networks in the community will be key to helping clients to maintain improvements in wellbeing.

- **Sustainability of the service:** At the time of writing, the service has continued in various forms across all Phase 2 sites. While the journey from the pilot to a commissioned service has varied, seven of the sites have been commissioned to deliver the service by either the local authority or CCG, with one site also receiving funding from other sources.

Factors critical to creating the conditions for sustainability include:

- Evidence of the impact on the programme's Triple Aim

- Flexibility to adapt the referral criteria and model to respond to local context

- The strength of local relationships between the Age UK team and primary and community care (and other health and social care professionals)

## Legacy of involvement in Phase 2 of the PICP

Irrespective of the commissioning status, for almost all the sites, the legacy of their involvement in Phase 2 of the PICP is a positive one and has, for example:

- Enhanced healthcare professionals' and clients' understanding and perception of local Age UKs' offers, thereby improving the reputation of Age UK

- Strengthened the position of local Age UKs as credible strategic partners in the health and care system

- Created new opportunities for collaborative working

- Built a foundation from which to adapt the model for different cohorts of older people

## Conclusions and recommendations

These findings provide evidence that the programme has made a positive difference to older people's wellbeing and experience of care, as well as releasing time from primary care and improving the quality of care. Beyond the Triple Aim outcomes, Phase 2 of Age UK's Personalised Integrated Care Programme has been effective in enabling:

- **Personalised care for older people** – in particular, personalised care and support planning

- Connecting people and services in the community through **holistic social prescribing**

The findings also highlight how the intervention extends beyond 'signposting and care navigation'. While these are important, it is the combination of personalised care planning, 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.

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. Phase 2 of the PICP has thus laid foundations that have the potential to support sustainable transformational change to local health and care systems over the longer term.

More generally, the learning about delivery of the model will be of value to other health and care systems as they develop and implement holistic and personalised preventive care models involving the VCS – be that, for example, in the context of delivering the transformational change set out in

Sustainability and Transformation Partnership (STP) plans, the General Practice Forward View or the five key shifts underpinning Integrated Personalised Commissioning.

Finally, the Phase 2 pilots have generated learning and insights that can be used to underpin continuous improvement of the model. Building on the improvements already made by Age UK, 13 recommendations for consideration are presented to further strengthen the development and delivery of the PICP:

*Understanding the target cohort for the programme*

**Recommendation 1:** Undertake further research and testing to understand whether and how the risk stratification approach can be optimised.

*Tailoring messages to potential clients to increase uptake*

**Recommendation 2:** Create targeted messages for potential clients to raise awareness and understanding of the benefits of becoming involved and to create 'bottom-up' demand for the service.

*Helping clients to improve their health and wellbeing in a sustainable way*

**Recommendation 3:** Explore and test how to create sustainable and holistic care and support pathways /networks for older people that will continue beyond their involvement in the programme.

**Recommendation 4:** Strengthen a focus on supporting clients to improve their knowledge, skills and confidence to better manage the physical aspects of their LTCs.

*Embedding the programme within primary care*

**Recommendation 5:** Continue to raise the programme's profile and strengthen primary care stakeholders' understanding of the service and its value to encourage engagement.

*Workforce model and development*

**Recommendation 6:** Consider the merits of developing a competency framework for PICs and a complementary training programme to support workforce development and emphasise their expertise.

**Recommendation 7:** Define and develop further the role of the volunteer in order to enhance quality of care and support and strengthen the programme's impact on connecting people and services within the community.

*Knowledge exchange to underpin continuous improvement, maximise the programme's success and support scale and spread of the model*

**Recommendation 8:** Consider developing communities of practice to support knowledge exchange beyond the national learning and PICs' forums.

*Active performance management and evaluation*

**Recommendation 9:** Co-produce local and programme-level performance dashboards to strengthen the focus on tracking progress and achievement across the care pathway, and to bring to life how the data collected through the framework can add value locally.

**Recommendation 10:** Review performance data and its use to identify how improvements can provide a robust and timely view of performance at every level.

**Recommendation 11:** Further embed formative evaluation to allow prompt understanding of how the model is working on the ground and opportunities to maximise success and to spread real-time learning.

**Recommendation 12:** Consider the feasibility and merits of developing a digital analytics platform to allow for more real-time performance management and evaluation.

**Recommendation 13**: Consider the merits of undertaking an economic evaluation of the costs and benefits of the model – including a Social Return on Investment.

# Acknowledgements

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## Abbreviations

A&E            Accident and Emergency
ACO            Accountable Care Organisation
CCG            Clinical Commissioning Group
CEO            Chief Executive officer
CSU            Commissioning Support Unit
GP             General Practitioner
ILT            Integrated Locality Team
LTC            Long-term condition
MDT            Multi-disciplinary team
NHS            National Health Service
PIC            (Age UK) Personal Independence Coordinator
PICP           (Age UK) Personal Integrated Care Programme
STP            Sustainability and Transformation Plan
SWEMWBS        Short Warwick-Edinburgh Mental Well-being Scale
VCS            Voluntary and community sector

# 1    Introduction

## 1.1    The Age UK Personalised Integrated Care Programme

The Age UK Personalised Integrated Care Programme (PICP) was ahead of its time when it commenced in 2011. Prior to the emergence of national policy drivers – including the Care Act, the Five Year Forward View, the Better Care Fund and the Vanguards – Age UK and its partners began their ambitious journey to design, test and pilot an innovative model of person-centred care for older people with multiple long-term conditions (LTCs). From its inception, the Age UK Personalised Integrated Care model has sought to:

- Take a coordinated, community-based approach to care through primary care-led multi-disciplinary teams (MDTs) involving the voluntary and community sector (VCS).

- Adopt a whole-system perspective, embracing an outcome-based model.

- Flip the question from 'how to manage a health condition' to 'how to help older people live well'. In doing so, the PICP identifies various solutions to improve outcomes for older people, and for health and care systems. These solutions shift away from the traditional 'deficit' and reactive-based models of care, and instead focus on prevention and harnessing existing assets (be they the assets that older people themselves possess, assets within the community or across local health and care partnerships).

### 1.1.1    The aims of the PICP

Figure 1.1: The vision for the Age UK Personalised Integrated Care Program



The programme has the Triple Aim of:

- **Improving the health and wellbeing outcomes for older people** with long-term conditions who experience high numbers of avoidable hospital admissions

- **Improving the experience and quality of care and support amongst older people** by tailoring services to meet their needs

- **Reducing cost pressures** in the local health and social care economy, with a particular focus on acute care

By achieving these aims, together with demonstrating how statutory health and social care sectors and the VCS can work together to deliver person-centred care, the programme also aims to **support and deliver transformational change to the whole system**.

*Figure 1.2: The Age UK Personalised Integrated Care model*
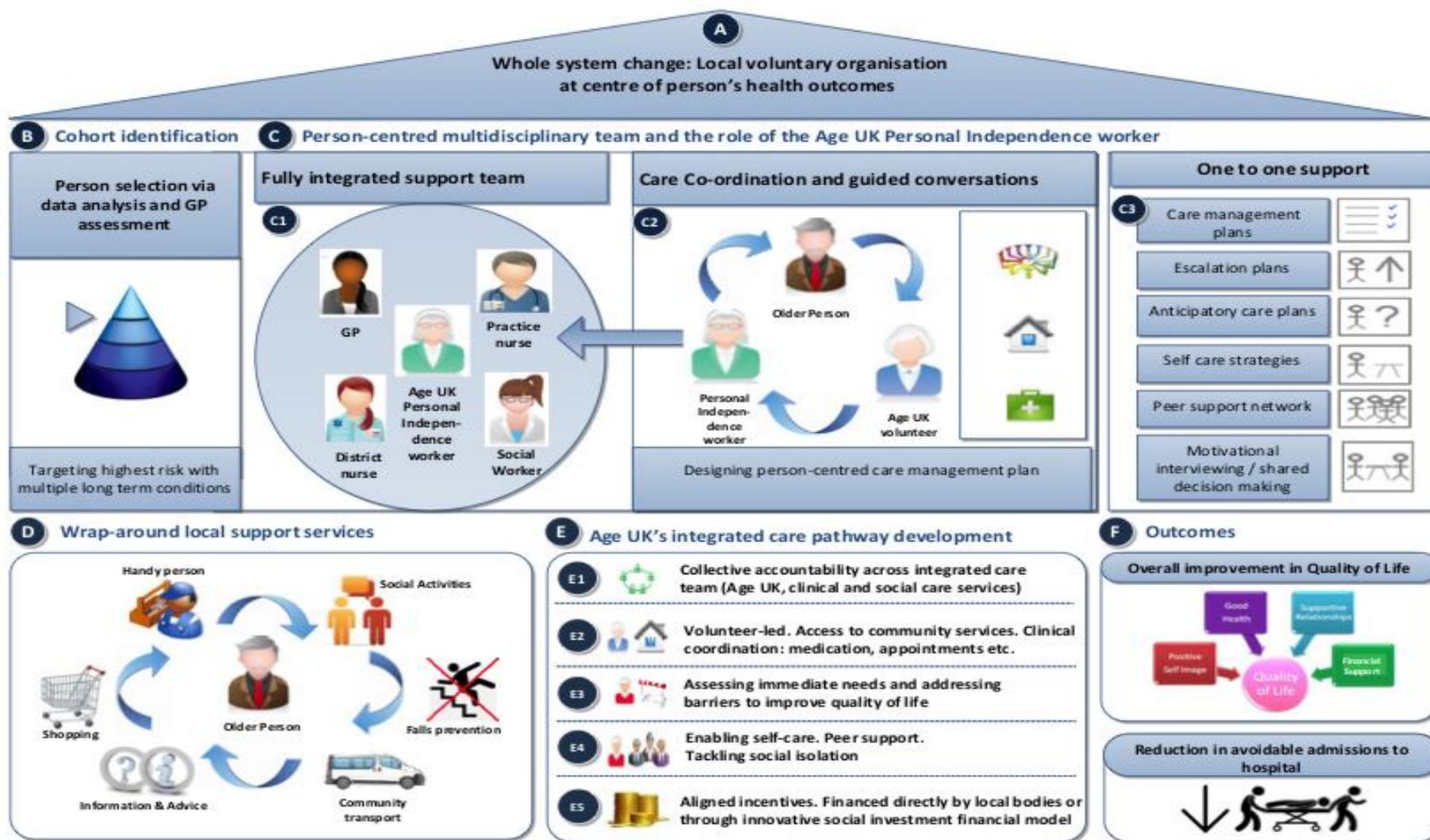
## 1.2    The PICP model

The Age UK Personalised Integrated Care model (see figure 1.2) can be considered a social prescribing model. How care is provided is also consistent with what Nesta describe as 'good help'[1]. The model comprises the following elements:

- **A risk stratified case-finding approach** to identify a cohort of older people with long-term conditions and who are at the greatest risk of avoidable hospital admissions – with a specific focus on the seven morbidities which drive high admissions.

- **A guided conversation** between the Personal Independence Coordinator (PIC) and the older person to draw out the goals that he/she identifies as most important to them.

- **A multi-disciplinary team based within primary care** and including Age UK, and the development and ongoing review of a shared care plan drawn up with the older person to coordinate and support integrated working.

- **Wrap-around support** for the older person, including care coordination to increase independence and prevent a cycle of dependency. While intensive support is provided by a PIC and/or matched volunteer over approximately a three-month period, all older people are encouraged to take the lead in managing their own care and wellbeing.

- **Active performance management** supported by a performance-management and outcomes framework to enable evaluation and continuous improvement.

Local health and care partnerships, together with Age UK, tailor the design of the model to their local context through a structured co-design phase. The co-design work streams (see annex 1 for further information) draw on effective practice in co-producing sustainable change, and focus on designing a care model that best delivers the programme's aims within the local context.

## 1.3    The phases of the PICP

The Age UK PICP has adopted a phased approach (see table 1.1). It has evolved iteratively over time, reflecting the need for flexibility to be built into the programme to respond to learning on the ground and to adapt to the changing context, both locally and nationally.

*Table 1.1: Summary of the phases of the PICP*

| The PICP timeline | |
|---|---|
| 2011 | Initial proof of concept study |
| 2013: Phase 1 | Pathfinder in Cornwall, UK |
| 2015: Phase 2 | Piloting the model with eight local health and care partnerships across England to test the model in different local contexts to learn key lessons about successfully delivering its core elements |
| 2017: Phase 3 | Rolling out a proven approach across five additional local health and care partnerships to see how it works different local contexts |

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[1] Nesta (2018) *Good and Bad Help: How purpose and confidence transform lives.* Nesta describes 'good help' as help that supports people to feel hopeful, identify their own goals and confidently take action, whereas 'bad help' is characterised as help that undermines people's confidence, creates dependency and leads to inaction.

In 2011, Age UK commissioned Hope Consultancy to undertake an initial proof of concept study for the Age UK Personalised Integrated Care model. This study included scoping the LTCs driving high service costs, scoping the wider determinants of wellbeing, and researching evidence-based best practice for care pathways for different LTCs and developing a proof of concept model.

In 2012, Cornwall expressed an interest in becoming a pathfinder for the proof of concept. Improving Care undertook high-level diagnostics with local health and care partners. Strong local Age UK leadership was the driving force for testing the model in Newquay, where a pathfinder (involving 100 older people) commenced in 2013. The pathfinder aimed to test whether the proof of concept model could improve outcomes for older people and reduce admissions and readmissions to hospital.

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 (see table 1.2).

*Table 1.2: Summary of the Phase 2 local health and care partnerships and delivery models*

| Site | Delivery model | Name of the local programme |
|------|----------------|------------------------------|
| Ashford and Canterbury | Through individual GP practices within the locality | Living Well Service |
| Blackburn with Darwen | Through individual GP practices within the locality | Here to Help |
| East Lancashire | Through individual GP practices within the locality | Integrated Care Programme |
| Guildford and Waverley | Through individual GP practices within the locality | Living Well |
| North Tyneside | Integrated within Care Plus, a CCG-led Accountable Care Organisation to support older people with high needs | Integrated Care Programme |
| Portsmouth | Through individual GP practices within the locality | Living Well Service |
| Redbridge, Barking and Havering | Integrated within Health 1000, an Accountable Care Organisation | Care Navigators Service |
| Sheffield | Through individual GP practices within the locality | Integrated Care Programme |

Phase 3 of the PICP has now commenced with an additional five local health and care partnerships. This phase marks a shift for the programme. In contrast to the previous phases, Age UK and the local health and care partnerships will be delivering a model that has been tested. The focus of Phase 3 is on rolling out a proven approach to see how it works different local contexts.

### 1.3.1　Evaluation of Phase 2 of the PICP programme

Age UK has adopted a whole-programme mixed-method approach to evaluating Phase 2 of the PICP. This approach focuses on evaluating the programme against the Triple Aim outcomes, including evaluating:

- Changes in wellbeing scores, using the Warwick-Edinburgh Mental Well-being Scale (WEMWEBS)

- Changes in hospital utilisation using a matched control group and conducted by the Nuffield Trust

- Qualitative evaluation of the impact of Phase 2 of the programme

Throughout Phase 2, local sites have also collected client case studies, which provide additional qualitative evidence of both the impact of the service on older people, and insights into how that impact has been achieved. The whole-programme approach has also included formative evaluation, drawing on performance data collected locally, national learning forums and health checks. These have enabled Age UK and the local health and care partnerships to adapt the model and its delivery based on continuous learning and improvement, and to identify and adopt best practice. Several sites have also commissioned independent evaluations of their local programme.

Drawing on the programme's existing evaluative evidence and performance data, this evaluation aims to:

- Blend together the evidence captured during Phase 2 of the PICP to understand more fully the change the programme has delivered against its Triple Aim and beyond

- Highlight what has worked – and why and how – with respect to the elements of the model and the associated outcomes, together with the challenges experienced and opportunities for improvement

- Generate replicable lessons learned and suggestions to support the ongoing development of the programme

- Create an evidence base from which Age UK can promote the learning from the PICP as a whole to influence wider, person-centred care agendas through professional networks

# 2 Evaluation methodology

## 2.1 Overview of the evaluation approach

This report draws on the programme's existing evaluative evidence and performance-management data collected up until September 2017. The data sources include:

- Independent evaluation of the co-design phase of the PICP focused on Phase 1 and early Phase 2 sites (2015)

- Independent qualitative evaluation of Phase 2 of the PICP (2017)[2]

- MSc thesis completed as part of a Masters in Health Policy at Imperial College London: *Bird C. (2017) What are the key success factors in developing a sustainable integrated care programme for adults with long-term conditions and what lessons from this experience can be drawn for policymakers seeking to reduce avoidable pressure on health and social care resources?*

- Independent local evaluations:

    – Realistic evaluation of Age UK Portsmouth's Living Well (2017)[3]

    – Interim evaluation of Sheffield's Integrated Care Programme Pilot (2016)[4]

- Programme-level performance-management data, collected by all Phase 2 sites

- Programme-level analytical summary of the changes in the Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS) scores. This summary details the descriptive and statistical analysis undertaken by Age UK and using the SWEMWBS scores collected and reported by local sites.

- Programme documentation, including reports to funders and minutes from the monthly national learning forum sessions

## 2.2 Analysis of the findings

### 2.2.1 Analysis of the programme's existing evaluative evidence

The evidence assessment used a deductive content analysis methodology, i.e. a bespoke analytical framework was defined prior to the assessment of documents and used to systematically analyse the information from each source of evaluation evidence. The framework, which was tailored to the programme's theory of change, captured qualitative and quantitative evidence relating to:

- Outputs, outcomes and impact, and how these have been achieved

- Lessons learned (including challenges, successes and enabling factors)

- The quality of the evidence/methodology used

The framework, therefore, captured evidence to enable:

- The development of an analytical summary of each source of evaluative evidence

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[2] The findings from the qualitative evaluation are informed by semi-structured, in-depth interviews with 77 professional stakeholders and 12 volunteers, and focus groups and interviews with 97 clients (including 11 carers – clients' spouses or sons or daughters) across the Phase 2 sites. The evaluation was undertaken by Yvonne Fullwood (Understanding Value Ltd) and Chris Bird.

[3] Undertaken by the University of Portsmouth.

[4] Undertaken by the University of Sheffield and Care Connect.

- An understanding of the why and how, as well as the difference the programme made
- Confidence in the findings from each strand of evaluative evidence to be assigned
- Triangulation of the findings from diverse evaluative evidence sources

A thematic analysis of the evaluative evidence captured in the analytical summaries was then undertaken using the Framework approach. This approach allowed for themes to develop from both this evaluation's research questions and from the findings of each source of existing evaluative evidence.

### 2.2.2  Analysis of the programme-management data

Detailed analysis of the programme-management data was confined to the following files:

- The PICP evaluation data file
- Sheffield and Ashford and Canterbury data files, which contained information about the services and organisations with which clients were connected in these two sites (this information was absent in the PICP evaluation data file)

The PICP evaluation data file comprised anonymised performance-management data from each Phase 2 site relating to a sub-cohort of clients who had:

- Consented to the sharing of information for evaluation purposes *and*
- Had a guided conversation between April 2015 and the end of September 2016

This sub-cohort comprised of a sample of 2,071 older people, of whom 1,218 had graduated from the programme and 853 were still receiving support at the end of September 2016. Given that the Nuffield Trust evaluation will provide a detailed analysis of the profile of clients, such analysis was not undertaken as part of this evaluation.

Due to the variation in the quality and consistency of data from each Phase 2 site, the analysis was limited to:

- Analysis 1: the duration of clients' involvement in the programme
- Analysis 2: source of referrals to the programme
- Analysis 3: signposting destinations (i.e. the services and organisations with which clients were connected to help them achieve their goals[5])

For analyses 2 and 3, a typology for referrals sources and signposting destinations was developed iteratively through the analysis process. Each data entry (data was reported at an anonymised yet individual client level) was categorised according to the final typology. For example, the types of organisations with which clients were connected were categorised as either VCS, NHS, local authority, other statutory sector, private or not specified.

## 2.3  Limitations of the evaluation findings

- A process evaluation of Phase 2 of the programme has not been undertaken. The findings from the qualitative programme evaluation, local evaluations and programme-level documentation do provide, collectively, a detailed evidence base of how the elements were implemented in practice. However, these evaluations, or scope of the programme documentation, were designed with different aims and objectives, and at different stages of Phase 2. Therefore, a robust comparative analysis of how the model was implemented and the impact and delivery of the service (across each of the Phase 2 sites) has not been possible. Nonetheless, it has been possible to identify common

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[5] Data relating to signposting destinations was unavailable for Blackburn with Darwen and East Lancashire.

features of the model that have worked well and common challenges, as well as shared elements of effective practice that might be replicated elsewhere.

■ The process for recruiting participants for the independent evaluations could have resulted in a sample of stakeholders (be they professional stakeholders, clients or volunteers) that presented the best impression. However, none of the independent evaluation reports indicate that this was generally the case. Professional stakeholders interviewed have had varying levels of engagement and involvement over the lifetime of the pilots, and have described a range of perspectives from their positions in different parts of the local system. Similarly, clients involved in the research were diverse with respect to their levels of frailty, loneliness and need, the duration, intensity and type of support received and their age.

