

Age UK Personalised Integrated Care Programme

**Sustainability, impact on hospital
attendances and admissions, and
lessons learned about spreading
and scaling the model**

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Abbreviations

A&E	Accident and Emergency
CCG	Clinical Commissioning Group
CSU	Commissioning Support Unit
GP	General Practitioner
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
VCS	Voluntary and community sector

Key messages

1

A long-term programme focused on improving and adapting to support sustainability

Following a promising pathfinder in Cornwall (Phase 1), in 2015 Age UK began Phase 2 of its ambitious programme to spread and scale its Personalised Integrated Care model across England. The programme incorporated two important features:

- It was phased and designed to be long term, not just to last for one year
- A learning journey was embraced from the outset: Age UK focused on improving rather than just proving, and adapting instead of replicating as the service was rolled out across different areas.

This approach has enabled sustainable change – three years on, the Personalised Integrated Care service remains commissioned in six of the Phase 2 areas and in the remaining two areas elements of the model have been adopted in other services.

The findings from the blended evaluation of Phase 2 of the programme provided evidence that it has made a positive difference to older people's wellbeing and to their experience of care. Although not quantified, the support provided by the Personal Independence Coordinators (PICs) has released time from primary care and has been effective in enabling holistic, personalised care for older people. More recently, the Nuffield Trust has published its evaluation of the impact of phases 1 and 2 on hospital activity and costs.

Reflections on the findings from the Nuffield Trust's evaluation

2

Understanding the impact of the programme on hospital care

The Nuffield Trust evaluation was based on a sub-cohort of 1,601 older people who were involved in Phase 2 of the Personalised Integrated Care Programme (PICP)¹ for the first ten to 18 months' operation of the service depending on the individual area.

At programme level, A&E visits, emergency admissions and outpatient attendances and associated costs increased for this cohort during the nine and 16 months after joining the service, relative to the matched control groups. However, the findings indicate variation at a local level, for different types of hospital activity and different client profiles and depending on whether older people joined the programme at the start or towards the end of the study period.

Nevertheless, no analyses of any of the above variables suggest that the service has reduced hospital activity and costs relative to the control group (at best there is no statistically significant difference).

More generally, the Nuffield Trust evaluation highlights the value of capturing a more nuanced view of impact beyond that on total hospital costs and activity – with the analysis providing insights about the impact of the service on different types of hospital admissions and attendances, including avoidable admissions.

3

Responding to older people's previously unidentified needs and other factors influencing the programme's impact on healthcare

The service has helped to fill a gap by responding to older people's unmet holistic needs. Critically, the model has brought into the open previously unidentified needs. Through the approach:

- Older people's needs that were not previously on health and care professionals' radars have been identified
- Older people have become more attuned to and accepting of their needs, and therefore better able to manage and make decisions about their own health and wellbeing in the long term – including seeking help.

In doing the above, the model has brought about sustainable improvements for older people. In the short term, it could have also increased demand for hospital care. However, the absence of any observed reduction in hospital admissions in the longer term relative to the control group could suggest that identification of unmet need alone is unlikely to explain the programme-level findings. Other factors that are likely to influence the programme's impact on avoidable hospital activity and costs include: wider system change and capacity; changes in client behaviour; and targeting the 'right' cohort of older people.

Footnote

¹ The Nuffield Trust evaluation also included 395 clients who were involved in the pilot service in Cornwall, giving a combined total sample size of almost two thousand older people.

4

Real-time and long-term learning is crucial

Experience gained from the PICP journey corroborates current thinking around how best to capture learning about the impact of 'new' interventions being delivered in complex adaptive systems:

- More real-time approaches combining mixed methods are required – for many of the Phase 2 areas, evidence of the impact on hospital activity came three years after the end of the pilot
- Learning about whether a new service 'works' should go on for longer – operation of more than 12 – 18 months is likely to be needed to look beyond the effects of implementation and to understand the impact of a more stabilised service
- Pay attention to the value (or otherwise) on different parts of, and actors across the health and care system. Primary care, for example, played a key role in the service, yet the PICP's impact on GP and practice workloads and ways of working was not quantified, nor was it explored qualitatively from the outset.

The wider benefits of the service

5

The importance of providing ongoing personalised and preventative care after the intense support has ended if unplanned hospital admissions are to be avoided

Whether the findings from the Nuffield Trust evaluation will impact on the ongoing commissioning of the current service in the Phase 2 areas is uncertain. If reductions in avoidable hospital activity and costs are the desired outcomes, keeping older people connected to the health and care system once their involvement in the service ends is likely to be critical given the profile of the target cohort. This means ensuring that there are mechanisms in place that enable ongoing proactive and personalised care and multi-disciplinary working across the system.

Such mechanisms will require wider-system support – particularly at the level of primary care – and could involve developing further the design of the local service. For example, extending the duration of the intervention beyond the intense support could provide an opportunity for the PICs to carry out lighter-touch reviews with clients. This would allow PICs to support and co-ordinate ongoing preventative care for older people should their circumstances change. It is also worth considering whether and how the service, working in partnership with local self-management/patient-activation initiatives, could provide more support to help clients to better understand and self-manage the physical aspects of their long-term conditions (LTCs).

Whether the service has affected length of hospital stay and/or delayed transfer of care was also not assessed. While a focus on the impact on hospital admissions and attendances is likely to remain critical, examining other outcomes could prove to be more appropriate given the nature of the intervention.

6

How benefits are delivered – the key to creating sustainable improvements in older people's wellbeing

Beyond the impact on older people's wellbeing and on primary care, the ways in which the model has brought about change for older people are just as important as the positive outcomes it has generated. For older people, involvement in the programme has boosted their confidence and motivation. It has helped them to regain a sense of control and purpose to not only improve their own wellbeing in the short term but, for many, to also sustain the change they have created. Three aspects of the model have been critical to this change:

- The power of starting with a conversation focused on what's important to the older person and building trusting relationships – the PICs listen to, hear and respond to their clients' stories
- The continuity of care and support provided over a period of time, rather than signposting alone
- The focus on connecting people with services in their community.

7

A successful model for social prescribing

Overall, Age UK's PICP has clearly added value as a targeted, holistic, social prescribing model. It has improved older people's wellbeing and has helped them to connect with services in their communities and to maintain as much of their independence as possible. In the process, the programme has been effective in promoting the integration of statutory and non-statutory services and in harnessing community assets to benefit older people.

For the majority of local Age UKs involved, the positive legacy of their participation is still growing. Relationships with stakeholders in other parts of the system have been strengthened, and local Age UKs have become valued and trusted partners in an ever-changing health and care landscape. This has enabled them to help shape and improve care and support for older people and shift the conversation beyond a medical model. Local Age UKs are now in a position to advocate an approach that is based on building listening, trusting relationships with clients. Rather than 'fixing' their problems, it is an approach that delivers long-term sustainability by recognising older people's own strengths and by focusing on what each client could achieve for themselves, with a little help.

