Evaluation of Get Going Together - final report for Age UK Leicestershire and Rutland

Final findings for Age UK Leicestershire and Rutland

August 2016

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1 Introduction and methodology

1.1 GGT aims and objectives

Get Going Together (GGT) is a three-year programme funded by GlaxoSmithKline and managed by Age UK; it commenced in October 2013. The programme encourages older people with tong term conditions to lead more active lives and benefit from improved physical and mental health wellbeing. Exercise-based interventions are tailored to individual and group needs, ranging from one-to-one support in the home to group classes in a community setting. The programme also draws on wider community assets, using volunteers to provide support to older people and the delivery of GGT activities.

As well as improving the physical and emotional health and wellbeing of older people, GGT aims to reduce falls and unplanned GP and hospital attendances. It also seeks to reduce social isolation.

GGT is being delivered by five local Age UK partners in Cheshire, Coventry, Leicester Shire & Rutland (LS&R), Oldham and South Tyneside[1]. The localities differ in their make-up, size and geographical spread with some focusing their resource in a city with others based across a county.

1.2 National programme objectives

GGT will achieve its aims by:

- Delivering low level activities, aiming to support 4,500 older people with less intensive support needs. These activities may be delivered by non-specialist staff or volunteers and referrals are received through a broader range of routes including libraries, community groups, other Age UK services and self-referrals.
- Delivering high level, targeted activities requiring specialist support to 1,620 older people. These are most often provided one-to-one or in a small group setting and are delivered by qualified instructors. Referrals are primarily through health professionals including falls prevention teams and GPs.
- Distributing information and advice (I&A) resources to 90,000 older people. These materials highlight the importance of staying healthy and fit to older people and promote project-specific activities. They are disseminated through a variety of mechanisms including leafleting, social media, professional networking and public events.

1.2.1 National programme design

The typical participant pathway or 'journey' through GGT involves:

- Referral from a healthcare professional, from a community organisation, or self-referral;
- A needs assessment undertaken by a member of staff or volunteer at the local Age UK to determine which class(es) the participant might benefit from;
- Participation in one or more one-to-one, small or large group exercises, delivered by a paid instructor or by a volunteer; and
- Progression through high level to low level activities to sustain involvement in physical exercise (within or beyond GGT).

Within this general context, the five local Age UK partners have been able to take different approaches to meet these aims to ensure that the design is tailored to the local context. Projects vary in their local contexts, specific rationales for intervention and subsequently their project designs.

[1] As of August 31st 2016, Age UK South Tyneside is no longer operating and is now legally known as Age Concern Tyneside South. For the duration of GGT, the organisation was Age UK South Tyneside and so is referred to as such where relevant in the report.

1.3 Overview of the GGT evaluation

In February 2014, Age UK commissioned ICF to undertake an evaluation of the Get Going Together programme. The evaluation comprises three stages that will be delivered between February 2014 and September 2016. The evaluation framework and scoping reports were delivered to Age UK in November 2014 and presented the detailed evaluation approach and early overview of the programme's activities, key participant characteristics and initial lessons learned, respectively. The scoping report concluded with recommendations for the continuous improvement of GGT. The interim report was delivered in September 2015 and detailed the programme level findings at the 18 month point of the evaluation. It focused on the progress to date, emerging outcomes and lessons learned. Detailed findings and a profile were also produced for each local Age UK GGT project.

1.3.1 About this report

This report details the findings from the final point of the evaluation of the Age UK LS&R GGT project. The findings from the final evaluation of the GGT programme overall, and other local GGT projects are available in separate reports.

This report draws on a variety of data sources, including;

- Participant survey data[2] submitted up to the end of June 2016.
- Quarterly Monitoring Reports (QMR) for the first 11 quarters (October 2013 to June 2016) of the programme – these were used to obtain quantitative data on the uptake, reach and retention of the projects' low and high level activities and information and advice activities.
- Telephone and face-to-face interviews with the Age UK LS&R GGT team including senior members of staff to explore developments, outcomes and plans for sustainability.
- Telephone interviews with local health and social care stakeholders[3], and information and advice stakeholders to situate the local LS&R GGT project in a wider context and understand the effectiveness of local dissemination.
- Interviews with participants and volunteers[2] during a visit to LS&R and attendance at GGT classes to explore the experiences of older people and early outcomes.

1.4 Structure of this report

The remainder of this report is structured as follows:

- Chapter 2 presents final findings for the LS&R GGT project.
- Annex 1 presents details of the stakeholders interviewed in LS&R.