■ However, all research participants were ultimately self-selecting. Willingness to be involved in the research could suggest greater engagement in the pilots, particularly with respect to non-Age UK stakeholders. Therefore, the qualitative findings in the programme's existing evaluative evidence are not necessarily representative of all partners and their organisations (including all GP practices), clients and volunteers. Most notably, there is limited representation from local authorities. Nonetheless, the findings do provide an in-depth insight into the experiences of diverse stakeholders who have been involved in the delivery of, or have used, the service.

■ The performance-management data used in this evaluation is based on a sub-cohort of clients who have been involved in the programme (see section 2.2.2). Whether this sub-cohort is representative of all older people who were involved in Phase 2 of the PICP is unknown. Furthermore, given the variability and inconsistency of the performance-management information shared by each site, it has not been possible to undertake a detailed analysis of performance across the care pathway. It has also not been possible to draw meaningful conclusions regarding any trends or correlation between, for example, referral routes and types of goals identified or support provided.

■ The proportion of clients from each Phase 2 site within the PICP evaluation data file varies from 4% to 32% (see table 2.1). The analysis reported in Figures 4.1, 4.2, 6.1 and 6.2 are, therefore, biased towards the findings from Sheffield in particular. Instances where the findings in any one site vary materially from those of the programme level are indicated in the text accompanying the given figure.

*Table 2.1: Proportion of clients from each Phase 2 site in the PICP evaluation data file*

| Phase 2 site | Number of clients in the PICP evaluation data file (total:2071) |
|---|---|
| Ashford and Canterbury | 181 (9%) |
| Blackburn with Darwen | 276 (13%) |
| East Lancashire | 277 (13%) |
| Guildford and Waverley | 122 (6%) |
| Portsmouth | 90 (4%) |
| North Tyneside | 251 (12%) |
| Redbridge, Barking and Havering | 218 (11%) |
| Sheffield | 656 (32%) |

- The findings presented in section 3.1 are based on changes in SWEMWBS scores for a sub-cohort of clients included within the evaluation data file. Personal Independence Coordinators used the SWEMWBS tool at three time points with clients (at the start of their involvement in the programme, during the guided conversation: after they had completed their goals; and two months after their intense support ended).

- While effort was made to ensure that the tool was used in a consistent manner across the eight sites, it is not certain that the delivery was the same on all occasions. Staff often exercised their own judgement in introducing and continuing to use the tool, sometimes stopping if it was felt that it would not benefit the older person, or the older person was unsettled by the nature of the questions being asked. Whether the sample of clients for whom SWEMWBS scores were collected is representative of the full cohort of older people involved in the programme is uncertain. Furthermore, only 55% of the clients who completed the SWEMWBS tool at the start and end of their involvement (referred to as sample A), also completed the tool at the two-month review point. The sub-cohort of clients who completed the tool at all three time points was younger in age and contained a higher proportion of females compared with sample A.

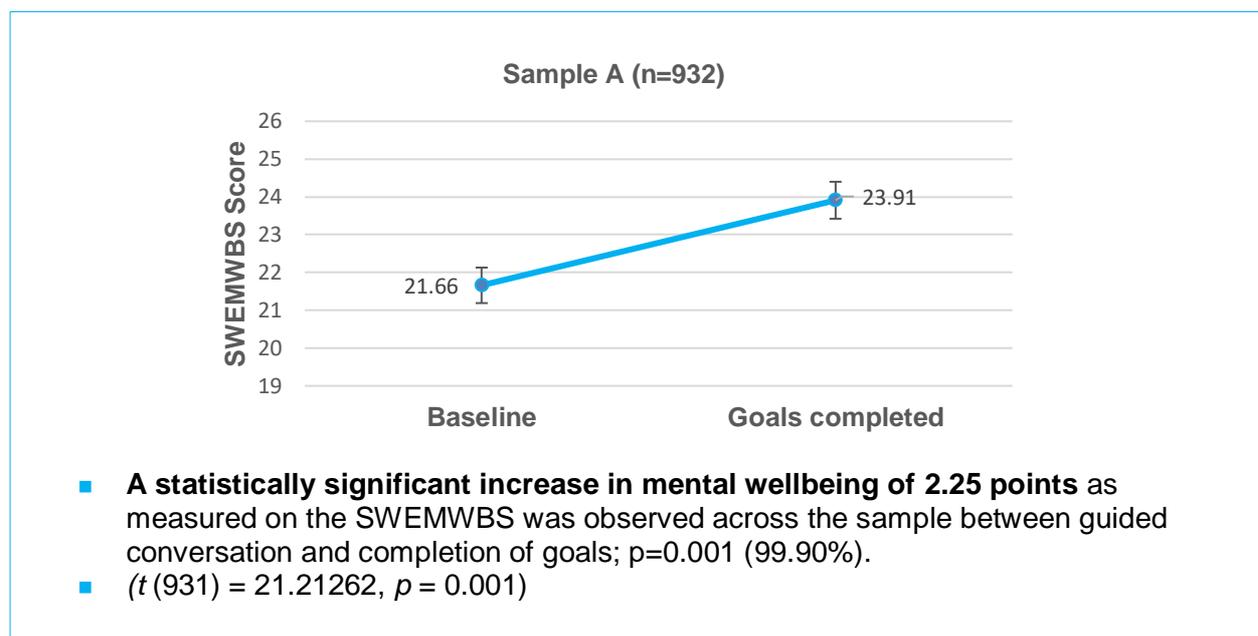# 3 Outcomes from Phase 2 of the programme

## 3.1 Improving wellbeing

The impact of the PICP on older people's wellbeing has been assessed quantitatively using the Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)[6],[7]. The SWEMWBS was collected by the PICs at three time points:

- During the guided conversation with client (the baseline)

- When client had completed his or her goals (at the end of the intervention) – this was based on the older person's individual progress, rather than following a fixed time period (goals completed)

- Two months after the client had completed his or her goals (2-months post intervention review).

### 3.1.1 Changes in SWEMWBS scores

A statistically significant improvement in older people's mental wellbeing, as measured by SWEMWBS, is observed following involvement in the PICP and when they have completed their goals (see figure 3.1); with a 10% increase in the sample[8] mean SWEMWBS score from guided conversation to completion of goals.

*Figure 3.1: Changes in mean SWEMWBS score (sample A)*



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

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[6] The SWEMWBS is a self-reported tool for measuring mental wellbeing comprising 7 of the 14 scale items (questions) of the full WEMWBS. The seven questions relate more to functioning than to feeling and therefore offer a slightly different perspective on mental wellbeing compared with the full WEMWBS. Responses to the seven questions are summed up to provide a single raw score, which is then converted to the WEMWBS score ranging from 7.00 to 35.00. For further information see:
https://warwick.ac.uk/fac/med/research/platform/wemwbs/development/swemwbs/

[7] See section 2.3 for limitations of the findings presented in this section.

[8] For the purposes of the SWEMWBS analysis, the population comprised those older people who had received a guided conversation and had consented to the sharing of information for evaluation purposes; n=2,069 (i.e., data from the PICP data evaluation file – see section 2.2.2 for further information). Sample A is representative of the population with respect to gender, age and ethnicity; analysis has not been undertaken to assess whether the sample differs from the population with respect other variables.

Analysis of a sub-cohort[9] of sample A for whom SWEMWBS were collected at all three review points suggests that improvements in mental wellbeing experienced by clients were maintained two months after the intense support from the PICs ends (see figure B); with a 16% increase in wellbeing in the sample mean SWEMWBS score from guided conversation to two months after completion of goals.

*Figure 3.2: Changes in mean SWEMWBS score post involvment in the programme*



**Sub-cohort of sample A (n=415)**
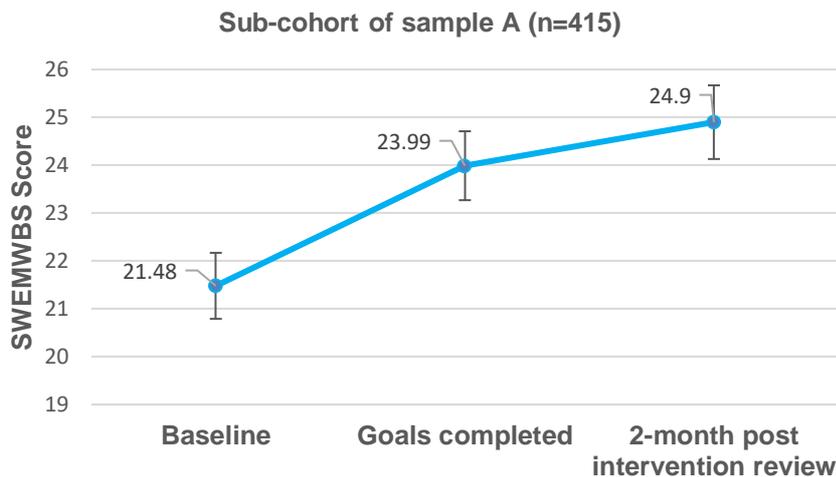
- A statistically significant increase in mental wellbeing of **3.42 points** as measured on the SWEMWBS was observed across the sample between guided conversation and two months post involvement in the programme; $p$=0.001 (99.90%). $(t\,(414) = 17.35750,\ p = 0.001)$
- A statistically significant increase in mental wellbeing of **0.91 points** as measured on the SWEMWBS was observed across the sample between goals completed and two months post involvement in the programme; $p$=0.001 (99.90%). $(t\,(414) = 5.70513,\ p = 0.001)$

Analysis of imputed SWEMWBS values was also undertaken to model the impact of the programme on the wellbeing of the population of clients[6]. This analysis supported the findings presented and indicated that not only does the intervention improve mental wellbeing, but that mental wellbeing continues to improve following the end of the intervention, up until at least two months after the intervention has finished (see Annex 2 for further information).

Finally, no evidence for correlation between the following factors and levels of improvement in wellbeing was observed:

- Baseline level of wellbeing as measured through SWEMWBS
- Gender
- Age
- Time spent on the programme.

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[9] While this sub-cohort is broadly representative of the population, it comprises more females and is younger in age than sample A.

### 3.1.2 How has wellbeing been improved?

Clients involved in the qualitative research consistently described the many ways in which participation in the programme had improved their wellbeing. The findings highlight the fact that the service has been effective in improving wellbeing through a combination of four key mechanisms:

- **Helping older people to become aware of their own needs and fostering agency.** Clients repeatedly spoke about how their PIC's support and approach had allowed them to explore their own needs and concerns, 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 the changes that were important to them. As a result, clients described regaining a sense of control over their lives.

  The findings also suggest that for some clients there has been a behavioural shift, from being passive recipients of care from statutory and non-statutory services towards being more attuned to their own wants and needs and more confident in expressing them.

- **Enabling independence and wellbeing through practical support.** Clients described how the support they had received had increased their confidence to go about day-to-day life, and given them a sense of independence and peace of mind. In turn, this has improved wellbeing. For example, installing external grab rails and ramps has given older people the self-assurance to leave the house; adaptations within the house have enabled people to move around their home and no longer be confined to one room. Having extra money in their pockets, as a result of help applying for benefits, has left many clients less worried about their financial situation and the affordability of everyday necessities. It has also allowed them to occasionally treat themselves and their loved ones. Greater financial security, together with access to low-cost transport, has also helped clients to address the practical barriers to getting out and about, be that to attend appointments, choose and buy the food they eat, or pursue interests and become more socially connected. The acquisition of a blue badge has made it possible for some older people to go shopping, or to accompany their partners or family members on trips.

*"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 it 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 (Guildford and Waverley)*

*"Age UK has been brilliant. [The PIC] has worked with Care Plus to get me walker wheels. Now I have them, I feel more confident going out and walking around the house. She got me a reader, which means I can read print between 41 and 55 font size, and a clock. I am going blind, so doing everyday things like reading letters and checking what time it is are difficult for me. Being able to read again is unbelievable. It means I can read my own letters rather than getting other people to read them to me; some letters are private, about my pension and things like that. But it also means I can read books again." Client (North Tyneside)*

*"[The PIC] helped me get a lot of adaptations for the home: I have stuff to help me get me out of bed. Now I feel more confident, I don't need as much help and I can do a lot more myself. I would have never thought I would have been able to be more independent if she hadn't come into our lives. I am happier now; my aspirations have changed because of the support Age UK gave me." Client (Sheffield)*

- **Reducing isolation and raising ambition by motivating clients to re-engage with interests and become more socially connected.** Many clients involved in the qualitative evaluation (particularly those from Ashford and Canterbury, East Lancashire, Guildford and Waverley, and Redbridge, Barking and Havering) described how they had re-engaged with old interests and developed new ones with help from the PICs (and, in some cases, from volunteers). These clients spoke passionately about how pursuing their interests had enabled them to widen their social circle and feel less lonely and isolated, as well as giving them a sense of purpose. In several instances, the nature of the activities that the older people interviewed had become involved in had also impacted positively on their mobility, strength and balance.

- **Providing an 'extra arm' of support for older people that endures beyond the intense intervention.** In addition to practical and social-action interventions, having regular contact, time and trusted relationships with the PICs, and knowing that support is available, has given clients, in their own words 'an extra arm of support'. This 'lifeline' has helped them to feel more secure and less worried about their circumstances, and, in some cases, less isolated. This in turn has also improved their confidence and wellbeing.

*"It was [the PIC's] enthusiasm that made me think about what I used to do and what I have actually let go of. I had been sitting there, not really feeling sorry for myself but definitely feeling down. Then suddenly she comes along and says, 'You can still do this, what's the problem?' I think a lot of it is motivation – we lose the motivation at some point and get stuck in a rut. But she sowed a seed of thought in my mind that I could do something if I tried. She has inspired me to go back and take up some of the hobbies I had abandoned. I've taken up sewing again, which I really enjoy." Client (Ashford and Canterbury)*

*"I am on my own, and I hadn't been out of the house for a very long time. I wanted to get out and do something to help with my balance, but I needed some help. I think a lot of it was about getting my confidence back. And [the PIC] really helped with that, she has made such a difference to my life. When she first took me to the Age UK centre, I just knew I couldn't walk up and down the slope to the door. I didn't even get out of the car. 'Never mind,' she said, and then we went round the side door and sat and had a cup of coffee in the cafe. That was the start of it. If she had said, 'OK, we'll take you home,' that would have been it, I would have given up. I now go to Tai Chi classes twice a week; I like being around other people, and to have a chat. It has helped me a lot – I've learned about exercises I can do in my chair. Now I can get out of a chair, as long as it has arms, and I can lift my arm more. I did have another fall and that set me back a bit, but I thought, 'Well, I got over it before, I will do it again'." Client (Ashford and Canterbury)*

*"I had been unwell with my chest and was sitting in the house most of the time. All of a sudden, I stopped going out. I suppose I was a bit nervous and that got me down. She asked me what I used to like doing. I used to go the Tuesday club at the church, but I didn't feel confident enough to go on my own. So they took me and someone from the church bought me back, and now I feel OK going on my own. I had just got in that state where I needed a push and someone with me to take that first step. I'm not back to normal yet, but I am getting there and I am working up to going back to another church club I used to go to." Client (East Lancashire)*

*"It was a lifeline when I really needed it. I didn't have to make a doctor or a nurse's appointment to ask, 'How do I go about this or that?', which I don't like doing. I had someone who I could talk to, and that helped me feel like what I need or what I was worrying about isn't a problem. That makes me feel better and more in control. Whatever you wanted to know or ask was at the end of that lifeline, even if it doesn't involve Age UK, they point you in the right direction." Client (East Lancashire)*

### 3.1.3 Improving the wellbeing of carers

Identifying and responding to the needs of clients' carers is a core part of the support the PICs provide. The qualitative evaluation findings suggest that involvement in the programme can deliver multiple benefits for carers[10]. In most of the sites, carers of clients (often their spouses) joined the focus groups. All said that Age UK's support – in addition to simply making them feel better because they could see how much their spouse's or parent's wellbeing had improved – had also been of direct benefit to them personally.

Carers of spouses, in particular, spoke emotionally about how the support they had received had helped them to feel comfortable about also looking after themselves. As a result, they had felt empowered to accept support and take action to improve their own wellbeing. The sons and daughters of clients described how the support from Age UK had helped to give them peace of mind when they were unable to 'be there' for their parent(s) due to family and work commitments.

*"I felt lifted after [Age UK] had been. During the first six months after my husband had a stroke, and after the immediate support had ended, we had nobody but the nurse, other than the family. It felt like we were on our own. Since Age UK, everything has changed, we have had such a lot of help. I sleep easier and it has made life so much easier, so much, because I know we have got this extra support if we need it. My family are there but they aren't always available, but I know I there will be somebody at the end of the phone at Age UK." Wife of client (Sheffield)*

*"Age UK helped me register as a full-time carer. I care for my wife 24/7 and I do get tired. Age UK have helped made me realise that I also need to look after myself. Through their help, we have vouchers for respite care if we need it." Husband of client (Blackburn with Darwen)*

*"My wife's health is getting worse. She falls a lot and can't get out. I was finding it hard to lift her and help her; I have back problems. And it was getting me down, I was getting really depressed. At first, I thought the help offered by Age UK was for my wife, but [the PIC] was there to help me, too. He made me feel comfortable getting help. He has been excellent, helped with lots of things. He also introduced me to Veterans in Communities (VIC). I can't get there that often, as I worry about leaving my wife, but I keep in touch with Facebook and the telephone. Being in touch with VIC gives me something else to think about, something else to do, and that helps me to feel better." Husband of client (East Lancashire)*

*"I care for my wife full time. I don't get much sleep and I was getting to the stage where I couldn't operate, which made it difficult to do everything I wanted for my wife. But then our [Age UK] Living Well Coordinator came into our lives and things started to turn around for us. She put us in touch with people who could help us, and she helped us to make things happen. I didn't know where to go or what was available. If it wasn't for Age UK I would have ended up having a breakdown. Even though I want to be the one who does everything for my wife, I was getting to the point where I couldn't cope. Now I have more support, I am more relaxed, less stressed and that means that I can look after my wife better. I really appreciate what she has done." Husband of client (Ashford and Canterbury)*

*"I care for my parents from a distance. Looking at the dynamics, I knew my dad would never do anything by himself, so I worried about my mum too. I worried about both of them, but I didn't know what to do. So knowing that someone else was there and making a difference took the mental pressure off me and allowed me to not worry as much and get on with my life. It has helped me too." Daughter of client (Redbridge, Barking and Havering)*

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[10] Eleven carers across five sites participated in the qualitative research along with clients. The small sample size limits the findings' generalizability. However, further evidence suggesting that the programme has delivered multiple benefits for carers is provided by two more key sources: the feedback from clients involved in the programme, and the PICs and health and care professionals interviewed, whose views corroborated carers' experience of the service.

## 3.2 Improving experience of care and its delivery

Clients and stakeholders alike reported that the experience of care was greatly improved by enhancing access to care and support and facilitating a more person-centred approach to care planning.

### ■ Improving care coordination and timely access to personalised care and support

Before they had the PICs' support, many clients involved in the research across all sites 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'. Language barriers had also prevented some older people from accessing support. Many clients mentioned that the PICs had been able to arrange access to practical and medical assistance especially much more quickly than other services they had experienced. Clients described being surprised and pleased at how fast the PICs had 'got things moving'; as a result, many 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 person-centred 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 of older people. Multi-disciplinary working has played a key role in this change (see section 4.1.2). 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.

In some instances, the service has also supported more opportunistic and responsive care. This is a result of the PICs' ability 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.

*"No-one was aware of the situation. We were quite isolated, we felt like we were being missed by services, and didn't know what help we could get. The language barrier was an issue. We couldn't get across what help we wanted and we felt like people couldn't relate to us or understand. [The PIC] spoke to us in our own language – she asked the questions nobody else asked and helped us access the support we needed." Client (Blackburn with Darwen)*

*"The contact between [the PIC] and medical centre is great. She has made things happen – she has worked along with the occupational therapist and got me handrails and a seat. She has helped me get a physiotherapist too. They seem like little things, but they are really important and make a difference to my day-to-day. I didn't know where to start or who to contact before she came." Client (East Lancashire)*

*"It has helped to join things up – it's the most holistic facility we have. Health trainers can do three to six sessions; social services do a different job. Age UK is the most holistic and joined up, which is really useful." Professional stakeholder (Sheffield)*

*"The PICs have helped to reframe the discussions in the MDT meetings, it makes the discussions 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. In many cases [the PICs] have been able uncover social issues and the underlying presentations of these patients that weren't obvious to us beforehand. The PICs would come back to the MDT meeting and mention it and that would help us to look at how we would care for that individual, informed by that softer knowledge." Professional stakeholder (Redbridge, Barking and Havering)*

*"[The PIC] will often identify a health need in a patient she has been seeing. She has been able to identify cognitive problems that we didn't realise patients had, and opportunities to improve meds management, and she has been able to help us become involved in things like Power of Attorney decisions." Professional stakeholder (Ashford and Canterbury)*

## 3.3 Reducing the cost pressures on the health and care system

### 3.3.1 Reducing hospital admissions

Because of the challenges in accessing local healthcare data (see section 5.5), stakeholders from most sites were uncertain about the impact the service has had on acute care. Two local Age UKs that have been able to access data have assessed changes in clients' hospital activity before and after their involvement in the programme. The results are promising. However, whether the observed positive changes are due to other factors, including regression to mean[11], is still uncertain. The Nuffield Trust evaluation – in which changes in hospital activity will be assessed using a matched control group – will give a clearer picture of the programme's impact. Factors likely to influence the programme's impact on hospital activity are discussed in section 8.1.