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1

Introduction

Introduction

1.1

The Age UK Personalised Integrated Care Programme

In 2011 Age UK commenced its Personalised Integrated Care Programme (PICP), developing and spreading an innovative model² of holistic, person-centred care for older people with multiple long-term conditions (LTCs) who are at the greatest risk of avoidable hospital admissions. The programme's three primary aims are to:

- **Improve the health and wellbeing outcomes for older people** with LTCs 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.

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

Following a promising pathfinder in Cornwall, Phase 2 began in 2015 and involved piloting the model with local health and care partnerships from across eight areas in England³. 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.

1.2

Evaluating the impact of Phase 2 of the PICP

Age UK adopted a whole-programme, mixed-method approach to evaluating Phase 2 of the PICP, focusing on evaluating the service against the three primary aims outlined above. The approach has incorporated formative evaluation and quantitative and qualitative evaluations of the programme's impact. The findings from the programme-level evaluations are reported in two key publications:

- Fullwood Y. (2018) *The Blended Evaluation of Phase 2 of the PICP*. Age UK (referred to as the blended evaluation from here on in). This report details the findings analysis of multiple evaluative evidence sources and performance-management information captured, at a local and national level, up until the end of September 2017. The focus of this report is primarily on the findings from the qualitative evaluation of the PICP and quantitative analysis of changes in older people's wellbeing.

- Georghiou T., Keeble E. (2019) *Age UK's Personalised Integrated Care Programme: Evaluation of impact on hospital activity*. Nuffield Trust (referred to as the Nuffield Trust evaluation from here on in).

1.3

About this report

This report sets out:

- The sustainability of the model and the legacy of participation in the PICP. The report draws on the findings from semi-structured interviews, undertaken in July 2018, with stakeholders from each of the local Age UKs involved in Phase 2
- Reflections on the findings from the Nuffield Trust evaluation
- Transferable lessons learned about spreading and scaling the Age UK model.

Footnote

- 2 The Age UK Personalised Integrated Care model is a targeted and holistic social prescribing model. Further information about the model and its core elements are discussed in the blended evaluation.
- 3 Ashford and Canterbury; Blackburn with Darwen; East Lancashire; Guildford and Waverley; North Tyneside; Portsmouth; Redbridge, Barking and Havering; and Sheffield

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Sustainability and legacy of the PICP Phase 2 pilots

Sustainability and legacy of the PICP Phase 2 pilots

2.1

The current status of the service

Across all areas, the service and/or elements of the model have, to varying degrees, continued beyond the pilot (see table 1 for a summary of the current status of the service in each of the Phase 2 areas). However, the transition from pilot to sustainability has not been seamless, particularly with respect to long-term funding, even for those areas that were able to demonstrate early local evidence of reduced hospital activity in addition to benefits to older people. Six of the local Age UKs involved in Phase 2 continue to deliver the service through one of the following routes:

- Commissioned by the Clinical Commissioning Group (CCG): Ashford and Canterbury; Lancashire; North Tyneside
- Funded by a blend of routes, combining CCG funding with other sources: Sheffield
- Commissioned by the CCG as part of a voluntary and community sector (VCS) partnership, enabling the provision of an all-adult offer to meet local need: Blackburn with Darwen
- Commissioned by the Local Authority: Redbridge, Barking and Havering.

Of the two remaining local Age UKs:

- Age UK Portsmouth was commissioned by Portsmouth CCG for a two-year period; the contract came to an end in March 2018. The local Age UK has adopted the guided conversation and follow-through support elements of the model as part of its veterans' Joining Forces programme, funded through the Aged Veterans Fund.
- After the pilot, the PICP was not commissioned in Guildford and Waverley. Age UK Surrey has adopted elements of the model within its Making Connections programme (which is funded through multiple sources, including the Local Authority) (see case study 3 for further information).

2.2

Whether and how the service has changed

2.2.1

Ongoing flexibility and adaptability, particularly with the target cohort

For the six local Age UKs continuing to deliver the service, the model has retained its critical elements: the guided conversation, multi-disciplinary team (MDT) working involving the Personal Independence Coordinators (PICs) and the follow-through support rather than signposting alone. However, ongoing flexibility and adaptability have been essential to ensure that the model remains responsive to local needs and changing contexts (See case study 1). In particular, for most areas the focus has shifted away from identifying older people based solely on their number of LTCs and prior hospital admissions, in order to make the service accessible to all older people who could benefit from it. Nonetheless, because most referrals come from GP practices and MDTs, across all areas the service is still implicitly targeting those older people who are at risk of losing independence and of future hospital admissions. There are some variations in emphasis depending on the funding source. In Sheffield, for example, some of the funding is aimed at improving the wellbeing of older people with cancer, rather than specifically at reducing hospital admissions.

2.2.2

Becoming embedded within MDTs and the wider system

The blended evaluation noted that embedding the PICP within the wider health and care system, and especially within primary care, was critical to its sustainability. Local Age UKs still delivering the service said that one of the key changes since the pilot is that the service and the PICs are indeed now integrated within the local system. In particular, there was a strong sense that the PICs had become established as equal members of MDTs.

Nonetheless, for those delivering the service through individual GP practices, views varied on the extent to which it is embedded across the patch. Ashford and Canterbury and Lancashire Age UKs both noted that, while the service and the PICs were well integrated within the locality MDTs, at the GP-practice level further engagement was still needed. As part of their current contracts, both local Age UKs have been asked by their CCGs to improve awareness of the service across primary care. In contrast, Age UK Blackburn with Darwen and Age UK Sheffield identified becoming embedded within all their local GP practices and their strong relationships with GPs as major benefits of delivering the service. They also highlighted ongoing referrals from GPs as a key legacy of their involvement in Phase 2 of the PICP.

Table 1: Summary of the current status of the PIC service across the Phase 2 areas (continued on the next page)

Phase 2 area (service name)	Pilot period	Current status of the service	How does the current service differ from the pilot service?	Adapting the model for new services
Ashford and Canterbury (Personal Independence Programme)	November 2015 – November 2016 Extended to March 2017 with funding from the CCG	Commissioned until 2019 by Ashford and Canterbury CCG Commissioned by the CCG on an annual basis since the end of the pilot Spread across Ashford and Canterbury and delivered by all five local Age UKs/ Age Concerns in the area	Case-finding approach revised An adapted version of the Wellbeing Star rather than WEMWEBS is used to assess changes in older people’s wellbeing The service includes a dementia-link worker in Canterbury and a dementia Personal Independence Coordinator will be recruited in Ashford (see case study 1)	
Blackburn with Darwen (Here to Help)	July 2015 – July 2016 Extended initially to March 2017 and then to June 2017 with funding from the CCG	Commissioned until March 2019 by Blackburn with Darwen CCG and as a partnership between Age UK Blackburn with Darwen, Lancashire Mind and Care Network The current three-year contract began in July 2017 at the end of the pilot	Age UK Blackburn with Darwen delivers the Here to Help service as part of the partnership contract; the service remains similar to the pilot model Collectively, the partnership is able to offer an all-age service	
East Lancashire (Integrated Care Programme)	September 2015 – May 2016 Extended to September 2016	Commissioned until March 2019 by East Lancashire CCG. Business case for 2019–20 commissioning to be submitted to East Lancashire CCG for consideration in November 2018 Commissioned on an annual basis since the end of the pilot	The service remains similar to the pilot model	
Guildford and Waverley	August 2015 – September 2016	The service was not commissioned following the pilot. However, elements of the model have been adopted in the Making Connections service, which was piloted initially in Farnham for a year and has been commissioned for a further two and a half years in Farnham and North East Hampshire*		The guided-conversation approach has been adopted in the Making Connections service (see case study 4)