[2]GGT participants are invited to complete a survey on entering the GGT programme and at six monthly intervals thereafter. The participant survey includes the RAND SF-36 survey questions. The SF-36 questions allows responses to be scored and analysed in eight dimensions of health and wellbeing; physical functioning, role limitations due to personal or emotional problems, emotional well-being, bodily pain, social functioning, energy/fatigue and general health. The baseline participant profile reported is derived from the surveys competed by participants' when they join the programme (round one surveys). Follow on surveys have also been collected by Age UK LS&R. Each participant's surveys were categorised from waves of survey (baseline, follow up wave one, follow up wave two etc.) and sorted by duration from the date of the first survey. The time categories used were:

- Up to three months from the date of the first survey (excluding those completed within two weeks);
- Between three and six months from the date of the first survey;
- Between six months and one year of the date of the first survey;
- Between one and two years of the date of the first survey;
- More than two years since the date of the first survey.

Statistical analysis of the difference in round one and follow-on surveys has been undertaken using these time categories to assess changes in participants' health and wellbeing.

[3] The details of stakeholders and GGT participants interviewed are set out in annex 1.

- Annex 2 presents an overview of SF-36 and healthcare utilisation data.

2 Age UK Leicestershire and Rutland: final findings

2.1 How have Age UK Leicestershire and Rutland GGT developed over time?

2.1.1 Recruitment, retention and referral pathways

- A total of 1,357 people have been recruited over the course of the LS&R GGT project; 988 older people have been recruited to low-level activities (with a retention rate of 45%) and 369 older people have been recruited to high-level activities (with a retention rate of 44%).
- Participants continue to be recruited to classes through a variety of different routes. These include referrals from Community Engagement Officers; a GP Exercise Referral Scheme Co-ordinator; the Care Navigator team at Leicester City Council, the Rehabilitation Department of Leicester General Hospital and from a Falls Prevention Programme.
- Age UK LS&R has also received self-referrals from individuals that have been signposted by their health professionals such as practice nurses and physiotherapists have.

2.1.2 Project delivery and activities

- Stakeholder engagement continues to be strengthened through LS&R's GGT project steering group. Membership comprises representatives from the local authority, the CCG and adult social care, in addition to senior management from Age UK LS&R.
- Over 80 physical activity sessions were set up by LS&R GGT, with 30 activities still taking place.
- A range of high and low level activities are delivered through GGT; such activities have included gentle exercise classes (seated/standing), social games (computer games and traditional games), dance sessions (Zumba, aerobics and bhangra blaze dancing), a walking group, walking football and a bowling class.
- Stakeholders reported that the popularity of the classes was often dependent on the location and the type of exercise offered. The most popular classes were those that were delivered in Birstall, Clarence House and Ramgarhia Temple. These classes were mainly seated and standing exercise classes. In addition to these, the walking football classes also proved popular and GGT provided extra classes in order to meet the high levels of demand – three walking football classes have now been set up.
- Most activities are run by volunteers (taking registers) and delivered by paid instructors. Some of the activities are also by in-house staff, for example, some staff in care homes deliver their own sessions after initial support from GGT.

2.1.3 Involving volunteers

- Recruitment of volunteers has been fairly consistent over the lifetime of the project. A total number of 26 volunteers have been recruited over the course of the LS&R GGT project, with a retention rate of seven volunteers by the end of the project.
- GGT linked in with five other Age UK projects to organise a volunteer recruitment event at Leicester City market. This increased interest in volunteering with Age UK and they also received a referral to their classes through this route.
- GGT facilitated volunteers to take part in Safeguarding & Dementia training which helped the development and knowledge of their volunteers when working with GGT participants.
- Volunteers work on a range of different tasks including administrative support but also supporting participants to complete the outcome surveys and supporting volunteers to deliver games sessions; for example one volunteer delivers Wii console sessions at a Day Centre for people affected by dementia.

- One volunteer heard about the volunteering opportunity through the 'Just Do It' website. Volunteers underwent a recruitment process including application forms and a relatively informal interview. Training that volunteers received ranged from a one day course about working in the social care industry and overview of the work of Age UK and also health and safety training. One volunteer also undertook dementia training.
- Volunteers reported feeling that they had support within their position *'I've never felt on my own…if I had a problem I could go to them and talk about it'.*

2.1.4 Information and advice (I&A)

- Over the lifespan of the project LS&R GGT have reached a total of 44,294 people through their information and dissemination activities.
- Adverts in magazines, newsletters and on websites reached the highest number of people. Such adverts included the Leicestershire and Rutland Sports magazine and website (reached 23,000 people), Aspire magazine (reached 7,000) and the Leicester Link magazine (reached 10,000 people).
- Information was distributed to the Alzheimer's Memory Café group for service users and carers. Talks and presentations to various organisations have been delivered including presentations at the Blaby Baptist Church and a community group in the New Parks area of Leicester.
- Flyers were also distributed to older people through partner organisations. Stakeholders suggested that this publicity was effective. These flyers are given to participants of the Public Health's Active Lifestyle project and participants on falls programmes. One stakeholder felt that LS&R GGT offering presentations during the falls programme was a particularly good way in getting the message across which also allowed older people to directly talk with someone and had an opportunity to ask questions.
- Several stakeholders reported that activities could be more widely publicised through free newspapers.