> *"We have tracked patients pre and post intervention and we have seen a statistical change in the number of hospital attendances: unplanned hospital admissions and A&E attendances have both decreased by 16%."*
> *Professional stakeholder (Ashford and Canterbury)*

> *"We have some preliminary data and have seen a reduction in patients under Age UK in terms of admission to hospital. However, because these patients are under Interdisciplinary Neighbourhood Teams (INTs), it's difficult for us to attribute directly whether it's Age UK or being part of the INT that has made the difference." Professional stakeholder (East Lancashire)*

### 3.3.2 Freeing up GPs and practice staff to focus on primary tasks

The qualitative evaluation of Phase 2 indicates that, for the majority of sites, the PICP has had a positive impact on the workload of practice staff. This is because the programme has supported those older people who would otherwise have sought help from their GP or other healthcare professionals for underlying non-medical needs.

> *"We have some evidence that the model has saved GPs' time. This is very much linked to Age UK, because the team and volunteers are able to respond to the non-medical needs of patients, so those patients are less inclined to contact the GP because they are lonely." Professional stakeholder (North Tyneside)*

> *"I would recommend other practices to get involved because it reduces your workload. Taking the time to engage with Age UK frees up some of your other time to deal with the more complex cases. It benefits your patients, because you have got somebody else out there identifying needs where people may not be asking for it, so it's a win-win." Professional stakeholder (Ashford and Canterbury)*

> *"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." Professional stakeholder (East Lancashire)*

> *"From a GP perspective, it's easy to spot the patients who come to the medical centre who have a non-medical need. We hadn't previously had anywhere to signpost these people to. So their need was unmet need. We didn't have anyone who had the time or expertise to deal with non-health issues. These patients didn't have anywhere else to go, or didn't know where to go. They would visit the GP because they are known and there is a perception that the GP will sort everything out for them. So that has been a big impact for GPs." Professional stakeholder (Blackburn with Darwen)*

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[11] The reductions in hospital activity in the two sites could have occurred as a result of the regression to mean. This statistical phenomenon signifies, in this context, that clients with frequent hospital admissions prior to involvement in the programme will, on average, have lower rates of hospital admissions in the future, even without the PICP's intervention.

> *"We haven't seen as much of some of our patients since the service, where previously we were their point of contact for non-medical things that we don't support. The fact that they have had someone else to go to or someone to talk to about things, or that the PICs have put in place support to help with their social issues has driven that difference." Professional stakeholder (Ashford and Canterbury)*

> *"It has helped address some of the social factors that GPs often get bogged down in. [The PICs] have been helpful in trying to sort out non-medical support that a patient might otherwise come to me for. But I wouldn't necessarily know how to help them – things like a blue badge, and supporting them in writing the application. The PICs' support takes away from a GP or social worker having to do things like that. So it has helped to free up time to devote to the clinical aspects of care." Professional stakeholder (Redbridge, Barking and Havering)*

### 3.3.3 Responding to unmet demand and supporting 'right care, right time, right place'

There was strong agreement across most sites that, by filling a gap in existing statutory services, the programme has been effective in answering previously unmet need. For some clients, involvement in the PICP has also filled gaps in their wider support networks. In addition, the findings from the qualitative research highlight that the programme has uncovered and responded to need that had previously been unidentified. When asked what they would have done had the service not been offered to them, clients involved from all sites replied that there was nothing comparable available so they wouldn't have done anything. Common responses to the question, *'Where would be you now if the service had been unavailable?'* included: '*I would have been lost'; 'I would have been depressed'; 'I would have been stuck in the house'; 'I don't know where I'd be now'; 'We would have just kept on like we were, struggling on*'; '*We would have just kept on feeling like we were on our own'*.

> *"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." Professional stakeholder (Ashford and Canterbury)*

In some instances, responding to unmet need will lead to an increased use of statutory healthcare services resources. Indeed, the analysis of the support clients receive to achieve their goals highlights that while referrals to social care account for less than one percent of all referrals to other services, a minimum of 286 clients have been referred to the NHS, particularly primary care, through their involvement in the programme (see section 4.1.3, figure 4.2). Nonetheless, stakeholders from several sites shared the view that the service has supported clients to access the right care, at the right time and at the right place.

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

Three key elements of the model have proved to be critical in improving the planning and provision of integrated, holistic, person-centred care. While each has been effective in its own right, when combined these elements have delivered real benefits to older people (irrespective of their profile) and added value, especially to primary care.

## The guided conversation and continuity of support

- Trusting relationships are built over several home visits, enabling the older person to express their desires and needs freely
- A conversation, not an assessment, that 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 address the client's reluctance to accept or seek help (from statutory organisations or elsewhere) and his or her motivation to make changes

**Older people are treated as equal partners in a discussion that empowers them to identify their preferences and goals – and their strengths.**

**Care planning goes beyond a set of actions for health and care professionals to take. Instead, it focuses on how services and support can help ensure that older people's preferences are met and their goals are achieved.**

## Multi-disciplinary teams involving the PIC

- Provide 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
- Shift the discussion and solutions away from a medical model
- Facilitate timely access to coordinated care

**MDT working builds 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 more coordinated care and support that recognise their holistic needs and preferences.**

## PICs' local knowledge and support that extends beyond 'signposting

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

**PICs are a single and trusted point of contact to access diverse care and support.**

**Older people are motivated and supported to take action to achieve their goals.**

**People and services are connected in the community.**

### 4.1.1 The guided conversation with older people and the continuity and duration of support

Unprompted, clients across all sites consistently described the guided conversation as being 'like chatting to your friends and family', and spoke about feeling valued, listened to (rather than 'talked at') and in control. The discussions they had with their PIC, they said, had not seemed in any way like an 'assessment'. Furthermore, clients felt that the PIC provided help because he or she genuinely cared about them – there was no sense of the conversations being a task or a transactional interaction. A critical aspect of these exchanges has been the additional time available to PICs to spend with clients in their own homes, and the continuity of their support over an extended period, thereby allowing trusting relationships to be established. In many instances, these elements of the model have also made it possible for PICs to understand and address clients' reluctance to accept or seek help, be that from statutory organisations or elsewhere.

*"She put me at ease. She spoke to me on the same level. I wasn't talked down to and she treated me as a person, rather than an object. That happens to me quite a lot these days – people speak to you like you don't know anything or don't know your own mind, but I can still function on an intellectual level. That's what was different: she made me feel like a person and she listened to what I was saying and I found that very, very encouraging. It made me think more about what I needed and wanted to do." Client (Ashford and Canterbury)*

*"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 (Redbridge, Barking and Havering)*

*"Straight away, I felt like she cared. She didn't judge me and she listened. And that meant I just opened up and spoke about what was worrying me. It also helped me to think about what I wanted. Age UK has helped me to turn my life around." Client (Blackburn with Darwen)*

*"She asked me what I wanted, what I would like to do, if I needed any help with anything. I felt like she put herself in my shoes, and she really acted on my behalf. She has a way of making me feel in control. Her help has improved my life. It has improved the way I do things." Client (North Tyneside)*

*"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 (East Lancashire)*

### 4.1.2 Multi-disciplinary working involving the PICs and other health and care professionals

Given the nature of many clients' needs, multi-disciplinary working involving the PICs and health and care professionals (including social care) has been key to helping older people to achieve their goals. Specifically, MDT working has facilitated the coordination of, and timely access to, support to meet clients' holistic needs in a person-centred way. MDT working has also provided an effective mechanism with which to establish and maintain trusting relationships and ways of collaborating between various disciplines, and to raise the profile of the value offered through the programme.

Non-Age UK stakeholders in several localities highlighted the fact that the involvement of PICs in MDT meetings had supported more person-centred care by shifting the conversation from a medical model to more holistic care planning for older people.

> *"[The PICs] have helped to reframe the discussions in the MDT so that they are able to be more holistic, and 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." Professional stakeholder (Redbridge, Barking and Havering)*

> *"Being part of the MDT means that I have access to lots of different services. It's really integrated – having the dedicated face-to-face time helps to get things moving really quickly for my clients." Professional Age UK stakeholder (Ashford and Canterbury)*

> *"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." Professional stakeholder (North Tyneside)*

### 4.1.3 Knowledge of the local statutory sector and community offer and support that extends beyond signposting

The PICs' knowledge of the local assets available to support older people, and their ability to connect their clients to those resources, were identified by commissioners, clinicians and clients alike as a key strength of the programme. PICs have provided clients and GPs with a welcome single point of contact to access a diverse range of help that they had previously either not known existed, or had been unaware of how to access/not had the capacity to access (see figures 4.1 and 4.2).

> *"I think 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 (Ashford and Canterbury)*

In several localities, stakeholders noted that the PICs' grasp of 'what's available in the community' extended beyond 'what's out there on paper or on the internet' to having a real understanding of the nuances of different clubs, groups and services (be they delivered by Age UK or other organisations). This insightful understanding enabled the PICs to work with clients to find opportunities that would better meet their individual needs and preferences in a way that a 'directory of what's on offer' could not.

> *"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 (Sheffield)*

> *"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." Professional stakeholder (Redbridge, Barking and Havering)*

A unique feature of the support they had received that clients most appreciated was the 'follow-through' after the initial conversations, with respect to both practical help and, in

some sites[12], support to connect with interests. In clients' own words, they had also valued the fact that their PIC's help had consisted in 'doing, rather signposting'.

> "A lot of organisations say, 'You can do this or that' and then they give you a list. They don't do the next thing, which is helping you to make it happen. You can be sat at home with your list thinking, 'I would like to do this'. But if you haven't done anything for a long time, you lack the confidence to take the next step, or you don't know who to contact to organise something, or you worry that it might be too expensive. Age UK was different: they helped to get things started, that initial organising of transport and things that are crucial in enabling you to actually do something." Client (Redbridge, Barking and Havering)

*Figure 4.1: Which types of organisations were clients connected with?*
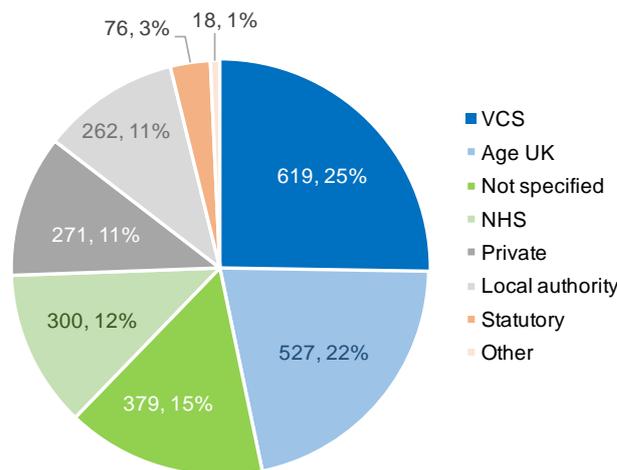


- Collectively and through the programme's support, 1,191 older people were connected with 259 VCS organisations distinct from Age UK. These were the most common type of organisation with which clients were connected, accounting for 25% (619) of all connections.

- Reflecting the patterns of services with which clients were connected (see figure 4.2), local Age UKs[*] were the second most common organisation type.

- 11% (271) of connections were made with private sector organisations. These include private home care and garden services providers, energy suppliers, mobility shops (specifically for wheelchairs and scooters), chiropodists and pharmacies*.

- In addition to NHS and local authority services, clients were also connected with other statutory services including, for example, information and advice from the DWP (for benefits advice and support), universities (for educational courses) and fire services (for home fire safety checks).
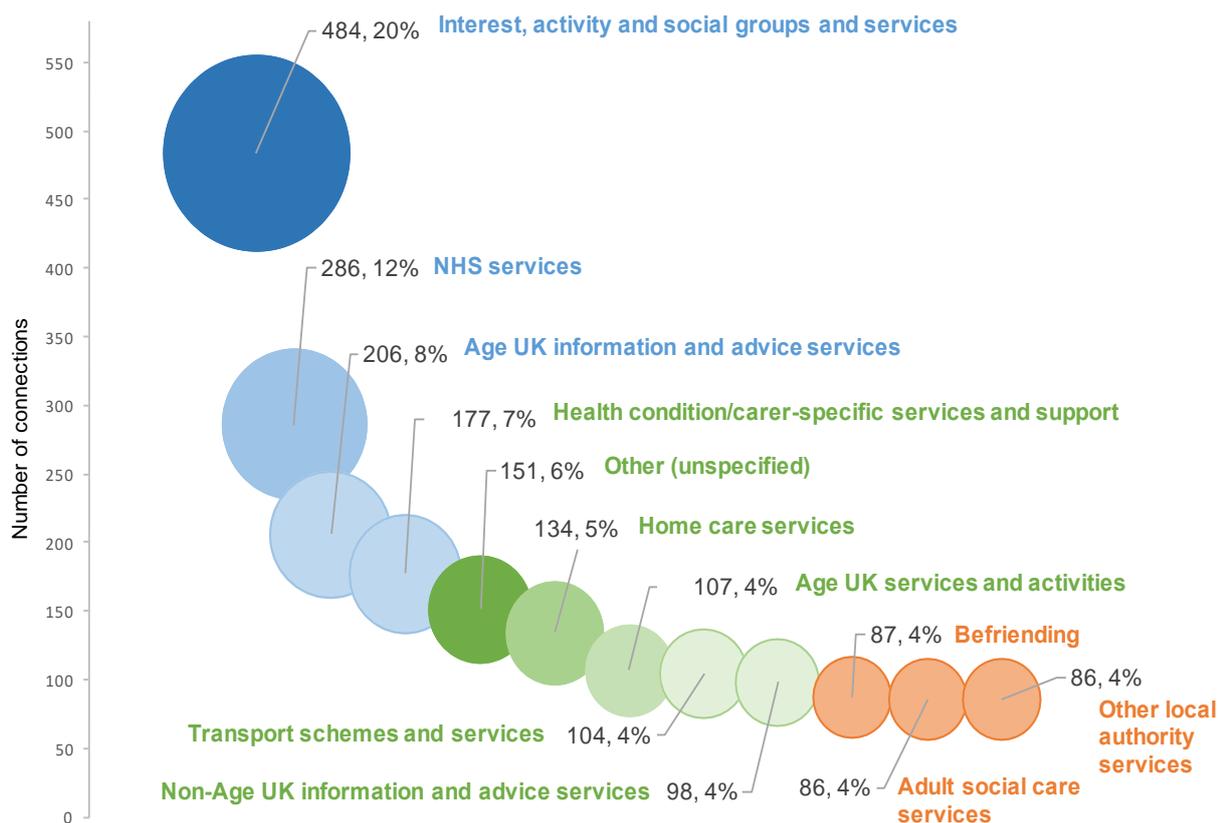
*Data source: PICP evaluation data file; Sheffield and Ashford and Canterbury data files (see section 2 for further information and limitations of the analysis) n=2,452 connections*

*From the evidence provided it is not possible to identify whether these were NHS dental and pharmacy services. The findings from the qualitative evaluation suggest that dental services, in particular, are likely to be NHS funded.*

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[12] All sites have provided follow-through support to help meet clients' practical needs. However, sites have varied with respect to their delivery of social support. Two sites (Blackburn with Darwen and Sheffield), neither of which has used volunteers, have typically (but not exclusively) 'signposted' clients to community offers, rather than providing 'hands-on support' to help clients participate in their chosen interests/hobbies. The findings from focus groups with clients from these sites indicate that the PICs do explore with clients whether they have pursued the social activities that they have been signposted/referred to. The signposting approach mitigates the risk of creating dependency on the service. However, the findings suggest that, for some clients, signposting or referral alone is insufficient in helping them overcome all of the barriers they face in reconnecting with hobbies and interests and/or expanding their social connections within the community.

*Figure 4.2a: The top 12 services, activities and groups clients were connected with to achieve their goals*



484, 20% **Interest, activity and social groups and services**

286, 12% **NHS services**

206, 8% **Age UK information and advice services**

177, 7% **Health condition/carer-specific services and support**

151, 6% **Other (unspecified)**

134, 5% **Home care services**

107, 4% **Age UK services and activities**

87, 4% **Befriending**

86, 4% **Other local authority services**

**Transport schemes and services**

104, 4%

**Non-Age UK information and advice services** 98, 4%

86, 4% **Adult social care services**

*Number of connections* (y-axis: 0, 50, 100, 150, 200, 250, 300, 350, 400, 450, 500, 550)

*Data source: PICP evaluation data file; Sheffield and Ashford and Canterbury data files (see section 2 for further information and limitations of the analysis) n=2,452 connections.*

- Collectively, a sub-cohort of 1,191 older people received 2,452 'signposts' to services, activities and support networks (referred to as services from here on in) within their community*,**. On average, each client was connected with at least two services.

- Interest, activity and social groups and services are the most common services with which clients were connected (see figure 4.1a). These include social groups such as lunch clubs, home library services, walking groups, exercise classes, University of the Third Age and special interest societies, provided, typically by VCS organisations, including Age UK.

- Referrals to NHS services account for 12% (286) of all connections (figure 4.2a), with physiotherapy and GPs being the two most common services to which clients were referred (see figure 4.2b)***. In contrast, only 4% (86) of clients were referred to adult social care services (see figure 4.2a).

- 8% (206) of all connections were with Age UK Information and Advice services (see figure 4.2a). Although not all sites have reported the nature of clients' queries, the evidence available suggests that requests for information and advice about financial support, including benefits checks, were particularly common. 4% (107) of all connections were with other Age UK services and activities**** (see figure 4.2a). These include funeral planning services, legal services, Age UK care-coordinator services (distinct from the PICP) and volunteering opportunities.
*[Continued on the next page]*

*[continued from previous page]*

- 7% (177) of all connections were with health condition or carer-specific services (see figure 4.2a). These typically include VCS services specialising in, for example, the management of respiratory and heart conditions, dementia advice and support groups and mental health support services.

- Additional services with which clients were connected include: equipment for independent living; personal alarms or telehealth services; home fire safety checks; eyesight tests and hearing aids; energy advice and support; podiatry services; housing support; and nuisance telephone calls and mail blocking services. Signposts to each of these services account for one or two percent of all connections.

*Figure 4.2b: Which NHS services were clients connected with?*
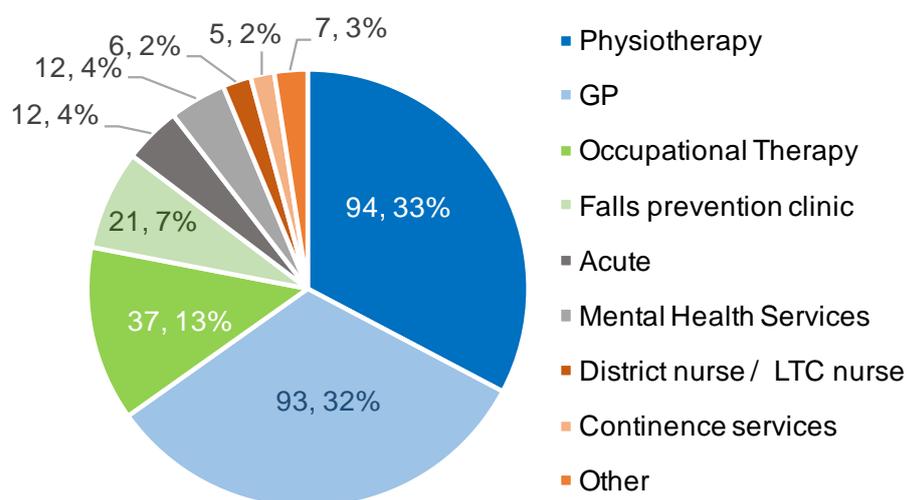


Data source: PICP evaluation data file; Sheffield and Ashford and Canterbury data files (see section 2 for further information and limitations of the analysis) n=286 services.

*The findings presented are based on data from Ashford and Canterbury, Guildford and Waverly, Portsmouth, North Tyneside, Sheffield and Redbridge, Barking and Havering. The evaluative evidence shared did not include data relating to the services with which clients were connected in Blackburn with Darwen and East Lancashire.*

**The evaluation data underpinning the analysis captures the services, activities and support networks to which clients were 'signposted'; information regarding whether the clients were supported by a PIC or volunteer to take the first steps to connect with those services is unavailable. Nonetheless, the qualitative findings suggest that with respect to practical support, clients were typically assisted, beyond the provision of information, to connect with services. However, the findings suggest that two sites (Blackburn with Darwen and Sheffield) typically signposted clients to social support, such as social and activity groups (see footnote 6, page 18 of this section).*

***Connections with NHS services vary across the Phase 2 sites included within the analysis presented, accounting for 8% of all connections in Ashford and Canterbury, Portsmouth and North Tyneside, 11% in Sheffield and 17% of all connections in Redbridge, Barking and Havering. No connections to NHS services were made in Guildford and Waverley.*

**** This figure could include connections to Age UK activity and social groups, and information and advice services – not all sites distinguished consistently between the precise types of Age UK 'services and activities' to which clients were signposted.*

# 5 Common challenges associated with delivering the model

## 5.1 The risk stratification criteria

Unlike other elements of the model, the Two Plus Two risk stratification criteria were contested from the outset in the majority of the Phase 2 sites – despite each site having a sufficiently large cohort of clients who met the criteria[13]. Commissioners, especially, were in favour of broadening the criteria to better reflect local context and need. Nonetheless, Age UK and local partners agreed that in the first instance they would test the Two Plus Two criteria, which were therefore applied as co-design and initial implementation went ahead.