* Age UK Surrey delivers the Making Connections service in Guildford and Waverley and Runnymede and Spelthorne and is funded by multiple sources, including a three-year commission from Waverley Borough Council. The service is also delivered in partnership with other VCS organisations in North East Hampshire and Farnham (NEF) Area – this service is commissioned by NEF CCG.

Phase 2 area (service name)	Pilot period	Current status of the service	How does the current service differ from the pilot service?	Adapting the model for new services
North Tyneside (Delivered as part of CarePlus)	January 2016 – January 2017	Commissioned by North Tyneside CCG until March 2019 as part of CarePlus The service has been commissioned on an annual basis as part of CarePlus since the end of the pilot	While the Age UK service is still the same as the pilot model, CarePlus has continued to adapt to changing need and context, but remains focused on providing multi-disciplinary care to frail older people	
Portsmouth	April 2015 – March 2016	Commissioned by the CCG from September 2016 until the end of March 2018 Elements of the model continue to be delivered through Age UK Portsmouth's Joining Forces programme for veterans, funded by the Aged Veterans Fund		Age UK Portsmouth has adopted the guided conversation and follow-up support elements of the model in its Joining Forces programme for veterans
Redbridge, Barking and Havering (Care Navigators Service)	August 2015 – July 2016 Delivered as part of Health 1000's Complex Care Practice	Commissioned until January 2021 The pilot service ended with Health 1000. The current contract commenced in February 2018 and is funded by the London Borough of Havering	The service is now open to all older people and self-referrals are accepted in addition to those from health and care professionals. The contract also includes funding for Di's Diamonds (an activity network established as part of the pilot service)	
Sheffield (Independent Living Co-ordination service)	May 2015 – May 2016 Extended by three months through existing funds	The service has been ongoing since the pilot and is funded through multiple sources: <ul style="list-style-type: none"> • 3 coordinators are funded by Sheffield CCG and work directly with GP practices • 7 coordinators have been secured through funding from Weston Park Cancer Charity, MOD Veterans, Integrated Personal Commissioning Pilot and National Lottery Reaching Communities 	The service remains similar to the pilot model. However, the emphasis varies depending on the funding source, with the CCG-funded posts focusing on older people living with long-term conditions and at risk of unplanned hospital admissions	The guided-conversation approach has also been applied to the Okay to Stay plan initiative. This is a partnership between Age UK Sheffield, Sheffield Teaching Hospitals NHS Foundation Trust, community nursing teams and GPs (see case study 3)

2.2.3

Involving volunteers

During the pilot, recruiting and matching volunteers to support the delivery of the service was challenging for all areas. Those areas that had previously used dedicated PICP volunteers continue to do so. However, in several of these areas there has been less reliance than anticipated on volunteers to support clients while they have been involved in the service. This is due in part to the complexity of clients' needs and in part to some older people's preference for being supported by a PIC, rather than by a volunteer (see case study 2).

Case study 1

Spreading, adapting and developing the model across Ashford and Canterbury

Post pilot, the service, now called the Personal Independence Programme, has spread across Ashford and Canterbury. Age UK PICs are involved in the locality-hub teams across the area and collectively cover 43 primary care practices. The service is commissioned by Ashford and Canterbury CCG.

As the model has spread, **the focus of the case-finding approach has changed**. The service is now open to anyone over the age of 55 living with LTCs and in need of additional support to improve their health and wellbeing. Cohort practice lists, which provided the majority of referrals during the pilot, are no longer created. Instead, most referrals come from the locality-hub MDTs, beyond which healthcare professionals can refer on an ad hoc basis. Older people can also self-refer. Consistent with the pilot service, the needs of clients have continued to be mixed. For example, self-referrers tend to require shorter-term support. Those referred from the locality-hub MDTs are often recovering from a hospital admission and/or are unwell. For many of these clients, the support focuses on befriending and engaging them with interests in their own home rather than with activities in the community.

Other new developments that have accompanied the spread of the model include **enhancing a focus on dementia**. Although previously funded by the CCG, an Age UK dementia-link worker role covering Canterbury has now been incorporated into the Personal Independence Programme. A PIC dedicated to supporting people living with dementia in Ashford will also be recruited.

Case study 2

Volunteering – a growing emphasis on longer-term befriending, rather than short-term support, to meet clients' needs

In Ashford and Canterbury, challenges around the recruitment and the timely matching of volunteers meant that dedicated PICP volunteers were not used during the pilot. To help address these challenges, when the service was commissioned a volunteer coordinator role was included from the outset. The intention was for volunteers to work alongside the PICs during the older person's involvement in the programme (typically 12 weeks). However, the local teams found the demand among their clients for such short-term volunteering support was limited. A major part of the programme's impact is borne out of the relationship between the PIC and the older person. Therefore, in practice the PIC has, in many instances, been best placed to provide short-term support. Nonetheless, many older people needed and wanted a longer-term befriending service to keep them connected to the outside world and provide regular companionship after their involvement in the programme ended. Yet, existing befriending services (whether provided by the local Age UK or other agencies) did not have the capacity to meet this demand and, as a result, waiting lists were long.

To address the gap, **an alternative volunteering model has now been established:**

- The Personal Independence Programme volunteer coordinator recruits' volunteers for long-term befriending roles and matches them with clients on the programme
- A telephone befriender has also been recruited and talks with clients if needs be while they are waiting to be matched
- Once matched, the client and volunteer are then 'handed on' as a pair to the local Age UK's befriending service, which also provides the volunteer with long-term management and support

For Age Concern Sandwich, delivering the Personal Independence Programme has enabled the organisation to establish a **new and free befriending service** for local older people beyond those involved in the programme.

Similarly, Age UK Surrey has found that **volunteers themselves want longer-term, rather than time-limited, volunteering roles**, so that they can continue their support once relationships with clients have been established. **Demand for weekend and evening volunteering opportunities have also increased** on its Making Connections programme (see case study 4). Crucially, the charity has put in place volunteer-management and support processes, including ensuring that Age UK Surrey staff are on call to provide out-of-hours help for volunteers if needed.