2.2 Survey Response rates

Table 2.1 LS&R GGT survey response rates as at June 2016

	Number of individuals completing surveys in total	Number of surveys completed in total	Number of individuals included after data cleaning	Number of surveys included after data cleaning	Number of individuals to be used in impact assessment	Number of surveys to be used in impact assessment
LS&R	757	1,178	646	976	277	607

We have completed a detailed analysis of the participant survey which was carried out throughout the programme. Table 2.1 shows the number of surveys collected and then used in the impact assessment for LS&R.

The data cleaning process started by removing duplicate entries from individuals from the data set and then involved scoring the survey responses to the SF-36 survey. This was done according to guidance from RAND Europe, who developed the survey. However, not all survey responses included answers to all questions. Where a respondent had answered fewer than ten of the SF-36 questions, the survey was removed from the analysis. Each participant's surveys were then categorised from waves of survey (baseline, follow up wave one, follow up wave two etc.) and sorted by duration from the date of the first survey.

Some of the individuals only completed a baseline survey, and therefore could not be used in the analysis of impact.

2.3 Participant profiles[4]

Table 2.2 Summary of participant profile; interim and final evaluation stages[5]

Profile characteristics	LS&R – interim evaluation	LS&R – final evaluation
Response rate	64% (447/700)	55% (742/1357)
Age	78	77
Female respondents	74% (315/423)	77% (567/734)
People who live alone	50% (187/377)	41% (190/460)
People who look after someone sick or disabled	9% (34/376)	10% (44/435)
Have had a fall or loss of balance in the last month	35% (128/369)	50% (190/381)
Unplanned GP visits per respondent	0.52 (127 days from 243 responses)	0.47 (187 days reported by 396 people)
Unplanned hospital visits per respondent	0.51 (123 days from 241 responses)	0.28 (105 days reported by 369 people)
One or more long term condition	90% (332/367)	87% (421/483)
Feel in control of their LTC	76% (281/372)	72% (407/563)

2.3.2 Age UK LS&R GGT has targeted a broad range of participants (Table 2.2)

- The majority of Age UK LS&R participants are female (77%), which is in keeping with the traditional demographic of projects such as this. However Age UK LS&R do provide a range of activities which attract a higher number of male participants including walking football and bowls.
- In total, 50% of participants reported having a fall or loss of balance in the last month which perhaps reflects the referral pathway established with a local Falls Prevention Programme.
- The majority of participants (87%) involved in GGT reported suffering from one or more long term health condition. This number is likely to be higher in light of the self-reported nature of this question. Of those who do suffer from long term conditions, 72% (407) feel in control, which represents a reduction from the interim stage of the evaluation.
- Consistent with the programme level findings, arthritis is the most frequently self-reported long term condition (Table 2.3). Although arthritis is the most commonly reported long term condition, the reasons and conditions for which people have been referred to the project vary.

[4] This profile is derived from the surveys competed by participants when they join the programme (round one surveys). Follow-on surveys (second round surveys) from participants have been excluded from this analysis to provide a baseline profile of participants.

[5] The number of surveys used to create participant profiles differs from the number used in the impact assessment as a number of surveys were removed from the impact assessment following the application of certain criteria to ensure data reliability.

- Dementia was the fifth most commonly self-reported long term condition. This reflects a focus on providing support to older people affected by this, for example through delivery of Wii console sessions at a Day Centre for people affected by Dementia. However, this finding is interesting given the way in which answers to this question are shared; i.e. self-reported.