However, in practice, focusing solely on older people who meet 'Two Plus Two' proved unworkable across all Phase 2 sites for several interrelated reasons:

- For many of the clients who met the Two Plus Two criteria, achieving sustainable improvements in independence was challenging, given their frailty and the instability of their health

- Older people in the initial local target cohort were often already receiving packages of care

- Local need drove demand for greater focus on earlier prevention, combined with recognition that the Age UK Personalised Integrated Care model could benefit a wider cohort of older people

Post implementation, and in response to learning on the ground, the risk stratification criteria were therefore expanded to better reflect local context, demand and need, yet still retained a focus on a high-need, high-cost cohort of older people[14]. In every Phase 2 site the criteria were broadened to include older people who had experienced one or more hospital admissions in the previous 18 months. The findings indicate that, as the pilot progressed, the criteria were relaxed further to varying degrees across the sites. This was in response to the identification of older people who were clearly in

## Box 5.1: The 'Two Plus Two' risk stratification criteria

The model uses risk stratification to identify those older people who can most benefit from the programme. Reflecting the limited maturity of the use of predictive risk stratification tools in each Phase 2 site, a threshold (criteria-based) approach to targeting older people was adopted. The proof of concept study and subsequent data analysis suggested that the participants in the programme who are most likely to achieve its Triple Aim are older people who meet what is termed the Two Plus Two criteria and:

- Have two or more long-term ambulatory sensitive conditions (LTCs), *and*

- Have experienced two or more unplanned hospital admissions in the previous 18 months, and are at high risk of becoming frequent users of hospital services

These are 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 the programme's three aims. Based on the proof of concept model, the programme therefore focussed on targeting older people who meet the Two Plus Two criteria.

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[13] The application process for involvement in Phase 2 and early co-design included confirming whether, in each site, a large enough cohort of older people who met the Two Plus Two criteria existed to deliver the expected savings associated with reduced hospital admissions. The data analysis undertaken confirmed that a sufficiently sized local 'Two Plus Two' cohort existed in each locality (i.e. there was a local 'problem' to which the Age UK PICP could provide a solution).

[14] Given the risk stratification criteria for the Accountable Care Organisations in which the PICP programme has been integrated in North Tyneside and in Redbridge, Barking and Havering, in these sites the healthcare needs of clients involved in the programme have typically been complex. Many have high levels of frailty, despite the relaxing of the criteria for inclusion in the PICP programme.

need of the support offered and in recognition that the model could benefit a wider cohort of older people.

Across all sites, stakeholders' views were mixed as to whether the criteria should be broadened or tightened further. Some thought that the programme should be available to those who could benefit, irrespective of their prior hospital-admission status. Others felt that, instead of prior hospital admissions, the criteria should reflect different risk factors. A minority of stakeholders were in favour of 'tighter' criteria, defined locally to mitigate the risk of dilution of the value of the programme and/or the risk of the programme becoming another 'generic' service in the landscape.

> *"Partly the reason we tweaked the criteria and the model is that the people referred were very, very poorly – most had four or five LTCs. There were definitely things we could do to improve their quality of life, help them or their carers, but we couldn't make a dramatic impact because we were getting to them too late. I think that was partly because of the target criteria, and also because that's how the system works at the moment – we wait for people to be in crisis." Professional Age UK stakeholder (East Lancashire)*

This study has found that in practice, staying faithful to the core elements of the model needs to be balanced with the flexibility to adapt it to the local context. Furthermore, taken together, the findings highlight the tension between a targeted service model, which aims to deliver cost savings for the health and care system in the short term, with a more wide-reaching or 'earlier prevention' service that might better meet local need or demand but for which impact on acute care use in particular could take longer to become apparent.

## 5.2    Engaging General Practitioners (GPs)

Securing genuine GP involvement consistently across 'the patch' has been challenging for sites delivering the service through individual practices. Inevitably, while some practices engaged early on, others have been slower to become involved. This in turn has led to peaks and troughs in referrals – ultimately with the number of older people referred from primary care being lower than expected.

The barriers to GP engagement have been inextricably linked and are not unique to this programme: lack of capacity; lack of understanding and appreciation of the quality and potential value of the support offered; concern about sharing patient information; and the pilot status.

While the breadth and efficacy of the action taken to address these barriers has varied across the Phase 2 sites, all have taken steps to support GP engagement (see box 5.2) by building trusting relationships and demonstrating credibility. In most sites, GP engagement has improved during the pilot. However, many stakeholders underlined the need to further embed the PICP within primary care in order to ensure the programme's sustainability.

**Box 5.2: Engaging GPs and primary care – what has worked?**

✓ **Engaging with GPs and practice managers during co-design involving a collaborative approach between the CCG and Age UK.** By collaborating closely with the CCG, sites have raised awareness and tested the case-finding process during co-design and early implementation. This has ensured that a cohort of GP practices are engaged enough to refer older people when the service 'goes live'.

✓ **Investing energy in a rolling programme of engagement to build relationships, understand needs, secure buy-in and strengthen perception of how the service works and its value.** Revisiting practices and sharing client case studies has improved appreciation of the support offered and the difference it has made to older people locally, thus encouraging GPs who were initially less engaged to buy in to the programme.

✓ **Providing hands-on support to GP practices**. By creating the lists of patients who meet the risk stratification criteria and preparing invite letters, local teams have addressed primary care capacity issues, secured engagement and increased referrals. PICs in several sites have also created goodwill, built trust and demonstrated credibility early on by supporting practices with other, similar initiatives and challenges. *"We started to prove our worth by helping to solve the problem that some patients were not attending all of their appointments. We got feedback from the older people and organised four or five appointments on one day/in the same location, which we supported people to attend. We have also been doing the Friends and Family Test for all of Care Plus."* Professional Age UK stakeholder (North Tyneside)

✓ **Using and nurturing champions to spread the word**. Hearing the message from trusted peers or those with power and influence has encouraged GP practices to engage. *"We had two very engaged GPs, our CCG clinical leads, who were very supportive. They worked alongside me to get the right sort of comms out to the practices with the right messages. Getting those recommendations certainly helped."* Professional stakeholder (East Lancashire)

✓ **Having a clear, straightforward referral process and explaining how the programme differs from other service**s. East Lancashire Age UK produced an infographic for GPs showing the differences between the PICP and other VCS services. Several local Age UKs have introduced a central referral point, where cases are triaged and passed to the appropriate Age UK service (also reducing inappropriate referrals).

✓ **Using a variety of communication channels to share information about the service and individual clients and their progress**. Honorary NHS contracts have allowed PICs and GPs to share data about individual patients by email, for example. But face-to-face and telephone conversations have also been essential to building relationships and understanding of ways of working, and to creating a real-time dialogue about the service and older peoples' needs.

**…. and opportunity for improvement:**

✓ **Switch GP engagement up a level by reviewing whether communication loops are effectively demonstrating value. Show the scale of the support offered.** Find out if GPs actually use the information shared with them and what kind of information they need to help them better understand the service and its value. For one site, Sheffield, taking the time to do this has supported the creation of effective feedback loops and thus increased primary engagement. *"I did a lot of work meeting with and getting into the heads of individual GP's. Seeing the world through their eyes, what is it that matters to them, what are their pressure points, how can we help them to achieve what they want to achieve? It meant we could tailor the service and the information we communicated back to each practice's needs."* Professional Age UK stakeholder (Sheffield)

✓ **Send practices concise and compelling summaries of the support given to *all* their PICP patients – not just individuals – and the goals achieved overall.** This will strengthen GPs' understanding of the scale of the value offered and is likely to boost their engagement.

Cross-cutting each of the above are building trusting relationships and demonstrating credibility – both been critical to securing the engagement of GPs and other health and care professionals.

## 5.3    Involving volunteers

In involving volunteers, the programme's aims are threefold:

- To draw on and build social capital to improve the quality and experience of care for older people

- To support the model's assets-based approach to care by helping people and services establish better relationships within the community

- To support the cost-effective and sustainable service delivery model

In sites where dedicated volunteers have been used, there was strong consensus that their involvement had been critical to supporting clients to achieve positive outcomes – particularly in reducing isolation and loneliness, and empowering clients to become more socially connected. Volunteer roles have varied depending on the clients' needs. They have ranged from 'a light touch' to 'more intense support' and have often blurred the boundaries between practical support, mentoring and befriending. In many instances, volunteering with a client has extended beyond the 12-week period.

In the sites where dedicated volunteers have not been used, PICs have:

*"The support is very much responsive to [the older person's] needs. My first client was a gentleman and it was quite a light touch. I gave him a lift to have lunch in a care home a couple of times. It was about getting him into the habit of going and meeting other people, so he could retain that after being involved in the project. Isolation was the main issue with the second lady. I spent time with her in her home, talking about family and going through photos. She also needed some practical help, so I would pick her up and take her shopping. It was more intensive for the third lady – her daughters were unwell, and she herself had her own health problems. For her, my support was about increasing her confidence, getting her out for a cup of tea and breakfast and things like that. But it was also about supporting her emotionally, giving her the space to off-load all the things that were going on in her family. I also did practical things, like tidying up. Working with [the PIC], I helped to get the client support for social care and to get her a referral for counselling." Volunteer (East Lancashire)*

- Provided the ongoing mentoring/practical support that volunteers would have given; *or*

- Typically, signposted clients to social activities and resources in the community to help them connect with their interests and widen their social circles

However, in practice, for all local Age UKs taking part in Phase 2, involving volunteers has been difficult. As a result, for many sites the full potential of the volunteering element of the model has not been realised. While all sites have drawn on other Age UK volunteer services, only four sites[15] have used dedicated PICP volunteers.

The challenges have been threefold:

- **Low levels of volunteering locally:** For some sites or within sub localities, the prevalence of volunteering in general is low, often as the result of demographic factors. Even with targeted recruitment activity, several sites have been unable to create sufficient demand for volunteering on the programme.

- **Timing of recruitment:** A number of sites established a pool of volunteers early on. However, delays in going live with the service and/or the lower-than-expected number of older people joining the programme resulted in some volunteers – being left with little to do – deciding to pursue other opportunities instead.

- **Matching clients and volunteers:** Having a pool of volunteers that matches clients' varied personal needs at any given time has proved difficult. There has been a tension between recruiting and maintaining the involvement of enough volunteers, with the uncertainty about whether and how clients would like to be matched with a volunteer.

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[15] East Lancashire; Guildford and Waverly; North Tyneside; Redbridge, Barking and Havering

By exploring a range of workforce models and various kinds of support, Age UK and local PICP teams have tried to address the challenges of involving volunteers without jeopardising the significant contribution they can make to clients' wellbeing. Initiatives taken have included the introduction of a support worker as a substitute for the volunteer role (Age UK Portsmouth) and the recruitment of a volunteer coordinator (Ashford and Canterbury).

Involving volunteers offers a relatively lower-cost service delivery model. However, the findings are consistent with wider discourse[16] in highlighting that using volunteers is not cost-free. Greater investment in time and resources is essential to realise the full value that volunteers can bring, even though they themselves are unpaid. Beyond investing in recruiting enough volunteers, their effective management and support has involved:

- Ongoing team-working and a dialogue between the volunteer, the PIC and the client to identify and discuss the older person's goals and the support he or she needs.

- Providing supervision or regular opportunities to reflect and discuss experiences and challenges, and to explore ways to improve the service, either one-on-one or as a group involving other volunteers.

- Training volunteers – while volunteers were satisfied with the training (and indeed the support) they had received, many would have also welcomed some additional, more tailored training on the realities of supporting and motivating the target cohort of clients. This would be particularly useful to volunteers with limited experience of working with older people and little knowledge of how different LTCs can affect a client's quality of life.

- Putting mechanisms in place to ensure both the volunteer and client are supported appropriately when the client's involvement in the programme comes to an end. This includes creating processes to safeguard both the volunteer and client, should the volunteer-client relationship continue past the duration of the intense support.

> *"Age UK have been very, very supportive of me. While I have not had a lot of formal training, I have had a sense that, whoever the PIC is (I have had three different ones), they have always been at the other end of the phone. I might be doing the frontline support work, but there is a lot of dialogue with Age UK so they can also provide support, advice and wider care coordination. It's a team effort: between us we can pull on a lot of resources to help the client and it doesn't feel like my responsibility to sort everything out. If that dialogue wasn't there I would struggle to volunteer because I am not involved 100% of the time; you are just doing a bit of the support that clients get. We always have debrief conversations too. That's very important, especially when the client has more complex needs – having someone who you can reflect and speak with about what's happening and what might help is essential." Volunteer (East Lancashire)*

> *"Once the 12 weeks were up it was hard to detach, and I still wonder how [the client] is. I would like to have more contact, but I am uncertain whether it's really appropriate. It was in a professional capacity that I was seeing her, even though I was a volunteer. It's an odd one because it's professional but, by its nature, it's also personal. It blurs the boundaries a little bit." Volunteer (North Tyneside)*

> *"One of the ladies I supported has become very special to me, and we have become friends. I didn't expect to get attached. I've worked in the care sector all my life and never got attached to any of my patients. But this time it was different. I don't visit her every week, but I do get in touch once a month at least. After each visit I still fill in the report for Age UK. It has made me a bit wary of doing more volunteering, though." Volunteer (Redbridge, Barking and Havering)*

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[16] For example: Naylor C, Mundle C, Weaks L, Buck D (2013) *Volunteering in health and care - Securing a sustainable future*, The King's Fund

## 5.4 Addressing gaps in the community offer and creating sustainable networks of support

> *"There are real gaps in the support available. We really need to be responsive to what people want. If people keep requesting it [an interest they want to pursue], we need to do something about it. We need to think about how we can use what's available already, and whether we can make it possible for others to deliver it. If not, can we [Age UK] do something and how do we make the support sustainable? One of the benefits of delivering the service is that it strengthens our understanding of what people need. For many people, daycentres are old fashioned – they want something different. We are capturing information about what's changing and what people actually want and need to do, and that gives us a real opportunity to help make a difference for older people."*
> *Professional Age UK stakeholder (Ashford and Canterbury)*

Considerable time has been invested in mapping and continually exploring how to connect to community assets beyond wider Age UK and statutory services. This has been critical, not just during the programme's co-design and early implementation stages, but throughout the delivery phase – not least because local services can come and go.

Inevitability, however, not all clients' needs and preferences (with regards to their interests) are easily met by existing community resources. This in turn can limit the extent to which clients engage with their interests (be that in their own home or in the community) and/or grow their social networks.

While the PICs from several sites have been creative in linking different community assets to help clients connect with their interests, few sites have actually sought to fill the gaps in the existing local community offer. This is in part due to a lack of funds and capacity and the lead time required to create new activities during a pilot. Nonetheless, some sites have been proactive in using their understanding of clients' interests and aspirations to identify such gaps. In response, PICs have established group activities and/or secured the use of existing facilities and/or the support of other organisations to help engage clients to live their lives to the full (see box 5.3).

> *"One of the challenges for Age UK is that they are dealing with people who between them have a 40-year age gap, and not every 75-year-old is the same. I am not one for sitting in a group having a cup of tea and chatting. I would rather be doing something like learning, but they don't do things like that, it's more knit and natter. I am more interested in doing things where I am using my mind." Client (Blackburn with Darwen)*

Stakeholders from several sites felt that, given the duration of the pilot, it was appropriate to focus on existing and established community offers that would endure beyond its lifetime. Yet many highlighted the importance of further exploring the feasibility of creating new, sustainable community offers that better meet some clients' needs during subsequent phases of the programme.

## 5.5    Tracking outcomes for the health system locally

Difficulties in accessing NHS Hospital Episode Statistics (HES) data have limited Phase 2 sites' ability to track and evidence outcomes in a timely way. This has created a dependency on the programme-level impact evaluation being undertaken by the Nuffield Trust, as well as increasing dependency on GPs to create the risk stratified lists of eligible older people[17]. The barriers to data access have largely been due to national and local Information Governance protocols and NHS capacity issues. Early involvement of the Commissioning Support Unit (CSU) during co-design has, to some extent, helped to address the challenges associated with accessing HES data. However, even when the problems have been overcome initially, changes in Information Governance during the later stages of the pilot have often prevented ongoing outcome tracking.

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[17] The aim at the outset was to use a methodology that involved the Commissioning Support Unit (CSU) preparing initial practice-level cohort lists of patients meeting the Two Plus Two criteria using HES data. GP practices would then review the lists and apply clinical judgement and their knowledge of their patients to ratify the appropriateness of the older people identified, prepare a final cohort list of eligible patients, and invite them to participate in the programme.

# 6 Lessons learned about delivering the model in practice

## 6.1 Co-design

Together, 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 strategic and operational delivery and ultimately success.

> *"Co-design was done with all the partners sat around the table for a good length of time. We really got to the crux of what all the partners wanted to get out of the programme and the outcomes we wanted to see. And that helped to establish a shared vision. It meant we were able to agree the data-sharing elements between the partners and build a strong performance-management framework that captured the information we needed to track performance and outcomes, so we could build a bigger picture of the service. It was very much about having the right people around the table at the right time who would carry out the tasks too, as well as involvement at a strategic level. Our strong co-design meant that when we went to implementation we were all aware of what was happening and why, and it meant that we were able to deal with any issues very quickly."*
> *Professional stakeholder (Ashford and Canterbury)*

However, the price to pay for robust co-design has been the time commitment required, which can often be in tension with competing priorities, particularly those of senior partners, and with the desire to 'get going' as soon as possible.

Stakeholders from various sites also reflected that, while the partnership had seemingly been effective in working collaboratively during co-design, with the power of hindsight, several partners had not necessarily bought into the full vision for the programme. As a result, it was felt that these partners had, on occasion, lacked responsibility and accountability. This in turn had led to a failure to maximise opportunities and provide consistent leadership to ensure the success of the pilot during delivery.

Taking the time during co-design to really understand each partner's motivations, ways of working and the value they are seeking has proved to be critical to establishing a genuinely shared vision that is owned by all – and one that endures for the lifetime of the pilot. Where this approach has been used, it has also paved the way to embedding a collaborative leadership culture that is able to respond to the inherent tensions between the programme's ambitions and how things work on the ground. A willingness to resolve conflict,

## Box 6.1: Critical factors identified by local partners that need to be in place before the service 'goes live'

Stakeholders across all sites have identified common challenges and lessons learned regarding co-design, and critical factors that need to be in place prior to going live:

- ✓ **The wider health and care system** needs to be ready to support the co-design and implementation of the service

- ✓ **Information Governance issues** should be resolved – this can delay co-design, but ensures patient-level data can be shared with the PICs and other healthcare professionals and that data-reporting systems to demonstrate impact are available from the outset

- ✓ **IT systems** for collecting performance data must be in place and tested to avoid later duplication of data-inputting and the use of multiple reporting systems

- ✓ **Start small and scale up:** a small number of GP practices need to be fully engaged and to have identified potential clients to refer to the programme in advance in order to mitigate the risk of low demand during early implementation.

identify what is not working and implement solutions collaboratively has been essential. In instances where these elements have not been in place, or have not been sufficiently robust, the success of the pilot has been compromised.
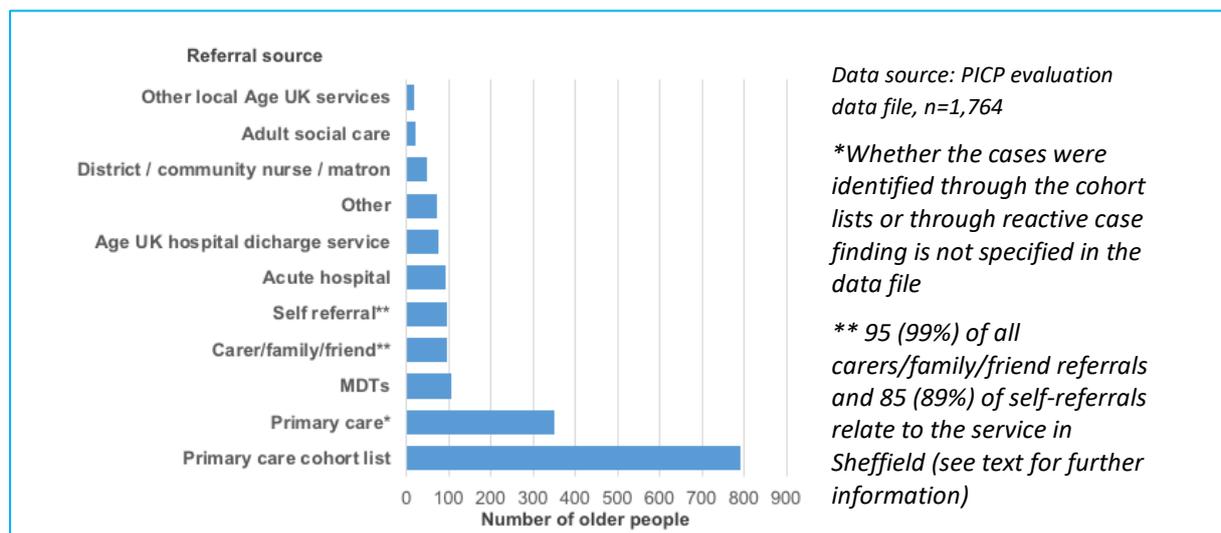
## 6.2    Case finding by healthcare professionals

A key element of delivery has been the creation of sufficient demand for the programme and equality of access. To achieve this, a combination of proactive and reactive case finding has proved critical[18].  This dual approach has made it possible to identify not only older people who are at crisis point and already on the radar of GPs and other healthcare professionals, but also those who are less visible to the statutory health and care system.