2.2.4

Capturing evidence of impact

While all areas have continued to monitor activity and outputs of the service, capturing evidence of outcomes has varied. During the pilot, only Ashford and Canterbury and Lancashire were able to access data locally to assess impact on hospital activity – the preliminary results were positive⁴.

Exploring impact on hospital activity post pilot has necessarily continued to place a dependency on the CCG to drive access to data and its analysis via the Commissioning Support Unit (CSU). Only Portsmouth and Lancashire have captured such evidence. In both instances, the analysis has assessed changes in clients' hospital activity before and after their involvement in the programme, rather than relative to a matched control group:

- **Portsmouth:** While the sample size was small and covered only an eight-month period (between September 2016 and April 2017), a reduction in A&E attendances and hospital admissions was observed.
- **Lancashire:** Analysis of changes in hospital activity for the older people participating in the PICP between April 2016 and March 2017 revealed a reduction in unplanned hospital admissions following involvement in the service, whereas planned admissions increased. (This increase was expected, given the programme's effectiveness in responding to older people's previously unidentified or unmet needs.) The CCG intends to repeat the analysis on the 2017–2018 cohort of clients as part of its up and coming review of the service.

Whether the differences⁵ in the findings between the Nuffield Trust evaluation and the local analysis can be attributed to the different methodologies used⁶ and/or regression to the mean is uncertain. Alternatively, other factors, such as the timing, could account for the variations in results. Compared with the Nuffield evaluation sample, most of the older people included in the local analysis joined the programme at a point at which the service had been operational for over 18 months and was therefore more likely to be stabilised and embedded – it is possible that the service had become more effective at this point (see section 3.1.1 for further information).

Age UK Lancashire and Age UK Blackburn with Darwen have also explored the impact of the service on primary care – working with individual practices, rather than the CCG, to access the data. The results have been promising.

“We focused on one GP practice and did a ‘dip sample’, comparing the GP contacts made by 40 patients involved in the service three months before and three months after the service. We included telephone consultations, home visits and surgery visits. We saw something around a 54% reduction in contacts.”

– Age UK Blackburn with Darwen

2.3

Applying elements of the model to other services to support personalised, holistic care for older people

Recognising the value of the guided-conversation approach in delivering personalised care and support for older people, several local Age UKs have adapted this element of the integrated care model to other services (see case studies 3 and 4).

Case study 3

Okay to Stay plans: using the guided-conversation approach to develop person-centred plans for older people to help prevent unnecessary hospital admissions in central Sheffield

The Okay to Stay plan is led by the NHS Sheffield Teaching Hospitals NHS Foundation Trust in collaboration with 21 GP practices, community nursing teams and Age UK Sheffield. Each plan paints a picture of how an older person manages at home and ‘what’s normal’ for them. This helps any visiting health and care professionals (including paramedics and out-of-hours GPs) to make decisions and take action to avoid unnecessary hospital admission in the event of the person appearing to become more unwell and not able to cope at home. The plan also helps the older person to recognise any significant changes in their own health or situation.

The decision to complete an Okay to Stay plan is made with the older person and their carers and family. Community nurses/matrons complete the medically relevant sections of the plan, such as what that person's normal blood pressure and oxygen-saturation levels are. **An Age UK PIC, through a guided conversation with the older person (and family and carers), captures the more social aspects of what is usual for that individual** – from how they stay warm and do their shopping to who they call when they need help – as well as what matters most to them.

The older person keeps a copy of the plan; another is available on their GP's IT system. Each Okay to Stay plan is reviewed every three months, and feeds into the Virtual Ward MDT (also being piloted in central Sheffield), of which the Age UK PIC is a key member.

In recognition of the success of the Okay to Stay plans, the scheme was a finalist in the Health Service Journal's Patient Safety Awards and the Nursing Times awards in 2017.

Footnote

- ⁴ See section 3.3.1 of the blended evaluation report for further information.
- ⁵ The Nuffield Trust evaluation observed that there was no statistically significant change in total hospital costs nine months post guided conversation and relative to the control groups in Ashford and Canterbury, Lancashire and Portsmouth. However, in Portsmouth, at 16 months post guided conversation and relative to the control group, total hospital costs increased.
- ⁶ The before-and-after approach presents a different perspective of the programme's impact compared with that involving a matched control group. Therefore, the local results could be considered to be entirely consistent with those of the Nuffield Trust evaluation.

Case study 4

Making Connections: using the guided-conversation approach to help create sustainable, community-based networks for older people across Guildford and Waverley

Following the success of a one-year pilot in Farnham, Age UK Surrey is now delivering the Making Connections programme across Guildford and Waverley and Runnymede and Spelthorne, and in partnership with other VCS organisations in North East Hampshire and Farnham.

Making Connections starts with an Age UK coordinator visiting the older person and using a guided conversation to discover what they would like to do – it might be going for a walk, taking up a hobby, joining a group or having someone call on them at home. The coordinator then matches the older person to a trained volunteer. The volunteer's support is predominantly long term; the role is wider than the traditional befriending one, offering a variety of support that older people can choose from to help them to stay in touch with their community.

In North East Hampshire and Farnham access to Making Connections is by GP referral only; in the other areas it is open to anyone aged 50 plus. To help raise awareness of the service among older people and GP practice staff, Age UK Surrey has recently started a monthly outreach post in two GP surgeries in Spelthorne. A Making Connections coordinator and an Information and Advice advisor alternate their attendance at the practices.

As part of Making Connections, Age UK Surrey has also set up Café Culture. The aim is to try to reach the people who don't see themselves as needing to access a service but would like to meet up with people in their community. Age UK secured the support of several local cafes to host Café Culture sessions – typically two-hour slots during which anyone over the age of 50 can drop in for a drink and a chat. While Age UK Surrey oversees Café Culture, volunteers are always present at each session. The scheme has enabled many older people to build the confidence to pop into their local high-street café even on days when Café Culture isn't running, as they have got to know the café owner. As such, Café Culture has helped older people to get together with others in a friendly environment in the heart of their communities.

“Café Culture has really taken off. We've got about 50 members in each one – not all attend every week, but there's a core group of 10-15 that have started to look out for each other. It is helping to overcome the barriers faced by people who go and do their shopping and rush home – now they might go for a coffee because they have got to know George behind the counter, so they feel more confident going. The timing of the sessions means they also get to mix with kids and mums who go to the café after school.”

– Age UK Surrey

2.4

The wider legacy of being involved in the PICP

Consistent with the findings from the blended evaluation, for almost all the local Age UKs involved, the legacy of participation in Phase 2 of the PICP remains a positive one.

Prior to joining the programme, each of the local Age UKs had already embarked upon their own journey to ensure that older people received more personalised and holistic integrated care. The majority of local Age UK stakeholders interviewed felt strongly that taking part in the PICP had helped to accelerate that journey. In particular, most highlighted that their involvement gave them a 'seat at the table' and made it possible for them to develop a 'shared language' with health and care professionals. Participation in Phase 2 has also, crucially, allowed local Age UKs to clearly demonstrate what they can do to support older people with more complex needs – and at a scale that would not have been possible without the funding provided by Age UK.

