Working towards prevention

The Independent Evaluation of the West Sussex Partnerships for Older People Project (POPP)

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Chapter 1

Introduction

1. Introduction to the report

This report presents the findings of an independent evaluation of a community based pilot project, funded by the Department of Health (DoH), to develop services designed to increase independence and well-being for older people in West Sussex. The West Sussex pilot project was one of 29 projects funded in England between 2006 and 2009 as part of the Partnerships for Older People Project (POPP). The broad intention of the POPP was to increase the likelihood of older people maintaining their independence, to prevent older people becoming unwell and therefore requiring admission to hospital and/or care homes. We describe POPP in more detail below.

Since the POPP projects were pilots, both local and national evaluations were commissioned to contribute to a learning process about how more preventative approaches to working with older people might be achieved. The key purpose of this report, therefore, is to document the 'key lessons' arising from the West Sussex POPP pilot that can be used to inform and support the development of this project and similar initiatives in future.

For the purpose of this project, an older person was defined as 65 years of age and over (Moir, 2007). As we will see, the way in which teams established to deliver the POPP defined their 'target group' varied and experience did not always match expectations in terms of the group of people they worked with. This relates to the way in which 'prevention' was understood and was able to be operationalised in the project. In terms of older people, preventative services have been defined as:

- Services which prevent or delay the need for more costly intensive services
- Strategies and approaches which promote the quality of life of older people and engagement with the community.

Lewis and Milne (2000: 2)

Lewis and Milne go on to note that front line health and social care staff can have a narrow understanding of prevention that prioritises the relief of pressure on hospital beds rather than proactive approaches to preventing illness and well-being. In this report we reflect on the robustness of that conclusion in relation to the West Sussex experience and what this experience suggests for ways in which we might understand 'prevention' as this relates to older people.

2. Background and evaluation methods

Here we outline the background to the POPP nationally and in West Sussex, and the evaluation approach used.

The Partnerships for Older People Project provided £60,000,000 of ring-fenced funding to a total of 29 pilot projects across England.

Nineteen pilot sites were allocated funding on 1st May 2006 and tasked to deliver POPP services for the next two years. Ten further pilot sites were subsequently allocated funding on 1st May 2007 and tasked to start delivering POPP services for the next two years. West Sussex was awarded £3,402,279 and was included in this second phase of projects.

Each project had to be led by a Council with Social Services Responsibility (CSSR) and have at least one Primary Care Trust (PCT) as a partner. Each local project was expected to test and evaluate innovative approaches that were designed to sustain preventative work in order to improve the quality of life for older people:

> *Partnerships for Older People Projects (POPP) is about developing radical new approaches to the way in which we deliver services for older people. Promoting health, well-being and independence to reduce reliance on acute or institutionalised care lies at the very heart of this programme.*
>
> Philp, National Director for Older People's Health (2005)

The pilots were expected to release funding from across the system for reinvestment into preventative approaches, with the aim of:

- Providing more low-level care and support in the community to improve the health, well-being and independence of older people, preventing or delaying the need for higher intensity and more costly care.

- Reducing avoidable, emergency admissions and/or bed-days for older people.

- Supporting older people to live at home or in supported housing such as sheltered or extra-care housing as opposed to in long-term residential care.

Government policy in relation to older people is focused on ensuring good quality care, prevention, health promotion, ensuring dignity, independence and choice, and enabling active participation. Older people are recognised as people who have a contribution to make as well as people who may need support and care,

and who may become frail. The POPP programme is one of a number of policy initiatives - that also include the Department of Health's National Service Framework (DoH, 2001) and the Social Exclusion Unit's (SEU) Link-Age Plus programme (SEU, 2006) - that seek to ensure quality of life for people in their old age. Policy is also driven by an awareness of the cost of health and social care services for older people: in 1998/9 40% of the NHS budget and nearly 50% of the social services budget was spent on older people (DoH, 2001:1).