For those sites delivering the service through individual of GPs, the majority of older people referred to the programme have come from proactive case finding from primary care, and via patient cohort lists (see figure 6.1) [19]. Nonetheless, both variable GP engagement and the quarterly refreshing of cohort lists have resulted in peaks and troughs in referrals.

As a result, for most sites, reactive case finding has been critical to ensuring ongoing referrals and sufficient demand for the service. At a programme level, the involvement of PICs in MDT meetings has been the most common mechanism for reactive case finding. However, throughout the pilots, most sites have diversified their reactive case-finding routes beyond MDTs, and have also received referrals from other health and care professionals (e.g. community matrons, over-75 nurses, district nurses and social workers), as well as from wider local Age UK services. One site (Sheffield) has also used self-referral from older people and their families and carers (self-referrals made up a significant proportion of the cohort (see figure 6.1). Where sites have diversified case-finding routes in these ways, there has been less dependency on case finding by GPs.

*Figure 6.1: Referral sources*



*Data source: PICP evaluation data file, n=1,764*

*\*Whether the cases were identified through the cohort lists or through reactive case finding is not specified in the data file*

*\*\* 95 (99%) of all carers/family/friend referrals and 85 (89%) of self-referrals relate to the service in Sheffield (see text for further information)*

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[18] The model combines proactive case finding by population risk stratification using the Two Plus Two criteria and data analysis, and reactive case finding, which involves independently identifying cases at the point when older people who could benefit from the programme, and meet the criteria, become visible to GPs, MDTs and other health and social care professionals.

[19] For the ACOs, the identification of patients meeting the criteria is continuous; all such patients are invited to join the Age UK service upon registration with the organisation. Patients who meet the criteria post-registration are also referred to the programme as and when their circumstances change.

It is not possible to draw conclusions regarding the effectiveness of the different referral routes with respect to client uptake and/or achievement of the programme's Triple Aim. Nonetheless, the qualitative findings highlight the merits of both the proactive and reactive approaches:

- Proactive case finding using data analysis has been effective in identifying clients who could benefit from the programme but were not currently on the GP practice's radar, or were not discussed at any MDT meetings, despite having experienced hospital admission in the previous 24 months

> *"The [practice-level cohort] lists are also good for catching people who slip through the net. A recent example is a lady who was about to go into a care home – both she and her family didn't want that to happen, but they didn't think there was any other choice. The PIC supported the lady and involved her family to help address the issues she had living in her house, and that meant that she could stay at home. The lady was someone who wasn't going to the GP and she wouldn't have come from a MDT, so her case wouldn't have been raised in any way other than through the list." Professional Age UK stakeholder (Ashford and Canterbury)*

- Reactive case finding through MDT working has, in many instances, resulted in more appropriate referrals to the programme as a result of multi-disciplinary discussion about the older person

While the blended approach to case finding has created sufficient demand to test and evaluate the model, all sites have experienced a shortfall in the target number[20] of clients recruited during the Phase 2 pilots. Midway through the programme, and following a detailed health check, the original targets were roughly halved. The revised targets were based on the trajectory of actual monthly referrals achieved in the first six months of operation, but did include a 'stretch target' aimed at increasing GP engagement and MDT work. Subsequently, referral rates improved during the remainder of the pilot and the revised stretch targets have been met.

Nonetheless, despite confirmation during co-design that the target cohort size of 500 or 1,000 older people existed in each site, the findings highlight that the programme has in fact only reached 50% of its original target cohort size during the pilot phase. As the PICP is spread and scaled, therefore, future cohort growth plans and targets need to take into account the time it takes to generate demand for a new service from healthcare professionals – and to stabilise the delivery model (see section 6.10).

## 6.3 Creating demand from older people

In order to create demand, it has been important to target more potential clients than the programme aims to reach – not all those invited to participate will accept the offer. At the same time, it is also crucial to address the barriers older people could face to becoming involved.

A defining strand of the PICP's case-finding approach is the older person's decision to participate in the programme. A higher-than-expected number of older people declined the offer; initial uptake and retention rates have typically been lowest during the pilot's first three months. In part, this reflects the realities of implementing a new programme. For example, stakeholders in several sites reported that limited understanding of the criteria and a lack of clinical judgement in case finding resulted in inappropriate referrals early on.

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[20] Each target was defined and agreed among partners during co-design and was based on local data analysis of the target population. Each site set a target of supporting either 500 or 1,000 clients through the programme.

While uptake and retention rates have improved with time, on average 30% of clients meeting the criteria and referred over the lifetime of the programme have chosen not to become involved[21]. Limited direct evidence is available to assess the reasons why this has been the case. Nevertheless, the findings from the qualitative research carried out with clients strongly suggest that a combination of factors can prevent older people from wanting to take part:

■ **Reluctance to accept help**, due to factors including pride and a generational attitude of stoicism, reluctance to discuss their situation with an outside person, and fear of losing independence by accepting support. Several clients also noted that they had initially felt 'guilty' about accepting support, knowing that health and care resources are scarce.

■ **Feeling bombarded by the attentions of health and care professionals and wanting some 'normality'** in their lives, especially following discharge from hospital or the recent death of a partner.

■ **A lack of understanding of the service and/or preconceptions about Age UK**. Clients involved in the qualitative research reported that they had not really known what to expect of the service until they first met with the PIC. Many clients associated Age UK with charity shops and were unaware of the diversity of support it could provide. In addition, a significant proportion of clients had previously perceived Age UK as being an organisation that helps 'frail older people', rather than people 'like me'.

> *"Before Age UK I didn't like admitting that I needed help. I think a lot of people of our age don't want to feel like a burden or beholden to people. We have worked all our lives and been independent and that's how we want to keep it."*
> *Client (Sheffield)*

> *"If you have been really ill or just got out of hospital lots of people come to you. You end up bogged down with all of these people at a time when you just want to get back to your normal routine. And it's awful trying to remember the names of who is from where and what they do, I get embarrassed when I can't remember. It does feel like they come from every direction." Client (East Lancashire)*

> *"I wasn't aware of the things that Age UK can do to help you, and the care and attention they give to doing what's best for you. Most people think Age UK is an old people's club, meals on wheels, coffee mornings and things like that. I thought the same before I got involved with the Living Well Service, but they do so much more. Age UK has helped me more than I thought they could." Client (Ashford and Canterbury)*

*Addressing the barriers to participation*

■ In some instances, older people have proved more receptive to the invitation to take part in the programme if their GP, as someone they trust, made the introduction verbally, rather than just sending a letter. The evaluation findings also underline the need for PICs to be skilled enough to begin to gently overcome any barriers during the initial telephone contact with potential clients.

■ In Sheffield and East Lancashire, the local Age UK teams have created a discharge pathway combining the PICP with their existing hospital aftercare service, in which the PIC's help is timed to begin after the client's initial out-of-hospital support has ended. By

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[21] The consistency and quality of the information captured through the performance framework prevents robust analysis of the retention rates across the client journey at a programme level. However, insights captured through the learning forum, when combined with the available performance data indicates that retention rates across the life time of the programme are typically 30%, albeit that these rates vary and are higher during the initial three months of the service's operation.

staggering the support offered to older people when they leave hospital, this approach has helped to avoid the client feeling bombarded by professionals.

> *"As a PIC, being prepared for that initial call is important. Sometimes people get so many spam calls and people ringing to sell stuff that often people's first response is that they don't want to talk to you and they don't want to be involved. People can forget that the GP has asked them if they want to be involved, so that can be one of the initial barriers too. You need to be confident in being persistent, but not in a pushy way, to get over those initial barriers. You need to be prepared to go at the client's pace." Professional Age UK stakeholder (East Lancashire)*

## 6.4 Multi-disciplinary team (MDT) working

MDT working has been identified by the majority of sites as an important and particularly effective element of the model. However, the extent to which Age UK PICs have become embedded within MDTs has varied across and within sites.

The integration of Age UK into MDTs at all sites has been mediated primarily through involvement in MDT meetings [22]. Once relationships have become established, day-to-day informal communications and integrated practice have further enhanced MDT working.

Common themes influencing both the ease and extent to which Age UK PICs have become embedded within MDTs have emerged across the sites:

- **The maturity of the local MDTs' culture and infrastructure**. An MDT culture in which a holistic, rather than a medicalised, approach to care prevails has enabled PICs to become embedded more quickly, irrespective of the extent to which the MDT is already established. In several sites, involvement in the inception of MDTs has also helped PICs to become key team members. (However, dependency on the MDT already being up and running can delay progress and affect referrals in localities where new MDTs take time to become fully operational.)

> *"The practices I have worked with were already very holistic in their approach; the virtual ward meetings are too. They could see the benefits of our involvement in meetings straight away and that helped me to become part of the team." Professional Age UK stakeholder (Ashford and Canterbury)*

- **The perceived value and quality of the support that the PICs can provide to older people, combined with concerns about patient confidentiality.** Preconceptions about 'non-medical' voluntary-sector workers – and doubts about the benefits of including them in what are often rather hierarchical MDTs – have sometimes formed initial barriers to the PICs' integration. Proactive awareness raising, informal communications and shadowing members of the MDT have all helped PICs to build relationships, trust, credibility and understanding of the value of the service.

> *"The PICs spent a lot of time with other staff in the Integrated Neighbourhood Teams. They did a lot of presentations and some shadowing, with GPs, district nurses and social care colleagues. So that helped in terms of seeing them as part of the wider MDT team and understanding of what they could do." Professional stakeholder (East Lancashire)*

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[22] From inception, Age UK staff delivering the service in North Tyneside and in Redbridge, Barking and Havering have integrated into the ACOs' MDT ways of working and associated meetings. The other sites, delivering the service through individual GP practices, have typically become involved in MDT meetings at both a practice and area-based level. This two-tiered approach has maximised the opportunities for PICs to be involved in different models of multi-disciplinary working operating at varying levels of maturity across the local patch. It has also ensured alignment of the service with existing and emerging integrated working infrastructure within the given health and care system.

On occasion, however, GPs have prevented PICs from joining MDT meetings due to concerns about Information Governance, despite the PICs holding honorary NHS contracts. In some instances, and over time, an appreciation of the benefits the PICP can bring to their patients has alleviated these concerns. Nonetheless, changes to local Information Governance during the pilot have, in some instances, stopped PICs from joining MDTs despite their having previously been allowed to do so.

- **The skills and credibility of Age UK PICs**. Building relationships and MDT working require skills and behaviours that enable the PICs to gain the confidence and trust of health and care professionals, be that in a MDT meeting or day-to-day MDT working. The competencies PICs need include effective communication (including listening) skills, credibility and proactive case management, as well as having the confidence to ask questions, to challenge effectively and to offer solutions. Where these competencies are less developed, the extent to which the PIC is considered an equal partner in the MDT has been comprised.

> *"Age UK are embedded in the MDTs. At the beginning GPs wouldn't allow that. The GPs were saying it breaches patient confidentiality and [Age UK] wasn't a statutory organisation so they wouldn't let them in. We had to work with the ones that would, and then share that good practice with the ones who wouldn't. That resolved itself in the end, but only on the back of those GPs who weren't initially supportive realising what a difference the programme could make to patients. So Age UK was embedded, but some areas took longer than others depending on the individual GP's view." Professional stakeholder (East Lancashire)*

> *"You need to be relatively strong to voice your opinion in what can be a reasonably big group of professionals. It can be quite daunting. You need to be able to gain respect by walking the walk and not waiting to be asked to contribute. Some of the PICs have been more skilled in doing that, they were able to embrace MDT ways of working, as a result I think they were considered to be more equal than the ones that didn't." Professional stakeholder (Redbridge, Barking and Havering)*

## 6.5 Personalised shared care planning and case review

Given the timescales of the pilots, the focus has been 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.

The programme aimed to support integrated care through the use of a single care plan that documents the older person's preferences and goals, and the support required to meet these. Inherent within this aim is the need for interoperable information systems that allow various health and care professionals to access and combine plans. Also crucial is what will, in practice, be a cultural shift for some health and care professionals. Both the achievement of this cultural shift and the setting up of interoperable information systems have proved to be unrealistic for sites delivering the programme through individual GP practices. Although this is in part due to the timescale for Phase 2, bringing about the required changes in infrastructure and culture is likely to be beyond the gift of the Age UK programme alone.

While the use of a shared care plan is a critical enabler of integrated care, such a plan's existence, and indeed its use by multiple health and care professionals, do not necessarily go hand in hand with *personalised* shared care planning. For older people involved in the PICP, the absence of a single care plan has not prevented significant progress with personalised shared care planning[23], which has been facilitated at several levels and in

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[23] The phrase 'personalised care and support planning' is adopted from National Voices. In a recent publication, National Voices highlights that the use of this phrase, " … *helps to distinguish this type of planning from the one where professionals make care plans (or treatment or management plans) for their patients/clients. The statutory*

stages. Firstly, all clients involved in the programme co-produce a goal-oriented plan with the PIC – a key process that is enabled through the guided conversation. Secondly, although focused on clients' social and practical care and support rather than medical needs, the goal-oriented plan is shared with each client's GP and updated to report progress and/or achievement of goals. Thirdly, for those clients who are discussed in a MDT setting (either during meetings or on an *adhoc* basis when the need arises), the PIC, acting as the older person's advocate, discusses the client's personal needs and preferences when planning care with other health and care professionals.

However, although these mechanisms for establishing integrated personalised care planning have proved effective in many instances, they do have some limitations. For example, across all sites, case review by a MDT has not taken place for every client. The relatively low-level and short-term goals and needs identified by some clients have not warranted a MDT discussion. Additionally, older people who do not have acute needs and/or are not at or close to crisis point when the PIC becomes involved are unlikely to be discussed, given the criteria and priorities for many MDT meetings. It is uncertain whether opportunities for MDT working to benefit all older people participating in the programme have been missed, although neither clients nor professional stakeholders involved in the research indicated that they thought this to be the case.

## 6.6    Workforce

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 voluntary and community sector (VCS) and the statutory healthcare system.

The evaluation findings highlight that managing the PICP locally requires knowledge, skills and expertise in:

- The needs, ways of working and cultures of the various partners involved

- Engaging effectively with and navigating the VCS, Clinical Commissioning Groups, NHS and local authorities

- Building and maintaining relationships and influencing delivery partners to co-produce and co-deliver change

- Strategic and operational service planning and improvement

- Engaging older people and empowering them to live well

In practice, adopting a joint approach to programme management has proved effective and necessary. This approach has involved, to varying degrees, a senior Age UK programme manager working collaboratively with a programme manager from the health and care system[24] (the latter is referred to as the PICP manager from here on in). The PICP manager's knowledge and experience of the health system's processes, practices, ways of working and culture have complemented the Age UK programme manager's expertise in the VCS and knowledge and experience of supporting older people to live well. Nonetheless, it is the secondment of a PICP manager from the within the NHS, especially during co-design and implementation, that has been particularly highlighted by most sites as one of the key

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*guidance to the Care Act 2014, and the NHS England handbook for care planning, emphasise that this is a process done in equal partnership with the person, to assist them to identify their goals and preferences, and where they should 'own' the resulting plan."* See National Voices (2017) *Person-Centred Care in 2017 – Evidence from services users* (2017).

[24] Consistent with the roles proposed by Age UK, neither programme manager was dedicated to the PICP; the programme manager from the CCG was seconded on a part-time basis, typically three days per week, and funded by the programme grant provided by Age UK. For the Age UK programme managers, the PICP was part of a wider portfolio of services/programmes for which they were each responsible.

enablers of success. For many sites, the PICP manager has been critical to accessing data, addressing blockages and issues, engaging GPs and facilitating the alignment of the programme with wider-system initiatives. Given his or her importance, therefore, the PICP manager needs to have the capacity to commit, on average, three days a week to the programme; it is not a task that can be added on to the full-time 'day job'.

The roles undertaken by the PICP and Age UK programme managers and the balance of input between the two have varied throughout the lifetime of the programme and across the sites. Unsurprisingly, however, the findings consistently highlight the importance of a shared understanding of roles, responsibilities and accountability. Where this has not been the case, the effectiveness of the joint programme management has been compromised – GP and wider-system engagement and partnership relationships have been adversely impacted as a result.

The appointment of an experienced Age UK team leader to focus on the day-to-day management of the Age UK team and volunteers and to support the PICP manager with the overall management of the programme has also proved essential. In several areas, this role has extended to include engaging with GP practices and/or responsibility for a small caseload of clients. Without an Age UK team leader in place, there is the potential risk that the PICP manager role could be compromised by becoming focused on operational issues, and PICs may not be supported effectively and efficiently.

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.

The PIC role requires competencies in:

- Building trusting relationships with clients and listening to, supporting and empowering them to identify and achieve goals to improve their quality of life, rather than adopting a 'fixer role'. Co-producing sustainable circles of care with clients demands creativity and embracing the art of the possible, especially in instances where the existing resources do not directly meet the client's need. Where volunteers are used, PICs also require the skills to match clients and volunteers effectively.

- Building relationships, integrating with statutory health and care professional teams and gaining the confidence of primary care and other healthcare stakeholders (be that in a MDT meeting or day-to-day encounters at a GP practice).

While many PICs said that 'learning on their feet' had been a key element of their development, common opportunities to help boost confidence and effectiveness and to support ongoing development were identified by PICs across most sites, including:

- Early, brief training on:

  – Long-term conditions that are common in their cohort of clients and how these conditions can affect an older person's everyday life.

  – How best to use the guided conversation to uncover the client's needs and preferences.

*"We did have some guidance from the sites that were ahead of us with their pilots. When you normally start a new position, someone hands over and talks through how things are done, who is who and tips on what you must do. But we didn't really have that. The challenge was gaining that confidence; by the nature of the role you have to learn on the job. So it involved building your own confidence in people's houses, to have the best conversations to get the most out of people to be able to help them, or in a GP practice, trying to get GPs and other professionals to engage. Your confidence grows with time, and so does your knowledge of the support that is available to help clients." Professional Age UK stakeholder (Ashford and Canterbury)*

- Referral routes to statutory services to allow PICs to gain an understanding of which organisations to refer to for different needs and how. PICs from one site (Ashford and Canterbury) had completed the Trusted Assessor training courses on the processes for ordering equipment and telehealth. This had the added benefit of reducing their need to refer clients to occupational therapists and social services.

- Early opportunities to shadow colleagues (other PICs and health and care professionals).

- A peer network to provide a chance to share lessons learned and insights with PICs working in other localities and at different phases of programme.

## 6.7    Programme-level performance management

To facilitate programme-level performance management, significant time and resources have been invested in defining, collecting and analysing local performance data. Yet, if the data collected nationally is to support continuous improvement, it needs to be both fit for purpose and put to use. This has not always been the case.

Programme-level performance management has been supported by monthly and quarterly output and outcome reporting. However, while the Triple Aim outcomes were specified from the start, the detailed definitions of the outputs and reporting requirements were developed iteratively during Phase 2 by Age UK. Consequently, although each local site has captured and reported data to the national team, the quality and consistency of that data varies considerably across the sites. Analysis of the data collected highlights the challenges of defining, cleaning and processing outcome, output and cost data in order to create a robust picture of programme-level performance and at the same time add value to the local sites.

Throughout Phase 2, analysis and use of the reported data by the national team has largely been limited to driving improvements in the number of clients participating in the service locally – in response to the lower-than-expected demand for the service during implementation (see section 6.2). This approach has undoubtedly been effective in helping the Phase 2 sites to increase their cohort sizes. However, despite the large amount of data reported by local sites, there has been limited use of it, at a national level, to understand 'what happens along the client journey', how the model is working on the ground and whether the programme is on track to achieve its aims. As a result, opportunities to maximise and prove success during and at the end of Phase 2 are likely to have been missed – so too have opportunities to improve the quality and consistency of the data collected.

It's not just about measurement. Creating opportunities for reflective learning and strong feedback loops have been crucial in supporting continuous improvement and maximising success.