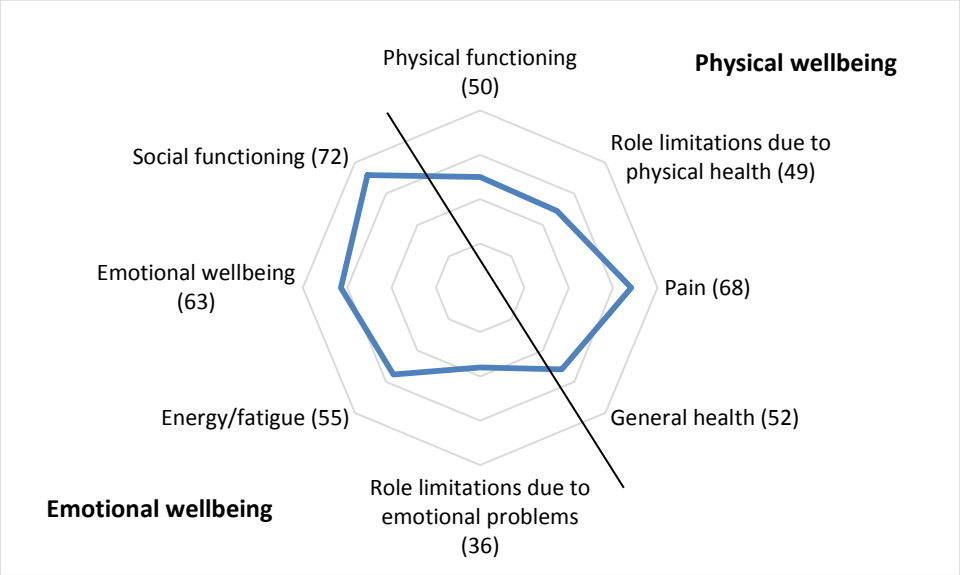
Table 2.3 Most frequently reported long term conditions in LS&R as at June 2016

Ranking	LS&R	LS&R – final evaluation
1	Arthritis (54)	Arthritis (418)
2	Other (36)	Other (231)
3	Heart conditions (29)	Heart conditions (117)
4	Diabetes (29)	Diabetes (100)
5	Respiratory conditions (18)	Dementia (69)

- Survey respondents also frequently reported a high number of 'other' conditions that had not been listed in the survey. These included vertigo, lung disease and glaucoma.
- Participants in LS&R had an unplanned GP usage of 0.47 days per participant and unplanned hospital usage of 0.28 days. Both figures are lower than those reported at the interim stage of the report, which could suggest that the participants recruited to the project more recently have lower levels of need than those at the start of GGT.
- Reasons for participating in GGT include: to increase confidence with mobility, to meet new people and to help maintain fitness.

2.3.3 Baseline emotional and physical health and wellbeing profile of participants as at June 2016

Figure 2.1 SF-36 domain profile of Age UK LS&R



SF-36 scores are illustrated in brackets – the higher the score the more favourable the health state. Please see introduction for scoring rules.

- At baseline, survey respondents have moderate levels of both emotional and physical wellbeing. Participants scored most highly on levels of social functioning yet role limitations due to emotional problems was the domain for which the lowest scores were reported, which reflects findings in other localities and at a programme level.
- The scoring reported across domains is reflective of the approach Age UK LS&R has taken to targeting and recruiting participants, indicating a mix in levels of participant health and wellbeing. This indicates that Age UK LS&R has not overly focused on recruiting one particular cohort of participants to GGT.

2.4 Outcomes and impact

Interviews with the Age UK LS&R team including project and senior staff, stakeholders, volunteers and older people explored whether and how GGT was delivering change and the desired outcomes set out within the GGT logic model6. Feedback from these interviews provide evidence of outcomes consistent with the programme's theory of change. Analysis of the data from GGT participant surveys has also been undertaken. In instances where statistically significant results have been found, the results are shared below.

2.4.1 GGT is increasing the participation of older people with LTCs in physical exercise

Stakeholders commented that a key difference GGT has made is demonstrating that older people with LTCs do not have to stop enjoying and benefiting from physical activity. Stakeholders reflected that showcasing this had sent out a really important message locally. The project has highlighted that older people can still enjoy a good quality of life through improved physical activity.

[6] The GGT logic model underpins the evaluation framework for the evaluation of the programme. It sets out the programme's inputs, activities/outputs, short-term and longer term outcomes, the programme's Theory of Change provides further narrative for the logic model and sets out the presumed mechanisms by which GGT is expected to deliver outcomes and impact.

2.4.2 Older people have increased mobility and independence

Participants felt that increasing their physical activity through GGT had resulted in improved mobility and flexibility which enabled them to be more independent. Stakeholders reported that the GGT team had numerous case studies of older people indicating that the latter were able to achieve an increased number of 'active daily living' tasks. For example, older people have reported that they can 'zip up their dress now', 'put their socks on without help' or 'reach things in high cupboards'. Stakeholders commented that this has helped older people to live more independently and this had impacted on the numbers of older people accessing primary and secondary health services, though they recognised that this attribution was difficult.