“Having a seat around the table is the starting point, but going with evidence and being able to show what we can contribute certainly helped us to get where we are now faster – being part of the PICP made that possible.”

– Age UK Blackburn with Darwen

“The funding meant we could have a full team working on the programme across the city. That made it easier for others to experience what we were doing and to see what we can achieve at scale. When you have a little pot of funding from here and there, it's harder to do that. Being part of the PICP also gave us some tools to help develop a shared language with our health and care professionals – and to create a dialogue through which we could better understand how to tailor the service to GPs' needs.”

– Age UK Sheffield

Most local Age UKs affirmed that the ongoing delivery of the service has allowed their organisations to become further established as key VCS partners within their areas' changing health and care systems. As a result, many of the Phase 2 local Age UKs are now helping to shape local transformation at both strategic and operational levels.

■ Case study 5

Shaping local transformation at all levels

Lancashire and Blackburn with Darwen Age UKs are represented – at a strategic through to an operational level – in the governance of the recently formed Pennine Lancashire Integrated Care Partnership. Their PICs have also been involved in the Making it Happen programme workshops, focused on how best to bring together the Integrated Locality teams, and GP locality meetings.

“Involvement in the PICP has definitely changed things for us. Our Integrated Care Service is one of the shining stars. It has upped our game and put us on a different playing field. Having a data-driven and evidence-based project made us more of a partner – it has changed our relationship with the commissioners. It’s almost like we are taken more seriously – we are recognised as having something serious to contribute to making a difference.”

– Age UK Lancashire

Beyond involvement in Sustainability and Transformation Partnerships (STPs) and Integrated Care Partnerships, wider opportunities to shape and deliver personalised care for older people have emerged. In these instances, the local Age UK stakeholders interviewed felt strongly that the quality of support and expertise demonstrated through the delivery of the integrated care service had been instrumental in generating these opportunities. For example:

- Age UK Blackburn with Darwen has been involved in the GP Federation-led development of the Care Navigation Service, in which practice reception staff have been trained to signpost patients to wider non-medical support. For the first phase of roll-out, which commenced in July 2018, a small number of services (such as dental, optician and pharmacy services) were selected for care navigators to signpost to. Age UK Blackburn with Darwen is the only VCS organisation to be included.
- Age UK Sheffield is a key partner in developing the city’s person-centred care approach – including supporting the capturing of Patient Activation Measure scores for sub-groups of older people and helping to shape the end-of-life care pathway.

For several local Age UKs, delivering the service provided greater insights into the skills, competencies and associated workforce development needed to successfully deliver personalised integrated care to improve the wellbeing of older people.

“We are also part of the Age UK delayed discharge service pilot. When it came to recruiting staff for that service, the learning from delivering the integrated care service meant that that we had a much better understanding of the skills and experience needed. We really knew what to look for beyond ‘knowledge and experience of NHS ways of working and ability to apply that to the role’ to ensure that staff were taken seriously by health and care professionals. It gives the team an instant step up. We are also looking at how we can enhance roles through training.”

– Age UK North Tyneside

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Reflections on the impact on hospital attendances and admissions

Reflections on the impact on hospital attendances and admissions

The Nuffield Trust evaluation of the PICP's impact on hospital activity was based on a sub-cohort of 1,996⁷ older people. These clients, from the Cornwall pathfinder and from seven of the eight Phase 2 areas⁸, were involved during, on average, the first 13 months' operation of the service (see section 3.1.1 for further information).

- At programme level (n=1,996), in the nine months following the guided conversation⁹ the Age UK cohort had higher levels of hospital activity and associated costs compared to the matched control groups:
 - A&E visits, emergency admissions and outpatient attendances were higher for the Age UK cohort by 33%, 35% and 23% respectively. These differences were statistically significant. There was no difference between the two groups in non-emergency admissions.
 - Total hospital activity (as measured by total costs to a commissioner) was higher in the Age UK cohort by 37% per person.
- At programme level in the 16 months after clients joined the service the higher hospital activity and costs in the Age UK cohort (n=1,601) versus the matched control groups remained. Again, the difference was statistically significant, although it was relatively lower than that observed at the nine-month time point for A&E visits and emergency admissions¹⁰:
 - A&E visits, emergency admissions and outpatient attendances were higher for the Age UK cohort by 27%, 30% and 25% respectively compared to the matched controls. Total hospital costs also remained higher (by 25% per person).
- Sub-cohort analysis indicates variation in total hospital costs at a local level for different client profiles and depending on whether older people joined the programme at the start or towards the end of the study period¹¹. Nevertheless, no analyses of any of the above variables suggest that the service has reduced hospital activity and costs relative to the control groups (at best there is no statistically significant difference).

Footnote

- 7 The sample comprises older people who completed a guided conversation between January 2014 and May 2015 in Cornwall and between April 2015 and September 2016 in seven of the Phase 2 areas, and had given their consent to share their healthcare data. Age UK estimate that a total of 3,000 older people participated in Phase 2 of the programme, indicating that the sample included in the Nuffield Trust evaluation represents 50% of the total cohort involved in Phase 2 of the programme.
- 8 Redbridge, Barking and Havering was excluded from the analysis given that the separate evaluation of Health 1000 (through which the Age UK Personalised Integrated Care service was delivered) was undertaken independently by the Nuffield Trust. That evaluation found no evidence of a reduction in hospital activity. However, no sub-cohort analysis was undertaken to explore the hospital activity of Health 1000 patients who had engaged with the Age UK Personalised Integrated Care service as part of their care.
- 9 The point at which an older person can be considered to have 'started' their involvement in the Personalised Integrated Care service.

10 The authors of the Nuffield Trust report note that the modest reductions relative to the nine-month time point, "are almost entirely due to the removal of Cornwall, the Phase 1 area, from the sample."