Age UK has embraced a 'test, learn and adapt' approach to Phase 2 to drive performance of the PICP, taking into account the fact that the programme is operating in multiple, complex, adaptive systems. The introduction of health checks and the monthly national learning forum have been important enablers of this approach (see box 6.2). There was a strong consensus from those who had participated (typically senior managers and team leaders) that the national learning forum in particular had been one of key advantages of being part of a national programme.

**Box 6.2: Supporting continuous improvement: the national learning forum and health checks**

The monthly national learning forum is a reflective community of practice for those involved in the programme. It has provided a source of inspiration and a welcome opportunity to share knowledge, challenges and effective practice. Importantly, the forum has sought to create a 'positive error culture', where participants are encouraged to talk openly and honestly about what isn't working, mistakes and uncertainty. This collective problem-solving approach has supported continuous improvement at both a local and programme level. Involvement in the learning forum has also created a sense of belonging to a 'bigger programme'.

Partway through Phase 2, programme health checks were introduced. These created a chance for local partnerships supported by Age UK to review various aspects of how the model was working on the ground. These stocktakes have been also effective in identifying opportunities to maximise success and in supporting local sites to adopt a 'plan, do, study, act' cycle. The health checks are now embedded at key stages of Phase 3 of the programme.

*"The learning forums were great. For us it's a whole day, but it's well worth it. [The chairperson] really pulled out the detail, and the effort the national team put in was great. It's always nice to know you are not the only one in a boat with a hole in it. Or sometimes to learn about things and think, 'Why can't we do that?'. It might turn out you can't, or you end up putting another bell and whistle on it and you go back to the forum and share it. Locally, it meant we were really sitting at the top table and not meeting in the anteroom, and that enhanced our reputation." Professional Age UK stakeholder (Ashford and Canterbury)*

## 6.8    Active local performance management to maximise success

Additional support, resources and time are needed to help local teams makes effective use of the data they capture capture through the programme's performance framework, and to actively manage performance to maximise success.

Local ownership of the programme's performance framework has been limited, with data collection typically being driven by the need to fulfil national reporting requirements and those of the Nuffield evaluation. For most sites, the use of the data captured has mirrored the programme-level picture, in that the data has typically been used to drive achievement of the target number of clients. Few sites have also made use of the evidence they collect to understand need, demand and supply across the PICP pathway.

Effective approaches taken by some local teams include:

■ Recruiting a data analyst with the expertise (and capacity) to bring the collected data to life for different audiences and purposes

■ Ensuring there are mechanisms in place (beyond the formal governance mechanisms, and including regular team meetings and supervisions) to reflect on and discuss progress, what is working well and less well, and potential solutions to problems (see box 6.3)

■ Developing local reporting dashboards summarizing key outputs and outcomes to provide a basis for understanding how the service is performing, to support continuous improvement and to communicate success

*"One of the strengths has been the learning culture. The [local Age UK PICP team] have reviewed how things have been working throughout the pilot and adapted them according to the learning. At the programme and assurance board I saw them reflect on their learning and the interim results. In response, they have gone back and revisited some of the work they had done earlier in the programme, such as going back out to GPs to re-engage them, to restate some of the aims and the referral process and risk stratification." Professional stakeholder (Ashford and Canterbury)*

- Fostering a positive error culture at all levels[25]

The support provided by the national programme – in particular the national learning forum and health checks – has also fostered continuous improvement at a local level (see box 6.2).

<br>

**Box 6.3: Embedding a culture of continuous improvement locally**

In addition to the operational team meetings, the Age UK Sheffield PIC team holds a monthly academy. The academies create a space in which the team comes together to reflect on and discuss what is working well, issues and potential solutions. Discussions can focus on individual cases, enhancing case management across the team, or performance and opportunities for improvement. As well as fostering continuous progress, the academies have been valuable in supporting the development of new team members. Age UK Sheffield also recruited a data analyst who had the skills and expertise to analyse and report the data in ways that provided insights that enabled the team to better manage and understand performance. The analyst also supported local GPs with proactive case finding.

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## 6.9 Factors that are likely to influence the support provided and the level of outcomes achieved: variables in the target cohort's profile and programme delivery

The profile and needs of the cohort of clients involved in the programme have been diverse – these variables impacted on the support provided and are likely to influence the scale at which the changes in the Triple Aim are observed.
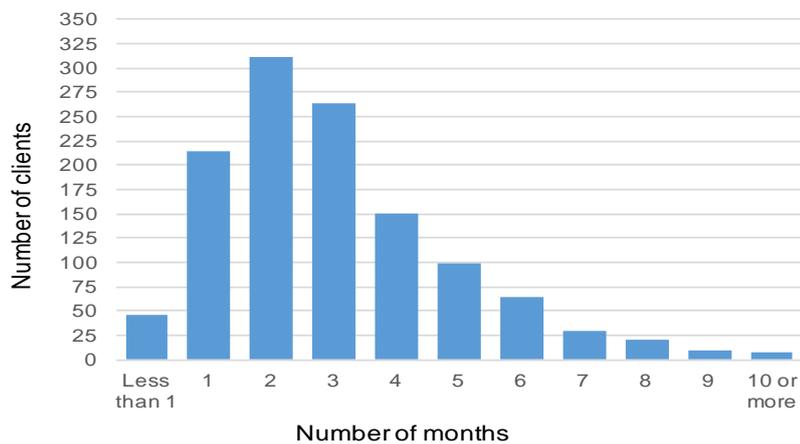
Stakeholders from all sites were consistent in their view that the achieved overall cohort of clients has been diverse with respect to their profile and need. Not all clients involved in the programme have required intensive support over a three-month period (see figure 6.2). PICs across all sites noted that, for a significant proportion of clients, interventions were relatively low level and short in duration. 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 if the balance between low and high need (in terms of both the duration and types of support needed) is tipped towards the former.

*"Very often we find we're doing a lot of reactive support work, so not everybody can step into a structured support programme. It might be an in-and-out job. You meet the client, they may be very poorly, chaotic lives, pulling in on carers' services, and have highly complex needs. There are a lot of higher-level services working with them, so you go in and do your bit and go, and that's where the joint working comes in with the locality team. So that doesn't always fit the model, but that's fine. I think it's OK to be flexible and do that different work, because it all works as a programme. People don't sit in boxes, they're different, every case is different." Professional Age UK stakeholder (Blackburn with Darwen)*

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[25] A positive error culture is '*one in which talking about mistakes, and the uncertainties that people feel about their practice, is viewed positively'*. See Davidson knight A, Lowe T, Brossard M, Wilson Julie (2017) *A whole New World: Funding and Commissioning in Complexity*. Collaborate and Newcastle University.

*Figure 6.2: How long were clients supported while on the programme?*



- On average (median), clients were supported for 5.8 months*. However, 26% (311) of clients were supported for two months, and 22% (264) for the expected three months.

- Consistent with the findings from the qualitative research suggesting that for some clients the duration of support could be considerably less or more than three months, 22% (262) of clients were supported for one month or less, and 26% (314) of clients were supported for four to six months.

- A minority of clients were supported for more than six months: 6% (67) were supported for between seven and 14 months[**].

*Data source: PICP evaluation data file (see text in section 2 for further information and limitations of the analysis) n=1,218 clients.*

*\* A normal distribution is not observed therefore the median average is quoted. This average decreases to 3.8 months when data relating to Redbridge, Barking and Havering is excluded; support provided to clients in this site was not time-bound, instead, older people received support from the PICs where needed throughout the period during which they were registered with Health 1000, the ACO in which the service was integrated.*

*\*\* It is possible that clients had graduated from the programme earlier than is recorded in the evaluation data file. This could happen, for example, if there were delays in PICs updating the spreadsheet, or in instances where the PIC's intensive support had concluded, but the client case remained open as a result of delays in the support from other organisations (for example, social care) to achieve his/her goals.*

The qualitative findings strongly suggest that, in each of the sites, the cohort of clients meeting the Two Plus Two criteria is more heterogeneous than expected with respect to:

- 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

These variables have necessarily influenced the intensity, duration and type of support provided to individual clients while they have been involved in the programme. Furthermore, the findings indicate that the profile variables listed above 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. In this respect, the findings suggest that refining the Two Plus Two criteria further, to include level of frailty, would enable the programme to target resources to maximise achievement of the Triple Aim.

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 figure 6.3). Gaps in the quality and consistency of the programme's existing evaluative evidence prevents any conclusions regarding how such variables as approaches to case finding (see section 6.2), case review involving a MDT (see section 6.5) and the extent to which clients are supported beyond 'signposting' to achieve their social goals (see section 4, footnote 6) influence the scale of outcomes achieved.

*Figure 6.3: Variables in delivery model and client profile which are likely to influence the scale of outcomes achieved*
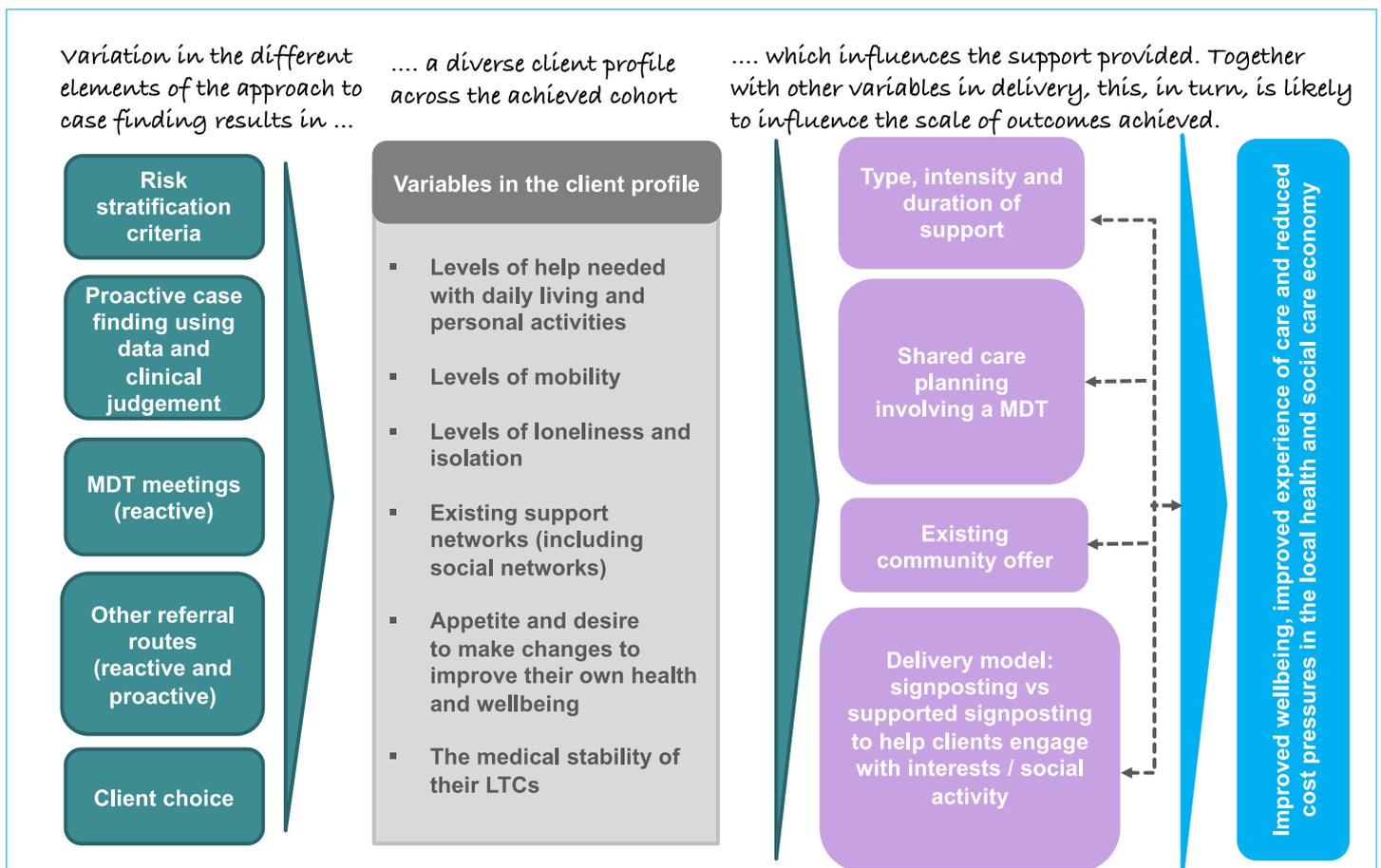
## 6.10    Duration of the pilot

One year's operation is insufficient to 'stabilise' delivery of the model.

Even with robust co-design, there was consensus that learning how the model supports delivery on the ground, and ironing out teething problems, have, necessarily, taken considerable time and effort. So, too, has creating momentum by establishing and strengthening relationships and understanding of the programme and its value at all levels. There is a consistent view across the Phase 2 sites that one year's operation was insufficient to 'stabilise' delivery of the model. All but one site received additional funding to extend the pilot. As highlighted by the Nuffield Trust, a corollary of the time taken to stabilise the model is that evaluation of impact after 12 months is likely to capture only the impact of implementation[26].

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[26] Bardsley M, Adam Steventon A, Judith Smith J and Jennifer Dixon J (2013) *Evaluating Integrated and Community-based Care – How do we know what works?* Nuffield Trust

# 7     Sustainability and legacy

## 7.1     Sustainability of the benefits for older people

Consistent with the sustained wellbeing score three months post involvement in the programme (see section 3.1), clients involved in the qualitative research from all sites confirmed that the benefits of participating in the PICP had continued after the PICs' (and/or volunteers') intensive support had ended. In particular, older people described how they had continued to feel in control and generally more optimistic about their circumstances than they had before participating in the programme. Many clients were also still engaged with the activities and interests they had been supported to connect with, and, in some instances, they had been proactive in pursuing other interests. For these individuals, therefore, the support had not created a dependency on the service.

Several clients from across all sites, particularly those who lived alone, said that they had missed the regular visits from their PIC after the intense support had ended. Many clients had appreciated the fact that their PIC would still 'call them or pop round' occasionally to see how they were. Furthermore, these older people, and many others involved in the qualitative research, noted that being involved in the programme had 'opened their eyes' to the types of support available. Many reported that they would no longer wait for a crisis, or 'struggle on coping' if their circumstances changed. Unprompted, a number of clients interviewed said that Age UK would be their first port of call for non-medical issues in the future, given the quality of the support they had received and the trusting relationships they had established.

> *"I feel as though my medical issues have evaporated thanks to Age UK's help. I have friends for life – whereas before I felt alone, now I feel that I have a lifeline with the groups they put me in touch with. And I am now in a place where I can take more advantage of them."* Client (North Tyneside)

> *"I now have a lot of contacts; we have been put in touch with so many people. It's like you put a stone in the pool – I have so many people now I can turn to if we need help, and that makes me feel more secure. The important thing is that when I am on my own and I am worrying about things, I have someone [Age UK] I can call on any time and I know that they will understand me."* Client (Blackburn with Darwen)

> *"Age UK gave us a stick of dynamite up our bums! You get into such a way of being so insular. In some ways, you want other people to come in and then you think, 'No, we don't, we're fine', so we just kept struggling on, coping as best we could. We had stopped going out, but after Age UK's support had finished, we joined a group called 50 Somethings, which we wouldn't have done before. We're the oldest in the group. It's great, there's a lot of us, just going to it makes you feel like one of the gang. We've rekindled our past interests and we enjoy life."* Client (East Lancashire)

Taken together, these findings give some grounds for optimism that the benefits experienced by a lot of older people as a result of their involvement in the PICP will continue.

Nonetheless, professional stakeholders across all sites 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 older people with a high level of frailty. For other

> *"I feel so silly, a bit stupid for not reaching out before – you know, having the confidence to know that it's OK not to be able to do everything. I think this is something we have to get over, not letting anyone know, insisting that we are OK. I now know the help is there if I need it, people do care, and you are not imposing. [Age UK] will not take charge of your life or take away your pride, it's wonderful. Go forward knowing [Age UK] are there as a back-up, a crutch. I will definitely ask for help when I need it in the future."* Client (Ashford and Canterbury)

clients, life events (such as declining health, or the absence of a PIC or volunteer whom they trust to help motivate them) could limit the extent to which they remain empowered to improve their own health and wellbeing when their circumstances change.

Professional stakeholders in Redbridge, Barking and Havering reported that staff turnover had been unsettling for a minority of clients who had built strong relationships with PICs who had left. As a result, some clients had decided not to continue to engage with the PICP, and the benefits they had experienced were compromised. The evaluation of the Portsmouth Living Well service also noted that several clients had voiced 'concern, especially around loneliness' after they had come to the end of their intense support or their PIC had left[27].

It is clearly often difficult to sustain the benefits experienced by older people, and there is also a potential for the programme to create a dependency on the relationship with a PIC. As a solution, several stakeholders emphasised the importance of creating sustainable networks of care within the community – and ones which also draw on older people's own assets, despite the challenges of creating such networks in the context of a pilot (see section 5.4).

> *"Linking patients to sustainable futures takes a wee bit longer than the time the project had. If I were redesigning the service, I would be looking into how we set up new opportunities and whether they were sustainable. It might be a pipe dream, but maybe if we developed that with the patients themselves it would become more sustainable and they would claim it as their own. It's reasserting the importance of living their own life, even though they are often in the last stages of it, which they often recognise. And the active contribution they can still make in those circumstances and how they can help others. Some clients are illness-behaviour specialists – they are very knowledgeable about the health and care system, and that is useful knowledge they can share with people who are new to the system." Professional stakeholder (Redbridge, Barking and Havering)*

## 7.2    Sustainability of the service

At the time of writing, the service has continued in various forms across all Phase 2 sites, although the journey from the pilot to a commissioned service has varied:

- Age UK Ashford and Canterbury, East Lancashire and Portsmouth deliver the service, commissioned by the CCG.
- Age UK North Tyneside continues to deliver the service as part of Care Plus, commissioned by the CCG.
- Age UK Sheffield received CCG funding for three PICs to work with GPs across the city. It has also received funding from other sources to secure a team of ten PICs (sources include Western Park Cancer Charity, MOD Veterans, Age UK and National Lottery funding).
- Age UK Blackburn with Darwen deliver the service as part of a partnership with East Lancashire MIND and Care Network, commissioned by the CCG.
- Subsequent to the end of the pilot phase for Health 1000 (the ACO in which the service was being delivered), Age UK Redbridge, Barking and Havering received funding from the London Borough of Havering to deliver the service through its Social Inclusion Contract.

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[27] Sheldrake L, Burnell K (2017) *Realistic Evaluation of Age UK Portsmouth's Living Well Service*, University of Portsmouth. The findings are based on the survey responses from 21 clients and the authors note that the findings shown are not representative of the Living Well population and must be treated with caution. Furthermore, the evaluation report highlights that limited befriending services and volunteering in Portsmouth could inadvertently have created a dependency on the PIC.

- In Guildford and Waverley, the service has yet to be commissioned, in part due to local CCG priorities. Nonetheless, Age UK Guilford and Waverly is working in partnership with other VCS organisations to secure funding.

The findings highlight that multiple factors are critical to creating the conditions to support the sustainability of the service:

- **Evidence of the impact on the programme's Triple Aim**. All stakeholders felt that, in order to secure sustainability, it was essential to provide evidence of the impact of the pilot on older people and on the healthcare system. They emphasised that it was also critical to provide evidence of financial impact and value for money, given the financial pressures on the health and care systems. In several sites, stakeholders pointed out that there was an unresolved difficulty in aligning the evaluation of pilot programmes with the commissioning business cycle, due to the time lag in the availability of HES data. This challenge, they felt, further strengthened the case for prolonging the PICP pilot to allow enough time to generate interim evidence of impact on healthcare use (see section 6.10 for further information).

- **Flexibility and relationships.** Stakeholders from several sites highlighted that, in addition to evidence of impact, the following factors have been essential in creating the conditions for sustainability:

  - Having the flexibility to adapt the referral criteria and model to respond to local context

  - The strength of local relationships between the Age UK team and primary and community care (and other health and social care professionals) through MDT working, and with the CCG

## 7.3    Legacy of involvement in Phase 2 of the PICP

Irrespective of the commissioning status, for almost all the sites, the legacy of their involvement in Phase 2 of the PICP is a positive one. The programme has:

- **Enhanced healthcare professionals' and clients' understanding and perception of local Age UKs' offers**. The majority of non-Age UK professional stakeholders noted that they had already appreciated the value the VCS can bring to health and social care. However, many had been unaware of the breadth of the support Age UK can provide, both directly and indirectly (e.g. by connecting people to other services in the community). Prior to involvement in the PICP, many participants had perceived Age UK as being about 'charity shops, fundraising, daycare centres and knitting clubs for old people', and so would not have necessarily have turned to Age UK for support.