> *'I don't need as much help getting in and out of bed now, or getting dressed and putting my own shoes on'* (Participant)

2.4.3 Social networks of older people are being created and are increasing the confidence of older people

Participants, Age UK staff, volunteers and stakeholders all felt that the GGT sessions improved older people's confidence and social networks. They reflected how older people can often be quite vulnerable and choose not to leave their houses because they lack confidence. Attending the exercise classes has opened up the opportunity of talking to other older people with whom they have socialised and shared experiences – participants reported that this is what has kept them going back. As one reflected 'well, I'm lonely and I need somewhere to go and I love coming'. Watching participants grow in confidence has contributed to an increased sense of purpose for staff and volunteers making the work more rewarding: 'just seeing them come out of their shells and getting out of their house…seeing a smile on their face makes it all worthwhile'.

> *'You can't underestimate the importance of socialising…they continue to see their friends outside of classes. It's that ability to get out of the house and make new friends, socialise and keep active'* (Stakeholder)

> *'It gives them something to get up and go out for and boosts their confidence and wellbeing.'* (Stakeholder)

2.4.4 Evidence suggests improvements in the emotional and physical wellbeing of older people

The project has increased the well-being of participants; mastering new physical skills from exercises they have never tried before has resulted in *'increased endorphins and feeling energised'* which participants feel has contributed to improved physical and mental wellbeing and the ability to 'do more'.

There was a consensus among stakeholders that the social benefits of the project were significant in the lives of older people.

> *'There's very good outcomes for those that have been involved, they can't fail to be positive experiences in terms of the human contact side of things and being part of a group psycho-socially' (Stakeholder)*

2.4.5 One cohort of participants reports less frequent use of healthcare resource

Analysis of reported, unplanned use of GP and hospital resource in LS&R uncovered a statistically significant decrease (from 0.14 to 0.02) in the number of unplanned GP appointments. This was reported for participants completing surveys up to six months after their original GGT survey. This suggests that GGT could have supported participants to rely less on healthcare resource over this period of time, reflecting findings detailed above on improved emotional and physical wellbeing. Please see Annex 2 for data.

Case Study 1: Mr D and Mrs I

Mr D is 74 years old and is married to Mrs I who is 73 years old. Mr D suffered a stroke over 6 months ago and he has very impaired balance and cannot walk unaided. He also became very stiff and inflexible.

Both Mr D and Mrs I have been attending the seated exercise classes for 6 weeks because their stroke consultant recommended regular exercise for Mr D.

Attending the class has improved the physical mobility of Mr D and he can do far more than he could before he joined the class: *'It's improved my flexibility and walking and also balance and movement.'*

Mrs I explained that she can see the benefits that the class has had on her husband far more than he can: *'it's improved him getting in and out of bed and putting his own shoes on, his own trousers… and reaching and stretching generally…I see the benefits more so than he does I think'.* Mrs I attends the classes because of her husband but was glad that she joined because *'I'm feeling a lot better for it too because exercise is bound to be good for you…and it's one of those things that you don't have to keep up with everyone, you can take it at your own pace… and we're glad to have found it'.*

Case Study 2: Mrs C

Mrs C is 78 years old and suffers from muscle spasms in her back which is sometimes brought on by stress, she also has carpal tunnel syndrome in both hands. She lives in a small first floor flat.

Mrs C used to attend a gym in the centre of Leicester that closed down so she wanted to do some other form of exercise. She now attends the GGT seated exercise class and a dance class. She has been attending the seated exercise classes for about 18 months.

Mrs C felt that attending the classes have increased her physical activity levels and have improved her flexibility: *'you can do a lot of exercise whilst seated and I'm more supple now than when I was younger, I can bend down further, I can put my hands on the floor; but then I pulled a muscle because I was showing off'*.

The GGT sessions have also helped her outside of the classes; she practices the breathing exercises that she has learned from the sessions and uses them at home to relax herself. She felt that the seated exercises help to ease the pain from the muscle spasms and the dance class helps her with her hand movements.

Mrs C has always enjoyed making handmade cards which often requires her to sit on the floor. She ensures that some of the equipment and materials she needs for this are kept a bit further away from her to encourage her to get up *'because you've got to keep moving and coming here is a reminder of that'*.

2.4.6 Volunteering is offering unemployed people the opportunity to gain work experience and build their confidence

Volunteers involved with LS&R GGT had previous volunteering experience with various organisations before joining GGT, but this was not specific to older people. A number of

'It's given me a lot more confidence. When you've been out of work a little while you lose your confidence and feel like you can't do things…now I feel confident in applying for jobs and going to job interviews.' (Volunteer)

volunteers interviewed reported that they were trying to build up their experience of working in the social care industry and felt that the experience of working with GGT had built up their confidence to do this. The experience has not only impacted on the employability of volunteers but it has introduced volunteers to the possibility of working in the social care industry.