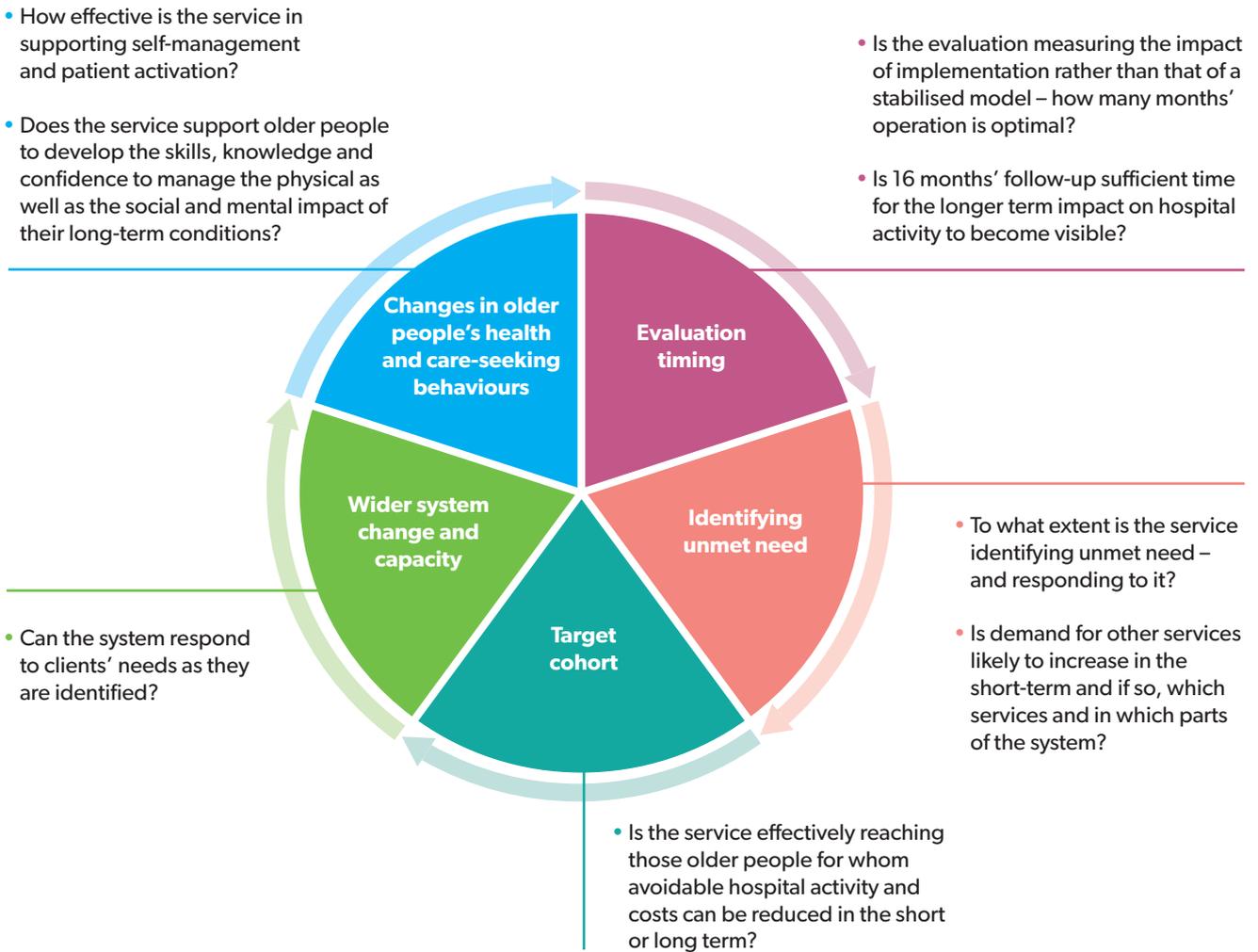
11 No statistically significant difference in total hospital costs relative to the control groups was observed for the following areas/sub-cohorts:

- At nine months post guided conversation: Ashford and Canterbury; East Lancashire; and Portsmouth
- At 16 months post guided conversation:
 - Ashford and Canterbury; East Lancashire; Guildford and Waverley; North Tyneside; and Sheffield
 - The sub-cohort of older people who joined the Age UK programme in the final three to five months of the study period (i.e. towards the end of the local pilot)

3.1

What factors could be influencing the observed impact of the PICP on hospital activity and costs?

Figure 1: Potential factors influencing the impact of the service on hospital activity and costs



3.1.1

Measuring the impact of implementation rather than that of a stabilised model

The Phase 2 areas launched the service at different times. Therefore, the data underpinning the Nuffield Trust evaluation necessarily comprises information relating to varied durations of service delivery, ranging from 10 months to 18 months depending on the area (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 that of implementation alone, remains uncertain but unlikely¹².

At programme level, although hospital costs were higher for the Age UK cohort compared with the control, the relative difference was lowest for clients who joined the

programme in the final three to five months of the study period¹³. At 16 months post guided conversation, there was no statistically significant difference between this sub-cohort and the control group.

More longitudinal evaluation is needed to understand whether the observed increase in hospital activity and costs reflects the service's 'bedding in' period in each of the Phase 2 areas. However, the findings from the blended evaluation, together with those reported in section 2 (section 2.2.2, in particular), suggest that a minimum of 18 months' operation is required to understand the impact of the stabilised service.

Footnote

¹² See section 8 of the blended evaluation for further information.

¹³ For some areas, for example North Tyneside, this later timeframe meant that the study period occurred early in the service-delivery cycle. The programme was therefore less well developed at that point in those areas than it was elsewhere.

3.1.2

Identifying and responding to unmet need

As a potential explanation for the observed increased hospital activity and costs, the authors of the Nuffield Trust evaluation suggest that: *“The [PICP] services may be identifying unmet need in the client groups, which manifests in greater use of hospital care. This might be to the ultimate benefit of the older people in the longer term.”*

Indeed, the findings from the blended evaluation highlight that the service has been effective in surfacing previously unidentified need by:

- Bringing into the open older people’s needs that were not previously on health and care professionals’ radars.
- Generating positive behaviour change by fostering agency and supporting older people to become more attuned to and accepting of their needs. This in turn has enabled clients to better manage and make decisions about their own health and wellbeing. For some, it has also made them more inclined to seek help and support.

In the short term, and when coupled with the coordination of care offered by the PICs while the older person is on the programme, the positive changes outlined above could result in increased hospital activity – for planned and emergency admissions, and for outpatient attendances in particular.

In the longer term, as a result of responding to this previously unidentified need, hospital activity and costs could be expected to decrease relative to the control group. However, at programme and sub-group levels, no such decrease was observed^{14,15}. Additionally, potentially avoidable emergency hospital admissions were also found to be statistically significantly higher for the PICP cohort relative to the matched control group at nine months post guided conversation. This suggests that the identification of unmet need alone is unlikely to account for the increase in activity at programme level. It is also unlikely to explain the lack of an observed reduction in hospital activity and costs for any sub-groups of clients included in the Nuffield Trust analysis.

3.1.3

Influencing factors?

Future success in preventing avoidable hospital activity and costs is likely to be dependent on a combination of the following factors¹⁶, all of which may also have influenced the Nuffield Trust findings:

- **Wider system changes and capacity** to respond to clients’ needs as they are identified and to support integrated care, timely access to quality care in the community and ongoing proactive and personalised case management of older people following involvement in service.

- **Changes in client behaviours** – the blended evaluation found that involvement in the service had been effective in supporting older people to self-manage the social and emotional impact of their LTCs. Participation had also motivated and empowered clients to take action to improve their overall physical health. However, there was limited evidence to indicate that older people had been directly supported to improve their technical knowledge of their LTCs, or to develop wider skills to allow them to deal with some of the physical aspects of their conditions themselves. This potential lack of knowledge and skills could in turn impact on how clients use hospital care.
- **Targeting the ‘right’ cohort of older people for whom future hospital admissions can be avoided.** The PICP’s threshold approach to risk stratification used the criteria of two prior hospital admissions and two LTCs (the ‘Two Plus Two criteria’) to target those older people for whom further hospital activity might be avoided through involvement in the service. The effectiveness of this approach remains uncertain at best¹⁷.