In this context investment in preventative services is designed to reduce the need for acute hospital care, although the prevention agenda has a broader remit to improve older people's quality of life and reduce their social exclusion. This is understood to require action to enable 'successful ageing' to occur. This has been defined as '*the ability to maintain three key behaviours or characteristics: (1) low risk of disease and disease related disability, (2) high mental and physical function, and (3) active engagement with life'* (Rowe & Kahn, 1999: 38). In earlier work these authors illustrated how increased risk of disease and disability, assumed to accompany advancing age, is not an inevitable outcome (Rowe & Kahn, 1997). Lifestyle factors were found to play a very important role as did behavioural factors. In effect, whilst disease could be present intrinsically, extrinsic factors that can be modified play an important role in increasing the ill health and dependency of older people.

There has been a particular focus on the importance of falls prevention (DoH, 1999; Health Development Agency, 2003:1). A critical review established that for those aged 65 years and over falls account for 71% of serious injuries (involving hospitalisation of four days or more) and that at age 85 years and over falls account for 78% of accidental injury deaths (Cryer, 2001). Three types of risk factors for falls in older people have been identified: environmental, extrinsic and intrinsic factors (Onslow, 2005:38). Preventative strategies have been identified that focus on physical and environmental issues (Lord et al, 2001).

Research conducted on behalf of Help the Aged has also identified psychosocial aspects necessary to preventative activities such as confidence building, enhancing social identity and fostering positive relationships (Help the Aged, 2005:5). The SEU (2006) has explored the social, cultural, material and existential factors that affect older people's experiences of inclusion or exclusion.

One means of supporting people to remain at home is assistive technology i.e. any purpose designed device or system that allows people to perform a task they would otherwise be unable to do (Metz, 2000). Such assistive technologies may include many currently available such as walking aids and wheelchairs along with new technologies that offer the older person control of their home environment remotely by way of adjusting heating and opening/closing curtains.

There appears to be a connection between the increasing number of older people requiring overnight stays in hospital and the absence of any increase in

provision of community nursing services and home care services (DoH, 2000:8). It has been acknowledged more recently how existing services *'were not designed with older people in mind'* (DoH, 2007). This has also been shown to be true in terms of mental health services for older people where discrimination remains a problem, prevention is a low priority and services can be inaccessible (Age Concern England, 2007). The direction of older people's policy now has a clear focus on helping older people to maintain their independence, to improve local community services close to older people's homes and to invest in low level care and support (DoH, 2005 & 2007).

This focus is informed by earlier research that explored the value older people give to low level care and support services specifically. It identified the importance older people placed on domestic help, personal relationships with paid carers and other older people, along with maximising a sense of independence (Clark et al, 1998:65). This research also stressed the difficulty for older people to challenge social isolation, to access reliable information about services available and it linked many low level activities with prevention i.e. being in receipt of help in the home for tasks that are physically demanding can prevent older people from sustaining injury or from falling (ibid:68).

A West Sussex survey highlighted that 88% of older people felt that their health was 'good' or 'fairly good' whilst, conversely, 18% of older people were classified as vulnerable in terms of social isolation (West Sussex Public Health Observatory, 2006). It is also clear from a West Sussex older people needs analysis that locally, the number of older people aged 85 years or over is growing significantly and that local older people want more control over their health, access to flexible services, company and to take an active role in their local communities (West Sussex County Council, 2006a).

3. The West Sussex Partnerships for Older People Project (POPP)

The original broad aims of the West Sussex POPP described in the application to the Department of Health were:

- To improve the quality of life of Older People in West Sussex in ways that they identify themselves

- To enable Older People to have greater personal control over their health and well-being, to remain independent wherever possible and to be free from discrimination

Specific objectives were:

- To provide, in partnership with older people themselves, carers and local communities, more choice of low-level and sustainable preventive support, including a single point of access, in order to improve health, well-being and independence, preventing or delaying the need for higher intensity and more costly care.
- To contribute to the reduction of avoidable emergency admissions and delayed transfers of care.
- To increase the number of active older people in employment or volunteering in social care and further develop the range of activities they will be able to undertake through training support and advice.
- To support more older people to live at home or in supported housing as opposed to in long-term residential care.
- To create a sustainable shift in resources and culture away from the focus on intensive and institutionalised care towards earlier and better targeted interventions for older people, as identified by themselves.
- To evaluate with older people and other stakeholders, our model of service delivery, including our financial and partnership arrangements against our agreed objectives and share our learning at local and national level.