Volunteers have gained experience in people facing roles; the opportunity to volunteer with GGT has given them 'the ability to deal with people' through engaging and communicating with older people but also with the GGT team and wider Age UK staff. Volunteers felt this had improved their social skills.

> *'I've never considered care work before but I'm considering it now and I'm looking for courses in care work.'* (Volunteer)

2.5 Stakeholder views

Some stakeholders felt that the GGT project filled an important gap because it operated as an exit route for programmes like the Active Lifestyles[7] and Falls programmes[8]. An Age UK staff member felt that working with people that have LTCs was '*very much'* on the agenda of local clinical commissioning groups because of the value that physical activities has in preventing people from being more dependent on medical and social care services. Several stakeholders reported that the project filled a gap in terms of providing services for those older people that do not feel comfortable attending a gym or for those people that find the falls programmes too basic. Thus GGT allows older people to access physical activity away from a health and fitness centre, geared more towards a social physical activity session.

> 'Our aim is for people to stay active for life and not just for the 6 months that we see them…GGT offers older people continued provision' (Stakeholder)

However, one stakeholder that is also involved in the LS&R GGT steering group felt that the GGT project does not fit into local strategic priorities for health and social care. The sharing of outcome evidence was key to this, where there was little evidence to demonstrate how much engagement was happening after initial taster sessions took place. The stakeholder felt that more information was needed in terms of how many sessions have been sustained and how many sessions are taking place. There appears to be disconnect between the overall findings of GGT and the sharing of these with stakeholders and partners. This stakeholder felt that GGT was not filling a gap in provision for older people but felt that it could potentially fill this gap in the future: *'GGT has recruited some people but it's not really a service. It needs a different strategy on a formal footing…there's no evidence to show that these activities reduce falls'*. NICE guidelines have listed three activities that might reduce falls - Thai Chi for balance and strengthening; environmental reviews; and medication reviews (people taking medication that might be making them dizzy and so increases the risk of falling). These guidelines could be considered for future GGT sessions, particularly in terms of Thai Chi provision. Thus GGT need to demonstrate activities and programmes that are in line with evidence.

2.6 Cost analysis

Data was collected for the expenditure in LS&R through GGT. There were a wide range of inputs into the programme, including staff time, venue hire, tutors, transport and equipment. Table 2.4 presents the total expenditure by type; outgoings and in-kind costs. The largest

[7] A scheme from Leicester City Council which gives people with medical conditions the opportunity to exercise under the guidance of qualified exercise professionals.

[8] A programme which provides an opportunity for individuals over 65 in Leicester to increase their strength and balance and thus reduce their falls risk.

item of expenditure was staff costs, followed by venue hire, equipment and tutors for classes. The total expenditure in LS&R was just over £240,000 over three years.

Table 2.4 Expenditure by category[9]

Category	(£)
Salary costs and recruitment	66,020
Staff training	
Volunteer recruitment, training costs	33,859
Staff travel	
Venue hire, tutors, transport and equipment	61,283
Promotion	5,141
Overheads	18,477
Management	21,174
Evaluation	1,280
Other	
Total expenditure	207,234
In-kind costs	
Volunteer hours	1,200
Volunteer cost	£10,400
Venues	£23,400
Transport	£0
Financial contribution	£0
Total in-kind	£33,800
Total overall	£241,034

Management information

The Management Information collected provided details of the number of volunteer hours used by the programme, venues provided free of charge for programme activities, transport costs and the financial contributions of participants. The approach from the Volunteer Investment and Value Audit (VIVA) from the Institute for Volunteering Research (IVR) has been used to estimate the value of volunteers' time.

This approach multiplies the number of volunteer hours by an appropriate wage rate. The hourly wage rate has been taken from the Annual Survey for Hours and Earnings (ASHE) for each area and the 25th percentile value of earnings has been used. The wage rate was multiplied by the total number of volunteer hours provided for the programme.

The management information provided information on venues provided free of charge. The value of hiring a venue for one hour was estimated using information on the cost of hiring community spaces in the local areas[10].

The total value of the in-kind contribution in LS&R was nearly £34,000. The two largest components of the in-kind contribution were volunteer costs and venue hire.