The Nuffield Trust evaluation findings further highlight the diversity of the profile of older people who have used the PIC service. At programme level, the cohort comprised multiple client-profile variables, such as prior hospital admissions, predictive risk of future hospital activity and prevalence of particular LTCs. It is not possible to draw firm conclusions from the analysis as to whether and how such client-profile variables were driving the observed hospital activity and costs subsequent to older people joining the service¹⁸.

Whether other client characteristics, in particular levels of frailty¹⁹, that are not captured by the data underpinning the Nuffield Trust analysis could be influencing levels of subsequent hospital activity and costs also remains unclear.

Nonetheless, in light of the findings from the Nuffield Trust evaluation, reviewing the older people being targeted to join the programme will be necessary if reduced avoidable hospital activity and costs in the short term is the key desired outcome.

Footnote

- 14 However, for some PICP sub-groups (see footnote 11), differences in hospital activity and costs relative to those of the matched control groups evened out over time.
- 15 It remains possible that, for some clients, the impact of early intervention on hospital activity and costs takes longer than 16 months to become visible. Although, arguably, for others (such as those who have relatively high levels of frailty when they join the service) 16 months’ follow-up is likely to be more than sufficient to observe a change in hospital activity.
- 16 These factors are discussed further in section 8 of the blended evaluation of Phase 2 of the PICP.
- 17 Sub-cohort analysis undertaken as part of the Nuffield Trust evaluation revealed that activity and total costs increased relative to the controls irrespective of whether the predictive risk of future hospital admissions was low, medium or high, and irrespective of whether the sub-cohort met the Two plus Two criteria.
- 18 For example, on one hand, two of the areas whose cohort comprised high proportions of older people with two prior hospital admissions and within the top 2% of the predictive risk band had a high total hospital cost nine months post guided conversation relative to the controls. On the other hand, at programme level, the sub-cohort of PICP clients with a low predictive risk for future hospital admissions had much higher levels of total hospital costs relative to those in medium- and high-risk bands when compared to the controls at both nine and 16 months post guided conversation. However, in absolute terms, the increase in total costs compared to the controls was similar across all risk bands.
- 19 The blended evaluation suggests that levels of frailty and loneliness and isolation are likely to be important variables to consider when defining the target cohort for the programme. While levels of frailty within the Age UK and control samples were not directly assessed as part of the Nuffield Trust analysis, levels of frailty are likely to be highly correlated with the risk-banding predictions used within sub-cohort analysis

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Conclusions and lessons learned about spreading and scaling the model

Conclusion and lessons learned about spreading and scaling the model

4.1

Conclusion

The route to sustaining the Age UK Personalised Integrated Care model within each of the Phase 2 programme areas has not been without its obstacles. In all areas, the sustainability journey is a work in progress. The task of adapting the model to meet the needs of changing local and national contexts is also, to varying degrees, ongoing. Nonetheless, three years after the start of Phase 2, the service is still being delivered in six of the Phase 2 areas and in the remaining two areas elements of the model have been adopted in other services.

- It is, as yet, uncertain whether and how the findings from the Nuffield Trust evaluation of the initial 10 to 18 months' operation of the service will impact on the commissioning of the current service/use of elements of the model in the Phase 2 areas. At the very least, and if reductions in avoidable hospital admissions and costs remain a key outcome of the service, the findings from the Nuffield Trust analysis are likely to prompt local health and care partnerships to:
 - Review the local evidence of the impact of the PICP on hospital activity (and on other parts of the system) to gain a better understanding of the value of the current service.
 - Review the profile of clients who have been involved in the service to understand whether it is effectively reaching those older people whose hospital activity can be avoided in the short term²⁰.
 - Review the intervention design, including the service pathway and the support provided to older people involved in the programme. For example:
 - When combined with the wider evaluation evidence, the findings from the Nuffield Trust analysis indicates that if a reduction in hospital activity is the desired outcome, keeping older people connected to the health and care system once their involvement in the service ends is likely to be critical. For local partnerships, this means continuing to work together to ensure that there are mechanisms in place that support ongoing proactive case management once older people 'leave' the service – initially, the focus could be on those clients with the most complex needs. Alternatively, extending the duration of the intervention beyond the intense support could give the PICs an opportunity to provide light-touch reviews with clients to support ongoing preventative care should their circumstances change.

- Local health and care partnerships could also consider whether and how the service (working in partnership with local self-management/patient activation initiatives) could provide more support to help clients to better self-manage the technical/physical aspects of their LTCs. The main causes of emergency admissions in the nine months after the guided conversation reported in the Nuffield Trust evaluation might provide a starting point from which to explore potential opportunities to further enhance the service's support for self-management/patient activation.

Overall, Age UK's PICP has clearly added value as a targeted, holistic, social prescribing model²¹. It has improved older people's wellbeing and has helped them to connect with services in their communities and to maintain as much of their independence as possible. In the process, the programme has been effective in promoting the integration of statutory and non-statutory services and in harnessing community assets to benefit older people.

For the majority of local Age UKs involved, the positive legacy of their participation is still growing. Relationships with stakeholders in other parts of the system have been strengthened, and local Age UKs have become valued and trusted partners in an ever-changing health and care landscape. This has enabled them to help shape and improve care and support for older people and to shift the conversation beyond a medical model. Local Age UKs are now in a position to advocate further an approach that is based on listening and on building trusting relationships. Rather than 'fixing' their problems, it is an approach that delivers sustainable benefits by recognising older people's own strengths and by focusing on what each client could achieve for themselves, with a just little help.

Finally, the journey has generated transferable lessons learned about spreading and scaling the Age UK Personalised Integrated Care model. These lessons are likely to be of value to others at both a local and national level.

Footnote

²⁰ For example, reviewing whether the service has inadvertently been reaching older people for whom hospital admissions are unlikely to be avoidable given the medical instability of their conditions and/or high levels of frailty.

²¹ Kimberlee categorised social prescribing models as basic (signposting), through to light, medium and holistic in Kimberlee R. (2015) *What is social prescribing?* *Advances in Social Sciences Research Journal*, Volume 2, No. 1. For further information about different models of social prescribing see Polley M.J. et al. (2017) *Making sense of social prescribing*. London University of Westminster.

4.2

Lessons learned about successfully spreading and scaling innovation

1

It's about being adaptable rather than replicable, and flexible rather than rigid

Each new place is different – a cut-and-paste approach based solely on what has worked elsewhere is rarely, if ever, effective.

From the outset, Age UK made sure that adaptability and flexibility were built in to the PICP at two levels:

- At programme level: phasing the piloting over several years made it possible to adapt the Personalised Integrated Care model as it spread from area to area in response to learning on the ground and to the changing local and national context
- At local level: a structured co-design phase, involving the local health and care partnership as well as Age UK, ensured that those adopting the model shaped and adapted its design to every new local context²².