> *"Involvement in the programme has enhanced tenfold what I think of Age UK North Tyneside. What I thought they could do and what they brought to the table – they have surpassed my expectations in that respect. Certainly within the CCG they are an equal partner. Their willingness to support our system change, their 'nothing-is-a-bother' attitude, the 'we will get there together and we will work through the solutions' and the no-blame culture are all refreshing. And it sounds a bit corny, but their willingness to work with us, and their drive to help older people – our patients – to improve health and wellbeing is what we need." Professional stakeholder (North Tyneside)*

> *"I think initially, when we think of the VCS, we think of that lower-level support. It's interesting about the level of complexity of patients that Age UK can actually deal with. Some patients for whom we always assumed that help should be provided by the NHS or social care, are actually better placed to be supported by Age UK, rather than statutory services. From a financial point of view, Age UK are a lot cheaper as well." Professional stakeholder (East Lancashire)*

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- **Improved and cemented relationships with local health and care stakeholders and strengthened the position of local Age UKs as credible strategic partners.** In most sites, existing relationships with CCG and primary and community care partners have been cemented and new ones created. The combination of enhanced reputation and improved relationships has helped to strengthen the position of most local Age UKs as key partners in their area's changing health and care systems. Furthermore, professional stakeholders (CCG stakeholders in particular) from several sites commented on the professionalism, expertise, can-do attitude and solution-focused approach of the local and national Age UK staff they had worked with.

- **Created skills and experience to support transformational change involving the voluntary and community sectors.** The findings reveal that, for the majority of the sites, involvement in the programme has strengthened the skills, knowledge and experience required to design, implement and deliver collaborative approaches to integrated, person-centred care involving the voluntary and community sector. In this respect, Phase 2 of the PICP has laid foundations that have the potential to support sustainable, transformational change to local health and care systems over the longer term.

- **Created new opportunities for collaborative working to improve outcomes for older people.** Without the programme, stakeholders noted that these opportunities might not have arisen, or would have taken longer to emerge.

- **Established a foundation from which to adapt the model to different cohorts of older people.** Most local Age UKs are now considering how the model – in particular, the guided conversation, continuity and duration of support, and MDT working – can be applied to other care and support services to meet the needs of different cohorts of older people and enhance person-centred care.

*"The flexibility, and how they are able to innovate and flex their resources in ways some other sectors aren't able to do adds value. They mobilise really quickly, they listen and respond, they find ways around challenges we've faced. They keep going with energy and commitment, and their commitment to making life better for older people. The leadership they show is a real credit to them." Professional stakeholder (Blackburn with Darwen)*

*"The reputations of Age UK and the VCS have been strengthened. The pilot has provided a good framework for a way of working in future pilots. The pilot has helped to shape the strategy and design of other projects, including the new models of care. We were using the Care Navigation model, but it was more signposting, rather than intensive support. But we are now looking to have a Care Navigator role more like the PICs. The model itself has informed how we are looking to work with our broader commissions across health and social care for older people as part of a wider Multi-Speciality Community Provider. So, we have been taking the learning from the pilot to wider work in Kent." Professional stakeholder (Ashford and Canterbury)*

*"I think at the time we launched it the PICP was quite unique. I don't think there was anything else like it, to be honest. Since the pilot came to an end we have set up some similar projects. We're also having discussions with another provider to deliver something similar as part of a wider service." Professional Age UK stakeholder (Guildford and Waverley)*

*"We are working with the CCG, the palliative care team at Queen's Hospital and some GPs to develop and test how the model can be adapted to support older people at end of life." Professional Age UK stakeholder (Redbridge, Barking and Havering)*

# 8 Discussion and conclusion

## 8.1 Achieving the programme's Triple Aim and supporting new models of care in the local health and care systems

The findings presented in this report show that Phase 2 of the PICP has brought about positive change for those who have been involved, and in doing so has supported achievement of the Triple Aim. 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 the 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 better understand this aspect of the PICP's impact.

Multiple factors could influence the programme's impact on hospital activity. For some clients, their medical instability (i.e. the progression of their existing conditions and/or the onset of one or more new conditions) could well result in non-preventable hospital activity. Success in preventing avoidable hospital activity is likely to be dependent on a combination of the following factors:

- 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

Additionally, the duration of Phase 2 of the PICP could also influence whether changes in hospital activity are observed in the short term.

*Wider system change and capacity to support integrated care and proactive case management for older people after their involvement in the programme has ended*

During Phase 2 the PICP has focused on influencing and supporting positive change in one part of the statutory health and care system – at the level of primary care. Many of the clients involved in the programme, given their profile, will require ongoing medical care after the PICs' intensive support has ended[28]. Preventing or reducing hospital activity for these clients will require proactive case management and integrated working within and across different parts of the statutory health and care system (i.e. beyond the level of primary care). The extent to which system-level integrated ways of working are already in place in each Phase 2 site has not yet been explored in the evaluations of the PICP. Shifting care out of the hospital will also, in some instances, require alternatives to be provided in the community and primary care settings.

In its recent publication reviewing initiatives that plan to support a shift in care from hospitals, the Nuffield Trust noted in its conclusions that, *"… interventions haven't been supported by*

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[28] For example, to ensure disease management of multiple conditions, such as Chronic Obstructive Pulmonary Disease (COPD), diabetes, and cardiovascular disease (CVD) and/or of the onset of new long-term conditions.

*wider system interventions and incentives, and have therefore failed to shift the balance of care and deliver net savings."[29]*

Throughout Phase 2, the local health and care systems in all sites have been progressing along their wider system-change journey towards new, more integrated and holistic models of care. Yet, given the timescales of Phase 2, such changes are unlikely to have reached the level of maturity needed to prevent hospital activity during the pilots. In both North Tyneside and Redbridge, Barking and Havering, however, the PICP has been delivered in the context of ACOs. In theory, therefore, ongoing holistic integrated care for clients after their involvement in the programme should be more mature in those sites. It will be of interest to note whether and how changes in hospital activity there vary from those in other Phase 2 sites.

Beyond the pilot, there will be merit in local partnerships delivering the model considering opportunities to integrate the PICP into a pathway of care. In particular, such partnerships should explore opportunities that that will enable both ongoing proactive case management and preventative care for older people after their involvement in the programme has ended.

### *Targeting the 'right' cohort for whom future hospital admissions can be avoided*

The Nuffield Trust highlight that, *"Maximising impact on hospital use requires accurately targeting initiatives at the groups most likely to benefit, and where a reduction in admissions will have most impact on resources, Risk stratification tools still struggle to identify 'at risk' individuals at the point before they deteriorate."[23]*

The model uses risk stratification to identify those older people who can most benefit from the programme. By using risk stratification the programme aims to target those older people who are 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 the programme's three aims.

Compared with other risk stratification approaches – including the threshold (criteria-based) approach used across all Phase 2 sites – predictive risk modelling provides greater accuracy in identifying people at risk of future hospital admissions[30]. While the threshold approach was necessarily adopted (given the limited maturity of the use of predictive risk modelling tools in each locality), wider literature indicates that this approach is of limited effectiveness in identifying those at risk of a hospital admission, as well as being susceptible to regression to mean[24].

Beyond the potential limits of a threshold approach to risk stratification, a question remains as to whether the Two Plus Two criteria (see section 5.1) are the optimal risk stratification criteria for targeting clients for whom unplanned hospital admissions can be avoided and whose loss of independence, in particular, is likely to be reduced by the support offered through the programme. Indeed, in its recent report on risk stratification, NHS England highlights that "*the success of risk stratification depends not just on identifying those most at risk of an adverse event, but rather in identifying those who are most at risk and most likely to respond to a given intervention – to be 'impactable'.*" Beyond the number of prior hospital admissions and ambulatory sensitive LTCs, the evaluation findings suggest that clients' levels of frailty and loneliness and isolation (see section 6.9) are also likely to be important variables when considering which sub-cohorts of 'high risk' older people are most likely to respond well to involvement in the PICP, thus lowering their risk of future hospital activity.

Finally, the findings highlight that ,as a result of the broadening of the Two plus Two criteria (see section 5.1), the programme has supported a sub-cohort of clients who are at high risk

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[29] Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, John Appleby A, Thorlby R and Lombardo S (2017) *Shifting the balance of care - Great expectations*. Nuffield Trust

[30] Lewis G, Curry N, Bardsley M (2011) *Choosing a predictive risk model: a guide for commissioners in England*. Nuffield Trust; Lewis G (2015) *Next Steps for Risk Stratification*; Operational Research and Evaluation Unit (2017) *Risk Stratification: Learning and Impact Stud*y, NHS England.

of developing needs for statutory care and support, in addition to those who could benefit from tertiary preventive support[31]. For these older people, the benefits of early intervention – i.e. delaying or avoiding subsequent hospital activity – could take longer than the current evaluation period to become clear. More longitudinal evaluation would be necessary to understand the PICP's longer-term impact on this sub-cohort of clients.

*Changes in client behaviours*

Making changes to patterns of statutory health care services also requires clients to change the way they use those services. Increasingly, doing so places an onus on clients to play a more active role in managing their own health and wellbeing. Involvement in the PICP has supported such behavioural change. In particular, the care and support provided by the PICs has been effective in fostering agency (see section 3.1.2). The PICs have empowered older people to recognise and develop their own strengths and abilities, and have helped clients to take action that enables them to lead lives that are as independent and fulfilling as possible. For some older people, involvement in the programme has also created a shift from being passive recipients of the medical care they receive to becoming more attuned to their own needs and better able to articulate them.

In the short term, this positive change in client behaviour could, in fact, increase older people's use of statutory healthcare services – especially when coupled with the care coordination support provided by the PICs[32]. Indeed, stakeholders across multiple sites noted that the programme has often helped to uncover previously unidentified need. Furthermore, NHS services are the second-highest destination of the signposts/referrals clients receive to help them achieve their goals (see figure 4.2, section 4 for further information).

The evaluation findings provide strong evidence that the programme has helped older people with LTCs to cope with the practical and emotional impact of these conditions on their lives. However, to support the self-management of health and wellbeing, older people also need the knowledge, skills and confidence to manage the physical impact of their LTCs. Clients involved in the PICP have clearly been motivated and empowered to take action to improve their overall physical health[33]. Nevertheless, there is limited evidence, beyond signposting to disease-specific charities, to suggest that clients have been supported to improve their technical

> *"I am having problems with my diabetes at the moment – all my readings up the swanny – but I have found it difficult to get someone to sit down and discuss it with me. And that gets you down after a while. I had called the community diabetic nurses last week, to see if I could sit down with them. The one I spoke with was a little offhand and it threw me a bit. I have to be re-referred because I haven't seen them for over six months. It doesn't make a lot of sense to me. But now I have more confidence, thanks to the support of Age UK. I have persevered and contacted my doctor. I have an appointment next week to discuss my results. She'll also be able to refer me back to the community diabetic nurses." Client (Ashford and Canterbury)*

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[31] The Care Act (2014) statutory guidance uses a triple definition of prevention. Primary prevention aims to prevent people who have no immediate health or care and support needs from developing them. Secondary prevention relates to targeting people at high risk of developing needs and intervening early. Tertiary prevention focuses on minimising deterioration and the loss of Independence for people with established needs or preventing the reoccurrence of a health and social care crisis. For further information and an example of each level of prevention see: British Red Cross (2017), *Prevention in Action.*

[32] For some clients, changes in behaviour, especially becoming more active, could also inadvertently have the unintended consequence of exacerbating their LTCs. This in turn could increase use of acute hospital services, especially in circumstances where case review by a MDT does not take place. However, the programme's existing evaluative evidence, in particular the qualitative evaluation findings, indicated that neither clients nor professional stakeholders thought changes in client behaviour had impacted negatively on clients' health.

[33] For example, by joining walking groups, Tai Chi and other physical activities, as well as more indirectly as a result of simply being more physically active by increasing everyday activity through getting out and about to join social activities and going shopping or becoming more mobile in their own homes.

knowledge of their LTCs, or to develop wider skills to allow them to deal with some of the physical aspects of their conditions themselves[34]. This is in part due to a dependency on the availability of local support – such as health coaching, education programmes and peer support groups – which can make such help difficult to put in place. It is also likely to be a result of the personalised approach given to identifying clients' goals to improve their health and wellbeing; some older people may not recognise or feel the need to improve their management of the physical impact of their LTCs. The findings therefore suggest that the programme's impact on self management could be enhanced by motivating and supporting clients in these aspects.

*The duration of Phase 2 of the PICP*

Finally, the duration of Phase 2 could also influence whether changes in hospital activity are observed in the short term. The Nuffield Trust evaluation is following the programme's cohort of clients and the control group's use of acute hospital services for 9 and 15 months after the guided conversation. Consistent with the findings of others[35], the findings presented in this report suggest that evaluation after one year's operation of the programme is likely to capture the impact of implementation alone, given the time required to refine and optimise delivery of the model locally (see section 6.10). The Phase 2 sites commenced delivery at different time points. Therefore, the data underpinning the Nuffield Trust evaluation necessarily comprises data relating to varied durations of delivery of the service, ranging from 10 months to 17 months depending on the given site (with an average of 13 months). Whether, at an aggregated level, this is sufficient time to capture the impact of the stabilised model, rather than implementation alone, remains uncertain. The extension of the Phase 3 pilots to 15 months is likely to provide an evidence base to help address this question. Nonetheless the Nuffield Trust evaluation will provide robust evidence of the short-term impact of the programme on hospital activity.

## 8.2    Beyond the Triple Aim – how else has the programme supported new models of care locally?

Beyond the outcomes for older people and for primary care, the findings from Phase 2 of the programme show that the Age UK Personalised Integrated Care model has been effective in enabling:

■ Personalised care for older people – in particular personalised care and support planning

■ 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.

*An effective mechanism to support holistic, personalised care planning within primary care*

In its review of personalised care in 2017, National Voices concluded, *"… evidence about the extent and quality of personalised care planning is very patchy, but suggests that in most mainstream NHS settings – and in some residential care – it is largely absent."*[36] The findings from Phase 2 of the PICP highlight that the model is an approach that could help local health and care systems to address this gap (see section 4). In particular, the guided conversation between the PIC and the older person, time afforded to the PIC to support the client, and MDT working involving the PIC have proved effective in:

■ Empowering older people to identify their goals and preferences

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[34] Through, for example, patient and carer education programmes, medicines management advice and support, and coaching and peer support.

[35] Bardsley M, Adam Steventon A, Judith Smith J and Jennifer Dixon J (2013) *Evaluating Integrated and Community-based Care – How do we know what works?* Nuffield Trust

[36] National Voices (2017) *Person-Centred Care in 2017 – Evidence from services users* (2017).

■ Planning care and supporting clients to help ensure these goals are achieved and preferences are met

The qualitative evaluation provides encouraging evidence that the PICs' involvement in MDTs has influenced practice (especially by shifting the dialogue from a medical model of care). However, further exploration is required to determine the extent to which GPs and other health and care professionals use the insights shared by the PICs[37] in subsequent care planning with the older person.

Nonetheless, the information captured by the PICs about the client's wider holistic needs and preferences provides a foundation on which GPs and other health and care professionals could build to support subsequent personalised care planning with the older person.

*Connecting people and services in the community through holistic social prescribing*

The PICP intervention can be considered as a social prescribing model – one of the 10 High Impact Actions to release time for care listed in the General Practice Forward View[38]. Given the continuity of support and the time the PIC (and, in some instances, the volunteer) spends with the client to understand their needs and preferences, co-produce solutions and help them to achieve their goals, the PICP's signposting model is consistent with holistic social prescribing[39].

This social-prescribing approach has delivered benefits to older people and practitioners alike, including supporting integration in the wider health and care system by providing access to practical and social community-based support for older people. Critically, it is the ongoing support (beyond providing information alone) that many clients identified as one of the unique and welcome features of the PICP – one that has been instrumental in helping older people to make positive changes. PICs (and volunteers) have helped clients to initiate contact with other services, access services and support, and build confidence and sustain motivation over time. As a result, many older people have been able to successfully overcome the barriers they face to improving their own wellbeing and wider determinants of their health. For GPs, the ongoing support from the PIC has reduced the need for them to follow up on the signposting their patients have received, thereby adding value by reducing the primary care workload.

## 8.3    Conclusion

Although the breadth and scale of impact has varied across the Phase 2 sites, the findings reported here provide evidence that the programme has made a positive difference to older people's wellbeing and to their experience of care. Although not quantified, the support provided by the PICs has released time from primary care and improved the quality of care. The findings also highlight how the intervention extends beyond 'signposting and care navigation'. While these are important, it is the combination of the shared, personalised care planning focused on what is 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 clients 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.

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[37] Through MDT working or through the goal-orientated plan shared with each client's GP.
[38] NHS England (2016) General Practice Forward View.
[39] Kimberlee (2015) categorised social prescribing models as basic, light, medium and holistic (Kimberlee R. (2015) *What is social prescribing?* Advances in Social Sciences Research Journal, Volume 2, No1.

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. Phase 2 of the PICP has thus laid foundations that have the potential to support sustainable transformational change to local health and care systems over the longer term.

Finally, the Phase 2 pilots have generated learning and insights to underpin continuous improvement to the overall PICP. Analysis of the findings confirms the challenges and risks identified by Age UK and the local health and care partnerships. These challenges and risks will require attention during the subsequent stages of the programme at a local and national level:

- 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

- Addressing barriers to active performance management and evaluation locally, including overcoming the challenges associated with accessing local healthcare data

- Reviewing the quality and consistency of the data/evidence collected and ensuring its timely use to support continuous improvement and evaluation

- Creating sustainable networks of support for older people – and pathways of care that will endure beyond their involvement in the programme

More generally, the learning about delivery of the PICP model on the ground and the difference the programme has made will be of value to other health and care systems as they as 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 qualitative evaluation suggest that Phase 2 of Age UK's PICP has generated significant value at a local and national level.

# 9    Recommendations

Throughout Phase 2 of the PICP programme, Age UK National 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 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. Examples include:

- Creating a toolkit of resources to support the five local health and care partnerships involved in Phase 3 of the programme with co-design – drawing on the lessons learned and consolidating the tools developed in Phase 2.

- Refining and honing national programme-management processes, including introducing a series of health-check tests at various key stages of Phase 2, rather than only halfway through. Drawing on data captured through the performance framework and local intelligence, these tests identify opportunities to maximise success. They also help local sites to adopt a 'plan, do, study, act' cycle – a key element of the programme's approach to active performance management.

- Refining and defining in more detail the outputs and outcomes underpinning the programme's performance framework and the reporting requirements.

- Exploring different workforce models to address the challenges associated with involving volunteers, while retaining the value they add with respect to financial sustainability and improving clients' wellbeing.

- Extending the Phase 3 pilot's implementation and delivery phase to 15 months, to allow enough time to capture the impact of the stabilised model of care.

- Convening a symposium to discuss and address the challenges associated with local evaluation of integrated care programmes. Also, creating a community of practice involving commissioners, providers and evaluators of complex change to further explore approaches to evaluating such programmes both locally and nationally.

Additionally, Age UK is:

- Undertaking proof of concept studies to focus on adapting the model to support hospital discharge and end-of-life care for older people – thereby supporting wider system change, beyond primary care.

- Working in partnership with the universities of Bradford and Leeds to design and deliver a randomised control trial (RCT) that will test whether personalised care planning can improve quality of life for frail older people as well as reducing health and social care costs.

- Working in partnership with South Gloucestershire Age UK and Bristol, North Somerset and South Gloucestershire CCGs to design a Personalised Integrated Care Social Investment Bond. Funding has been secured through the Life Chances Fund to support this development.

Building on the improvements already made and on work in track to support spread, scale and sustainability, 13 recommendations have been identified to further strengthen the development and delivery of the Age UK Personalised Integrated Care model.

- **Recommendation 1:** Undertake further research and testing to understand whether and how the risk stratification approach can be optimised. This will help to ensure that resources are targeted to maximise achievement of the Triple Aim.

Locally, there will be merit in exploring the feasibility of replacing the threshold approach to risk stratification with predictive risk modelling, given the latter's greater efficacy in identifying future risk of hospital activity. Nationally, research into the potential use of the existing predictive risk modelling tools to target those older people who are not 'too fit or too frail' to benefit from involvement in the programme could be undertaken. To support the use of these tools/models at a local level, the research should include analysis to help:

- Understand whether and how the profile of the target cohort of clients generated through predictive risk modelling varies from that generated through the use of the Two Plus Two threshold approach

- Define which risk profiles or scores generated by these tools/models could be used to target the 'right' cohort of older people, and to understand whether and how the profile of clients impacts achievement of the Triple Aim

Recognising that use of the threshold approach is likely to prevail for some time, considering whether and how the threshold criteria can be optimised is likely to be valuable. The findings from this evaluation suggest that, even within the Two Plus Two cohort, clients' levels of frailty and loneliness in particular can influence both the intervention and its outcomes. There is therefore likely to be merit in incorporating levels of frailty and loneliness and isolation into the Two Plus Two criteria. Suggestions for additional research and testing include:

- Where feasible – and using the data captured through Phase 2 of the programme – undertake modelling/impact analysis to understand whether and how factors other than prior hospital admissions and number of long-term conditions influence achievement of the Triple Aim

- Refresh the evidence review carried out as part of the proof of concept study to understand the current evidence base regarding which cohorts of older people are at risk of becoming frequent users of hospital services and are therefore likely to benefit the most from the service

- Informed by the findings from the research suggested above, consider the feasibility and cost-effectiveness of collecting, during Phase 3, the additional data required to assess how any variable factors identified (e.g. levels of frailty and loneliness) impact on achievement of the Triple Aim

While this recommendation focuses on optimising the Two Plus Two criteria, the findings highlight that reducing the criteria to Two Plus One (i.e. two long-term conditions and one prior hospital admission) and, in some instances, lower proved to be more workable on the ground for a variety of reasons (see 5.1). The findings from the research suggested above, together with the results of the Nuffield Trust evaluation, will provide insights into the costs and benefits of broadening the criteria with respect to prior hospital admissions. In response to those insights, and in the interests of supporting the spread of the model, Age UK and local partners could consider the merits of testing and creating a robust evidence base of the impact of different criteria (for example, Two Plus One, or criteria based on levels of frailty and loneliness and isolation). In considering additional research, Age UK would need to explore incorporating the use of predictive risk modelling tools.