[9] The budget is expected to be spent by the end of the project

[10] www.hallshire.com

Table 2.5 Average cost per participant

	Number of participants	Total spend (£)	Average spend per participant (£)
Leicestershire & Rutland	1357	241,034	177
Programme total	6,229	1,371,560	220

It has not been possible to calculate an average unit cost of activities provided. This is because it has not been possible to consistently and reliably identify the number of activities each individual has attended. However, the number of individuals in LS&R is known, as is the total expenditure in each area. This is presented in Table 2.5. This shows that the cost per participant in LS&R is £177, this is the lowest across all five localities in the programme and lower than the programme average overall. This suggests that the team in LS&R have utilised their resources in a cost effective manner to provide a range of activities for their participants. This finding also reflects the qualitative fieldwork, which suggested that LS&R has focused on participants with a lower level of need and therefore resource needed to support them.

In LS&R, the most significant impact observed across the time of the programme for this cost per participant was a statistically significant decrease in the number of unplanned GP appointments for participants completing surveys up to six months after beginning GGT[11].

2.7 Sustainability and future plans

This section focusses on the different activities, plans and strategies for the future sustainability of the LS&R GGT project. The section also includes ideas from stakeholders about what they feel the GGT team could work on to improve sustainability.

2.7.1 Nominal charges

One way in which sustainability of the sessions was possible was through the nominal charge for participants to attend sessions. Other exercise classes have utilised their own funding streams to cover the costs of the project, for example, day centres and community groups. In order to sustain a number of activities, the GGT team moved some sessions to a different venue, which they hoped would attract more participants and enable them to balance their income and expenditure.

2.7.2 Self-sustaining and funding avenues

The LS&R GGT Team have offered support to groups in planning ways to self-finance the activities. They have worked with these groups in offering support for self-sustainability and 50% of activities will be self-sustained.

The team have worked with some groups in applying for City Council funding to continue their activities. Consequently Leicester City Council have agreed to fund some of the

[11] It has been difficult to measure the value for money of the project in LS&R. This is due to the difficulty in identifying the additional impact of the programme due to the lack of a suitable comparator group. This means it has not been possible to conduct a Cost Benefit Analysis or a Social Return on Investment calculation, or measure the cost per outcome achieved. Additionally, it is difficult to measure the cost per output achieved, as it is not possible to readily identify and analyse how many activities each individual took part in. Therefore, in order to assess the value for money, the cost per participant has been calculated, and the changes in outcome measures over time have been collected.

These indicators have been compared to similar indicators from evaluations of programmes with similar aims, to estimate the performance and value of the programme.

exercise classes for 12 months. These sessions were largely for those groups that had become self-sustained during the GGT project.

2.7.3 Partnerships

One stakeholder suggested that GGT would benefit from background advice from GP Federations and seeking out retired nurses/GPs who want to engage in volunteering who could '*put their professional hats on in moving forward to demonstrate a clinical approach'.* Thus developing a clinical approach was deemed to be of importance to sustain the projects and possibly approaching the CCG for funds.

Other stakeholders who have worked more closely with LS&R GGT suggested that continuing funding of the main post holder was important for the future success of the project, stressing that many links and inroads had been made which have taken several years to build up and further nurturing of these relationships was important for the continuity of the project.

2.7.4 Robust outcomes

'An improvement percentage that can be converted into hard cash savings is vital' (Stakeholder)

Stakeholders suggested that the learning from this evaluation coupled with robust project outputs and outcomes including the number of participants attending regularly, number of sessions offered (number of weeks this was offered for) and how the project has improved the lives of participants would help with future funding. This data could potentially help evidence outcomes for commissioners like the CCG and public health when the team have future conversations about funding.

2.8 Conclusion and recommendations

- The LS&R GGT has steadily increased the number of exercise classes offered to older people. Over the course of the project approximately 80 activities have been introduced of which 30 activities continue to run. The project established a steering group with representatives from various organisations including from local community groups, CCG, the local authority, adult social care, and senior management from Age UK LS&R. This team have developed strong partnerships with various care homes, public health and within the local authority. These have materialised into collaborative working to deliver exercise classes (e.g. walking football) and have also operated as referral routes into GGT exercise classes. The older person's perspective has highlighted that the project has produced positive outcomes, including physical, social and psychological benefits. Several stakeholders felt that the project achieved social and psychological outcomes but more evidence is needed to evidence physical health outcomes for older people.
- Developing stronger partnerships with the CCG is recommended ensuring the continuity of this relationship throughout different phases of the project, including design, delivery, implementation and evaluation stages. This could be reflected in membership on the LS&R steering group; another possible avenue of communication for keeping members informed of progress and setbacks could include newsletters and monthly/quarterly update summaries.
- Creating partnerships and links with 'clinical people' at the design, delivery and implementation phases of future projects was deemed to be important for steering the project into a health related direction.
- The participant survey shows that arthritis is the most commonly reported long term condition for Age UK LS&R. Age UK LS&R could review local provision for older people with this condition and consider ways in which it may be able to complement or expand on this, for example offering tailored exercise sessions with specialised support. Age UK

LS&R could also develop partnerships with local organisations for people with arthritis, where possible, including Arthritis Research UK and Arthritis Care.