Inevitably, knowing which aspects of the model can be adapted and which must stay the same in order to achieve the desired impact can be a difficult balancing act.

A good dose of pragmatism and a focus on core principles that need to be adhered to, rather than a fixed model, helped Age UK and the local health and care partnerships navigate this balancing act.

Sharing on-the-ground experience from one place does not guarantee that mistakes made there won't be repeated elsewhere – and that can be a positive thing.

As important as it was to set out armed with learning from the areas that had preceded them, each local partnership still had to go on their own journey and acquire their own insights. They had to 'touch and learn' for themselves, a process that demanded patience and resilience from the national team.

2

Adaptability and flexibility continue beyond co-design – factor in the time and effort needed to stabilise the model in the new localities

Well after the initial launch of a pilot, hard work is required to continually fine-tune the model.

In each locality, the Personalised Integrated Care model continued to develop as it unfolded on the ground; the journey has not been linear, but instead has involved cycles of test, learn and adapt in each new patch. Creating and maintaining momentum locally has also demanded a relentless focus on building and strengthening trusting relationships and understanding of the model's value at all levels.

Even with strong co-design, refining and stabilising delivery of an adapted model on the ground takes time.

For the Age UK programme, this process has taken longer than was initially expected. In practice, it proved crucial to operate the pilot for more than 12 months in order to understand whether and how the model was working in the new patch, and to start to embed it. The majority of Phase 2 areas secured extra funding, typically from the local CCG, to extend their pilots by several months.

Maintaining adaptability and flexibility is essential, given that local systems and contexts are constantly evolving.

Even after the Personalised Integrated Care model has become relatively stabilised and embedded in a new area, and the service has been commissioned, most local health and care partnerships have continued to adapt and refine aspects of the delivery model and its application in line with changing local context and need (see table 1).

Footnote

²² For further information, see section 1 and annex 1 of the blended evaluation of Phase 2 of the Age UK PICP.

3

Creating opportunities for reflective learning and strong feedback loops is essential

One of the keys to success is the capacity to learn about patterns of change and insights that emerge on the ground as new practice unfolds and is subsequently adapted.

Without opportunities for reflective learning and strong feedback loops, this learning is often lost or, at best, is captured too late in the day to support timely continuous improvement. With this in mind, Age UK organised a monthly national Learning Forum with an independent chair. The forum proved to be vital – local health and care partnerships said that participating in it was one of the key benefits of being part of Phase 2 of the programme.

The Learning Forum has provided a space for those involved in spreading the model to come together and engage in a learning dialogue. Initially for team leaders/senior managers from across the areas, in Phase 3 of the programme additional forums were established for PICs.

At all the forums, the focus has been very much on encouraging participants to talk openly and honestly, not just about what's going well, but also about what isn't working. This has supported real-time collective problem solving and has enabled a more agile approach to improving the model at programme and local level. Another added benefit has been that, for those involved, the forum has created a sense of belonging to something bigger than 'what's happening on their local patch'.

4

Encourage collective leadership at all levels to avoid dependency on any one organisation or individual

Involving leaders from across the system and who are able to lead when they are not in charge, as well as when they are, is necessary to get a 'new' model off the ground and to make it stick.

For most of the Phase 2 areas, the spread of the model on a daily basis was led jointly by a local Age UK manager and a manager from the local health and care system (the CCG in particular). This really helped to foster and maintain a collaborative approach – especially during the early stages of co-design and implementation.

Among other benefits, this partnership approach resulted in the blending of the different capabilities, expertise and experience of the CCG and the VCS to provide the full set of skills needed to successfully run the local programme. It has also enabled the PICP managers to facilitate a wider collaborative approach locally, in particular by:

- Understanding the needs, ways of working and cultures of various partners and stakeholders across the local VCS and statutory health and care systems
- Navigating and engaging effectively with the different parts of system
- Influencing and encouraging others to co-produce and co-deliver change.

To pave the way for joint programme management, part of the Age UK funding for each locality went towards paying for the CCG programme manager's time. This helped to ensure that the role was not simply added on to their 'day job'. In practice, on average the CCG manager needed to be seconded to the PICP for between two and three days per week, especially during implementation, with input declining later on during the pilot.

5

Multiple factors help to create the conditions to support sustainability of service in a new patch

Demonstrating the difference any new service is making to its target cohort and to the system locally along the journey is a must if the model is to be adopted.

In the case of the PICP's Phase 2 areas, there was no escaping the need to evidence (in practice to varying degrees) value for money, including any potential cost efficiencies associated with shifts in care. Yet, personal stories of need, impact and how the programme brought about change (from the perspective of older people, their carers' and health and care practitioners alike) were also powerful in and necessary to winning hearts and minds.

However, while Age UK adopted a mixed-method approach from the outset, the evaluation of the PICP has been fragmented. The timing of the qualitative and quantitative evaluations has been misaligned – this may well have led to opportunities to further understand and use the findings from each strand being missed.

The experience gained from the PICP journey highlights four key (and old) lessons about capturing and using evidence:

- From the outset, ensure a shared understanding of the evidence needed to both demonstrate and understand impact and value from different perspectives
- Use quantitative and qualitative evaluation approaches simultaneously, rather than in isolation and at different time points
- Don't just capture evidence, make sure you also use it – along the way and not just at the end of the programme
- Recognise that the evidence needed might change as things unfold on the ground. Look out for signs that the data being captured is not genuinely useful and redirect efforts in order to capture the evidence that is actually required.

It's not just about the evidence. Other factors are also critical, including the strength of the relationships and partnerships that have been built.

This goes beyond the delivery partnerships – wider partnerships are also extremely important. For example, a partnership with AHSN has been a major enabler of the sustainable spread of Age UK's PICP service in Kent.

6

The VCS plays a vital role in spreading and scaling change

The VCS can be a key player in catalysing change and shifting the dynamic between traditional NHS partners and the VCS to improve outcomes for both populations and the health and care system more generally. The sector is uniquely positioned in this respect. In the case of the PICP, Age UK:

- Brought an independent voice – and a system-wide view of service users' perspectives on what was working and what wasn't
- Acted as a neutral agent to convene people and organisations within systems, and to provide healthy challenge
- Helped facilitate a shift in culture by maintaining a focus on a shared purpose, centred on supporting older people to live well
- Provided skin in the game to stimulate innovation – by providing 'pump priming' for localities to adopt and adapt the model and to maintain equitable partnerships locally.

The PICP journey also highlights the importance of having the right skills and capability to create and sustain change. This means that local and national VCS organisations need people with strong influencing and facilitating skills, who understand the language of the local authority and social care, as well as the language of health.

Yvonne Fullwood, PhD
Understanding Value Ltd
yvonne@understanding-value.co.uk

Company number 11131570