## Tailoring messages to potential clients to increase uptake

- **Recommendation 2:** Create targeted messages for potential clients to raise awareness and understanding of the benefits of becoming involved, and to create 'bottom-up' demand for the service. Use evidence available locally to identify the reasons why some older people decline the invitation to participate.

Creating tailored messages that reflect the potential barriers to older people's engagement with the programme could help to create more demand. One option is to produce bite-sized case studies capturing the voices of older people and highlighting their initial feelings about accepting support, or preconceptions about Age UK, together with the difference the programme has now made to them. Such case studies could be shared when GPs invite older people to participate in the programme and/or when the PICs first visit the clients. Alternative formats could include short videos that are promoted in GP practice waiting rooms. Any material produced would need to reinforce the criteria and referral route to ensure that it targets those who can most benefit from the programme.

Understandably, detailed information about older people who decline the offer to become involved in the programme is not shared. It is therefore not possible to assess objectively whether older people with a particular profile are more or less likely to participate. Nonetheless, capturing feedback from GPs and the PICs about the reasons why people decline could potentially provide further insights that could inform approaches to create demand for the service from those clients the programme aims to reach.

## Helping clients to improve their health and wellbeing in a sustainable way

- **Recommendation 3:** Explore and test how to create sustainable and holistic care and support pathways /networks for older people that will endure beyond their involvement in the programme.

In doing so there will be merit in focusing on:

- Creating networks that are not completely dependent on the local Age UK's input

- Empowering those clients (and others within the community) who are able and willing to help design, build and/or sustain new activities and support networks where there are gaps in the current community offer

- Understanding the cost and resource implications of creating such networks

A starting point could be to discuss and reflect on examples of the wrap-around support many PICs have facilitated during Phase 2. It would be particularly beneficial to focus on identifying common gaps in the community offer and on sharing effective practice in meeting the needs of clients for whom there is a mismatch between their interests and the local offer, or for those who are less mobile or are housebound. The PICs' learning forum or local team meetings could provide an effective environment for holding such a discussion.

Additionally, local partnerships delivering the model should consider the feasibility of, and the opportunities for creating pathways of care that enable both ongoing proactive case management and preventative holistic care for older people after their involvement in the programme has ended.

- **Recommendation 4:** Strengthen a focus on supporting clients to improve their knowledge, skills and confidence to better manage the physical aspects of their LTCs.

While the programme has been shown to be effective in helping clients to manage the practical, emotional and social impact of their LTCs, the evidence suggests that there is scope for a greater focus on supporting older people with the management of their LTCs' physical and medical aspects. However, there could well be limits, locally, to the extent to which this can be achieved in the short term (see 8.1).

It is worth noting that several Phase 2 and 3 sites have used/are using the Patient Activation Measure. Initially, understanding clients' level of activation could identify those older people for whom the guided conversation could be used to uncover opportunities to improve their knowledge, skills and confidence in managing the physical/medical aspects of LTCs. Addressing gaps in the support available could be a focus for the creation of new community activities and help and/or volunteering. For example, one site, Ashford and Canterbury, is exploring the feasibility of creating a pool of specially trained volunteers to work with clients with specific LTCs.

## Embedding the programme within primary care

- **Recommendation 5:** Continue to raise the programme's profile and strengthen primary care stakeholders' understanding of the service and its value to encourage engagement.

Research carried out for this study provides examples of what has worked locally to support primary care engagement with the programme (see section 5.2). Additional recommendations include:

➢ Creating tailored messages that connect with GPs' values, reflect what matters to them and address their concerns

The findings from this evaluation provide insights into GPs' perceptions of the added value to their patients, practice and workload of the support provided by Age UK. These insights could be used as a basis to prepare more targeted messages that resonate with primary care stakeholders. Such messages could be refined and adapted as understanding of the specific needs of local primary care stakeholders grows, and as evidence emerges of how the programme is working locally.

➢ Exploring opportunities and wider levers and incentives to encourage GP engagement and embed the service within primary care

When asked to identify potential ways of fostering greater primary care engagement, several stakeholders suggested including presentations and discussions about the programme at the protected learning initiatives. Strengthening engagement with GP federations during co-design and delivery could also help to influence and support primary care engagement.

At a national level, Age UK could continue developing the programme's national platform, positioning and promoting the model in the context of the General Practice Forward View and 10 High Impact Actions to release time for care. Age UK could also explore wider levers and incentives, for example by including referrals to the programme within local primary care quality frameworks.

➢ Reviewing whether feedback loops with primary care are working as intended, and whether they reinforce the value the programme offers

This includes taking time to find out what kind of information primary care stakeholders would value and use, at both a patient and practice level, and when and how they would like to receive such information.

## Workforce model and development

- **Recommendation 6:** Consider the merits of developing a competency framework for PICs and a complementary training programme to support workforce development and emphasise their expertise.

The PIC role is vital to the programme's success. The findings highlight that the role is challenging and requires a range of competencies in:

- Building relationships with clients and supporting and empowering them to identify and achieve goals and improve their own wellbeing

- Building relationships and integrating with statutory health and care professional teams

Establishing a competency framework which sets out the key knowledge, skills and behaviours required has multiple benefits. As set out by Health Education England in its *Care Navigation: A Competency Framework[40]*, such a framework can:

*"Support workforce planning and recruitment; support individuals together and teams to identify strengths and developmental needs; and provide some broad consensus, common language and understanding of the current and future training needs."*

A competency framework could also help to demonstrate to wider stakeholders the quality and skills of the PIC workforce. In the longer term, Age UK National could also consider designing a training programme made up of accredited modules to further enhance workforce development. Accreditation could well facilitate the recruitment, progression and retention of PICs.

- **Recommendation 7:** Define and develop further the role of the volunteer in order to enhance quality of care and support and strengthen the programme's impact on connecting people and services within the community.

The research findings suggest that there will be merit in:

- Defining whether and how the role differs from other Age UK volunteer roles, particularly with respect to mentoring and raising the ambition of clients to promote their independence

- Understanding how to create demand for volunteers, including considering recruitment, training/development and retention issues

- Exploring how to address the challenges associated with the time lags between recruiting volunteers and providing them with opportunities

- Establishing effective mechanisms to support and manage volunteers and harness the insights they capture while helping clients on the programme

Drawing on lessons learned from other programmes (both Age UK and wider volunteering initiatives) that have been effective in using volunteers will provide insights to support the actions described above.

At a local level – although dependent on the vibrancy of both the local VCS and the volunteer base – it is also worth considering partnering with other VCS organisations to establish and effectively support a pool of volunteers for the programme, as was done in Cornwall.

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[40] Health Education England (2016) *Care Navigation: A Competency Framework*.

## Knowledge exchange to underpin continuous improvement, maximise the programme's success and support scale and spread of the model

- **Recommendation 8:** Consider developing communities of practice to support knowledge exchange beyond the national learning and PICs' forums.

The national learning forum provides a successful and welcome space for discussing and identifying effective practice and exploring issues and solutions collectively. However, its membership is typically drawn from senior stakeholders from the current phase of the programme. The introduction of the PICs' forum during Phase 3 of the programme provides an opportunity for PICs to connect with their peers from other sites to share and discuss frontline challenges and effective practice. The evaluation's findings suggest that there would be an appetite for and benefit in establishing the following potential communities of practice:

- A forum for local Age UK CEOs to discuss and explore more strategically the wider challenges of engagement and of positioning the PICP within the local Age UK and the changing local health and care context.

- A forum involving partners from across all phases of the programme. The purpose of such a forum would be to share and discuss the lessons learned by health and care partnerships at different stages of their journey (including sustaining the programme post pilot phase) to support continuous improvement at local and programme level.

Consideration should be given to how, after Phase 3, Age UK will stay connected with those partnerships that have been involved in the programme, as well as other local partnerships (in particular local Age UKs), that have or are now adopting and adapting similar models of care and support independent of the PICP. Setting up communities of practice could provide a chance to instigate a dialogue with these geographically dispersed and, in some instances, unfamiliar teams to allow Age UK to:

- Share the lessons learned, insights and lived experience of the programme, and to encourage and support others further afield to adopt and implement the model successfully

- Capture evidence and lessons learned about the model's impact and how it is working in different contexts in order to continue the development of the programme at a national level

If Age UK does pursue creating communities of practice, it will be critical to establish a shared understanding of the purpose and focus of such groups to ensure that they add value locally, regionally, and at the national programme level. Exploring the preferred mechanisms and frequency to secure involvement will also be vital; a combination of face-to-face forums and digital ones (such as interactive webinars) is likely to be effective.

## Active performance management and evaluation

Age UK is currently revising the PICP's theory of change to reflect the learning from Phase 2. The refreshed theory of change (which provides a strong foundation on which to implement recommendations 9 –14) will help to maintain a focus on capturing evidence (be that quantitative or qualitative) that is valued. It will also allow Age UK and local health and care partners to identify whether there are any gaps in the evidence currently being collected that need to be filled in order to assess and understand the success of the programme, whether it is working as planned, is on track to deliver the expected benefits and how it can be improved.

- **Recommendation 9:** Co-produce local and programme-level performance dashboards to strengthen the focus on tracking progress and achievement across the care pathway, and to bring to life how the data collected through the framework can add value locally.

The findings from this evaluation suggest that there are opportunities to make better use, at a programme and local level, of the data currently collected and reported by local sites. The vital indicators needed to give a rounded view of performance impact across the full care pathway could be used to create performance dashboards. These are likely to help Age UK and local partners to identify timely opportunities to maximise and showcase success.

Different audiences will require differing levels of detail and scope. A hierarchy of dashboards is recommended to enable a scalable and flexible view of performance – allowing for both an overview and drill down to the detail where needed. In developing the dashboards, it will be essential to tailor their content to the needs of the target audience, rather than trying to cover all the things that it might be interesting to know. Importantly, the dashboards will not provide solutions, but a springboard to help Age UK identify successes and opportunities for improvement.

Co-production of the dashboards at all levels so is likely to foster greater local ownership of the performance framework and its use. In order to encourage a focus on the programme's intended impact, the dashboards should clearly illustrate the links between activity/outputs and outcomes. Ensuring that there are mechanisms in place that create a dialogue and facilitate reflection, both across the sites and within local teams, will be critical to both co-production and use of the dashboards. Such mechanisms will also reveal whether any extra resources or help might be required to further support active performance management.

**Recommendation 10:** Review performance data and its use to identify how improvements can provide a robust and timely view of performance at every level.

Phase 3 sites currently collect and report monthly output and quarterly outcome data aligned to the programme's performance framework. Age UK and local partners should assess whether the quality and consistency of the data collected provides a robust enough picture of performance across the client journey at both a local and programme level. The findings from this evaluation suggest that, as a minimum, there is likely to be scope to improve the quality and consistency of the information collected about the goals clients identify and the support they receive to achieve them. Improving this aspect of the data captured will enhance understanding of the extent to which the programme is already connecting local services and people. It will also make it easier to spot mismatches between supply and demand for resources in the community.

Any decisions to change the performance information captured and/or reported must be grounded in a shared understanding of how the refined data will be used and the value the changes are expected to add (i.e. improve understanding of what's working well, identify areas for improvement and showcase success). This co-production between stakeholders at every level – from those who collect the data on the ground to those who analyse and use it – is critical. Without it, there is the risk that ownership by different stakeholders could be limited and the approaches to data capture and reporting could be unfit for purpose, with the costs outweighing the benefits of any changes introduced.

Developing the programme- and local-level dashboards (see recommendations 9 and 10) will shine light on the quality and consistency of the data captured at the moment, and support co-production and a shared understanding of the value of any changes.

Finally, when reviewing the data, Age UK should be prepared to cease collecting information that will not be used to add value – and instead focus on ensuring the quality and consistency of the information required to give a critical view of performance.

- **Recommendation 11:** Further embed formative evaluation to allow prompt understanding of how the model is working on the ground and opportunities to maximise success and to spread real-time learning.

The national learning forum, and towards the latter parts of Phase 2, the health tests, provided a chance to explore and understand how the model has worked in practice, drawing on both qualitative and quantitative evidence. Nonetheless, opportunities to optimise programme delivery along the way may have been lost. For example, understanding of the profile and needs of the clients involved in the programme and the extent to which they met the Two Plus Two criteria was not appreciated until the end of Phase 2. The refreshed theory of change will provide a steer for the focus and timing of any structured formative evaluation and the health checks conducted at key points during Phase 3 of the programme.

Gaps in the programme's existing evaluative evidence that merit further exploration to understand more fully whether and how the model's delivery impacts on outcomes (see section 0) include:

- The effectiveness of the different risk stratification approaches to identifying older people for whom PICP support could have maximum benefit both in the short and longer term.

- The proportion of clients involved in the programme whose cases are discussed and reviewed by an MDT involving the PICs – and whether opportunities to support more integrated holistic, personalised care to improve the health and wellbeing of older people have been missed.

- Whether the benefits of being involved in the programme are influenced by whether clients are supported to achieve their goals using signposting alone (in which they themselves have to initiate contact with other organisations) or an assisted signposting approach.

- The sustainability of the benefits experienced by clients. While the post intensive support three-month follow up of the WEMWBS survey provides some evidence of whether the benefits have lasted, there is scope to better understand the why and how. For example, understanding whether clients' circumstances have changed – and if so, how have these changes impacted on the extent to which they take action to improve their health and wellbeing?

- Whether and how involvement in the programme has impacted on GPs and other health and care practitioners' behaviours and practice, particularly with respect to the personalised care planning for and case management of clients after the PICs' intensive support has ended. This should include whether and how clients' medical care is coordinated and preventation-focused, thereby helping to reduce potential hospital activity.

Recommendations 9-11 should identify opportunities to improve the data captured to better support evaluation of whether and how variables in the both the delivery on the ground and clients' profiles influence the impact of the programme.

- **Recommendation 12:** Consider the feasibility and merits of developing a digital analytics platform to allow for more real-time performance management and evaluation.

While undoubtedly ambitious, creating an analytics platform (drawing on, for example, primary care data and the data collected through the programme) could provide more real-time data. Such data would support proactive case finding and the sharing of information. It would also improve understanding of the programme's impact on primary and community care during and after the PICs' intensive support. Furthermore, the platform could facilitate the identification of opportunities and triggers for when clients could benefit from additional, preventive holistic care and support – be that medical, social or practical.

- **Recommendation 13**: Consider the merits of undertaking an economic evaluation of the costs and benefits of the model – including a Social Return on Investment.

Doing so will improve understanding of the return on investment for communities and the wider health and care system, beyond acute care. In the first instance, such an evaluation could focus on a single site, rather than operating at a programme level. Considering the PICP's social value and value to primary, community and social care will provide a more rounded picture of the costs and benefits of delivering the model. This, in turn, will inform local decision-making regarding subsequent commissioning of the service.

# Annex 1   Overview of the five work streams of the PICP co-design approach



| Work stream | Aims |
|---|---|
| Governance, Information Governance and communications | ■ To ensure a shared vision of what is to be achieved and a commitment to making it happen<br><br>■ To optimise accountability, integration, preparation for delivery and learning in order to maximise success and avoid duplication<br><br>■ To emphasise the importance of effective communication and dissemination |
| Cohort selection and risk stratification | ■ To ensure that a 'high-cost, high-risk and high-service use' cohort, local cost drivers and potential sources of savings are identified to help select older people for the programme (see section 5.1 for details of the risk stratification criteria)<br><br>■ To ensure that the characteristics of the selected cohort of older people support the assumptions underpinning the expected return on investment |
| Performance management, outcomes and evaluation | ■ To ensure that there are workable mechanisms in place to actively track and understand performance and financial flows (both costs and savings) at an older-person, cohort and system level once the model is implemented<br><br>■ To develop a baseline position against which costs and savings can be tracked (also allowing the potential savings that could be attributed to the programme to be established)<br><br>■ To provide evidence to support the case for subsequent investment or commissioning to secure the programme's sustainability |
| Care pathways | ■ To ensure that the pathways of care are tailored to the local context and align with wider strategic developments |

| | |
|---|---|
| | ■ To ensure that clinical leadership/ownership is embedded |
| | ■ To identify the local community assets and care pathways that can be leveraged and ensure duplication is avoided |
| Workforce development | ■ To ensure that the right people are able to provide support at the right place and right time, and that capability is mobilised to support delivery of the service |
| | ■ To build and develop teams of people who can effectively support the client by drawing on what they do best and to ensure that teams are trained and supported |

# Annex 2 Changes in the Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)

## A2.1 Changes in mean SWEMWBS score (sample A)

Please see section 3.1 for further information about the use of SWEMWBS and the analysis undertaken.

**Table A.2.1 Changes in SWEMWEBS scores (sample A)**

| n=932 | SWEMWBS Score | |
| --- | --- | --- |
| | Guided conversation | Goals achieved |
| Mean | 21.66 | 23.91 |
| Standard Error | 0.14 | 0.15 |
| Median | 21.54 | 24.11 |
| Mode | 19.25 | 26.02 |
| Standard Deviation | 4.34 | 4.51 |
| Range | 28 | 25.49 |
| Minimum | 7 | 9.51 |
| Maximum | 35 | 35 |
| Confidence Interval (99.90%) | +/- 0.47 | +/-0.49 |

Dependent t-test: $t$ (931) = 21.21262, $p$ = 0.001

## A2.2 Changes in mean SWEMWBS score (fo a sub cohort of sample A)

**Table A.2.2 Changes in mean SWEMWBS score (for a sub sample of sample A)**

| n=415 | SWEMWBS Score | | |
| --- | --- | --- | --- |
| | Guided conversation | Goals achieved | Review |
| Mean | 21.48 | 23.99 | 24.9 |
| Standard Error | 0.21 | 0.22 | 0.23 |
| Median | 20.73 | 24.11 | 25.03 |
| Mode | 19.98 | 26.02 | 28.13 |
| Standard Deviation | 4.24 | 4.44 | 4.77 |
| Range | 25.49 | 21.67 | 21.67 |
| Minimum | 9.51 | 13.33 | 13.33 |
| Maximum | 35 | 35 | 35 |
| Confidence Interval (99.90%) | +/- 0.69 | +/- 0.72 | +/- 0.77 |

Dependent t-test; Guided Conversation to Review: $t$ (414) = 17.35750, $p$ = 0.001

Dependent t-test; Goal achieved to Review: $t$ (414) = 5.70513, $p$ = 0.001

## A2.3    Imputation of SWEMWBS Values

Using a combination of Sample A, the subcohort of clients for whom data was also collected at review point and the full population data, it was possible to impute missing SWEMWBS values for the full population for all three time points.

Quantile-Quantile plot analysis confirmed a normal distribution of the SWEMWBS scores for sample A at both time-points. A two one sided t test was also carried out on the SWEMWBS scores conclude that we cannot reject the null of dissimilarity of sample A to the population (n=2069). Analysis was also undertaken to confirm that data was missing at random.

Bootstrapping-based multiple imputations of the missing SWEMWBS scores was run based on ethnic group, age group, living arrangement, marital status and gender.  This allowed us to examine the imputed values and re-run the t-test on a larger group. The 'review' scores based on sub-cohort of sample A (n=415) were also included.

t-test analysis revealed a statistically significant increase in wellbeing as measured using SWEMWBS (see table A2.3), with the change in wellbeing scores being of a similar scale to those observed with sample A and a sub-cohort of this sample. Furthermore, the analysis indicates that not only does the intervention improve mental wellbeing, but that mental wellbeing continues to increase following the end of the immediate intervention.

**Table A2.3 Changes in mean SWEMWBS score using imputing values**

| | SWEMWBS Score | | |
|---|---|---|---|
| n=2069 | Guided conversation | Goals achieved | Review |
| Mean | 21.65 | 23.79 | 25.05 |
| Standard Error | 0.08 | 0.07 | 0.06 |
| Median | 21.54 | 23.86 | 25.03 |
| Mode | 19.25 | 26.02 | 28.13 |
| Standard Deviation | 3.86 | 3.3 | 2.79 |
| Range | 28 | 25.49 | 21.67 |
| Minimum | 7 | 9.51 | 13.33 |
| Maximum | 35 | 35 | 35 |

Dependent t-test; From guided conversation to goal t (2068) = 27.92812, p = 0.001

Dependent t-test; From guided conversation to review t (2068) = 36.87183, p = 0.001

Dependent t-test; From goal achieved to review t = (2068) = 16.95068, p = 0.001