- Stakeholders recommended that outcome measures to demonstrate how temporary physical activity changes turn into sustainable long term activity should be incorporated from the outset, as commissioners are likely to be interested in this.
- Increased publicity and awareness about GGT will be useful for driving this project further forward, in particular reaching out to older people to highlight the importance of exercise.
- LS&R GGT might consider increased partnership with nursing homes. Stakeholders felt that residents in nursing homes often experience frequent falls and are poorly served because they cannot attend group exercise classes outside of the care home. Some of these residents attend the falls clinic but many are unable to due to transport and the additional support they need in order to attend. The costs of falls to public services is high due to the number of days spent in hospital following a fall. Falls prevention in care homes could be increased through links to services like GGT and this should be explored further.

Annex 1 Leicestershire and Rutland stakeholders interviewed

We would like to thank the following people for giving their time to speak with us:

Locality	Name	Role
Leicester Shire & Rutland	Anita Clarke	Leicester City Community Engagement Officer
Leicester Shire & Rutland	Mark Pearce	Strategy and Implementation Manager
Leicester Shire & Rutland	Cathy Carter	Commissioning manager
Leicester Shire & Rutland	Ben Smith	Policy Development Officer
Leicester Shire & Rutland	Cheryl Clegg	Head of I & A
Leicester Shire & Rutland	Jane Newstead	Clinical team lead, NHS falls clinic
Leicester Shire & Rutland	Troy Young	Assistant Director, Age UK
Leicester Shire & Rutland	Carla Broadbent	Physical activity officer, Leicester City Council
Leicester Shire & Rutland	Volunteer 1	
Leicester Shire & Rutland	Volunteer 2	
Leicester Shire & Rutland	Participant 1	
Leicester Shire & Rutland	Participant 2	
Leicester Shire & Rutland	Participant 3	
Leicester Shire & Rutland	Participant 4	
Leicester Shire & Rutland	Participant 5	
Leicester Shire & Rutland	Participant 6	
Leicester Shire & Rutland	Participant 7	
Leicester Shire & Rutland	Participant 8	

Annex 2 Data[12]

Table A2.1 Baseline and follow up SF- 36 scores and changes in healthcare utilisation across five time points

	LS&R		LS&R		LS&R		LS&R		LS&R	
	Base	3 months	Base	6 months	Base	1 year	Base	2 years	Base	> 2 years
Sample size	25		81		135		85		4	
Physical function	55.2	54.85	46.23	45.76	53.25	47.97	53.62	51.88	68.75	67.5
Role limitations due to physical health	37.01	44	46.77	44.32	48.17	49.41	44.64	48.54	26.11	37.4
Role limitations due to emotional problems	24.55	27.55	33.8	31.91	35.31	31.47	31.59	29.45	28.83	13.86
Energy/fatigue	55.74	57.78	56.59	56.96	54.69	55.1	53.47	55.81	66.26	58.71
Emotional wellbeing	64.33	62.56	64.67	63.51	62.15	60.21	61.82	61.23	61.04	68
Social function	76.55	74.49	73.95	78.09	74.06	72.13	77.89	76.89	81.25	89.06
Pain	66.35	66.2	67.88	68.24	69.26	65.98	69.76	67.37	89.75	81.25
General health	51.2	49.81	52.77	51.51	51.52	51.24	51.6	51.72	47.26	53.21

[12] ICF analysis; Cells shaded blue indicate a statistically significant change at a 95% confidence level. The analysis has been conducted using a 5% margin of error and 95% confidence level. The margin of error tells us the size of the error which surrounds the survey findings; the smaller the margin of error is, the greater confidence we can have in the survey results. The confidence level tells us how sure we can be of the margin of error. (Common standards used by researchers are 90%, 95%, 99%).

	LS&R		LS&R		LS&R		LS&R		LS&R	
Unplanned GP	0.4	0.04	0.14	0.02	0.27	0.73	0.46	0.35	0	0
Unplanned hospital	0.12	0.04	0.28	0	0.05	0.64	0.07	0.16	0	0.25
Unplanned other health	0	0	0.06	0	0.24	0.4	0.11	0.11	0	0