West Sussex County Council (2006b: 19)

To achieve these objectives the project established new teams, Community Partnership Teams (CPTs), in six locality areas across the county, consisting of a range of workers including social workers, health advisors, community link workers and benefits advisers. These staff remain employees of different organisations: West Sussex County Council (WSCC), the West Sussex Primary Care Trust (WSPCT), the Department for Work and Pensions (DWP) and a number of voluntary organisations in the case of Community Link Workers. These teams aimed to work with older people to identify and meet their needs for low level intervention and prevention services to assist in improving their health and well-being across a wide range of issues.

The project also developed seven Neighbourhood Networks with the same boundaries as the District and Borough Council areas within the county. The Worthing CPT covers both Worthing and Adur neighbourhood network areas. Each area has a Neighbourhood Network Steering Group (NNSG) with a membership primarily comprising those organisations contracted to provide POPP services. There is also a broader Neighbourhood Network (NN) which is open to any voluntary and community organisations with an interest in older people's services and involvement. The NNs are known differently in different areas dependent on how they have been structured and existing partnership profiles. In Worthing for example the NN is known as the Worthing Care Alliance and in Chichester as the CHOPP (Chichester Older People's Partnership)

Each Neighbourhood Network has a contingent of staff including neighbourhood network co-ordinators, administrators, community fundraisers, business development officers, publicity officers and community engagement workers. All staff are based in specific neighbourhood network areas except the business development officer posts where some are shared between areas. All the staff are employed by voluntary sector organisations.

A diagrammatic version of the full POPP structure is shown at Appendix 1

4. Evaluation design and methods

The evaluation was underpinned by a Theories of Change (ToC) approach. A ToC approach has been utilised in evaluations of complex system and social change initiatives as it offers the scope to clarify and reflect on strategies to implement change and to note outcomes at different points over a lengthy time scale. Exponents of a ToC approach have defined this as '*a systematic and cumulative study of the links between activities, outcomes, and contexts of the initiative*' (Connell & Kubisch in Fulbright-Anderson et al, 1998:16). Specifically, such an evaluation seeks to '*determine an initiative's intended outcomes, the activities it expects to implement to achieve those outcomes, and contextual factors that may have an effect on implementation of activities and their potential to bring about desired outcomes*' (Connell & Kubisch in Fulbright-Anderson et al, 1998:17). More recent exponents of this approach highlight the participatory nature of the approach with evaluators and stakeholders working together to develop the ToC and the key here is on making explicit '*what (outcome) they hope to achieve (in the long, medium and short term), how (action) they expect to achieve them and why the proposed actions should deliver intended outcomes (rationale)*' (Mason & Barnes, 2007).

Early discussion with WSCC POPP staff led to certain changes to the way in which we conducted the evaluation and to our remit. Discussion revolved around evaluating the success, or not, of the West Sussex POPP in terms of (a) maximising older people avoiding hospitalisation (b) in older people being actively involved in POPP and (c) in the development of a new resources/information database for older people in the county. During early POPP team/ evaluation team meetings it was agreed however that, because of the emphasis on preventative work and on community orientated work in the West Sussex POPP, we would rather focus on new ways of working with older people.

The key focus for the evaluation evolved into two discrete aspects. Firstly the gathering of rich in-depth data concerning the role, work and outcomes of the Community Partnership Teams and the Neighbourhood Networks. Secondly, the gathering of quality of life information about older people who had received some input from Community Partnership Teams. Because local data collection had to

feed in to the national evaluation this aspect of the work necessitated use of a slightly adapted version of the Quality of Life questionnaire designed by the national evaluation team, as well as individual interviews conducted face to face or over the phone. We also conducted interviews with strategic stakeholders to explore their view of the place of the POPP within the overall service system in the county.

The report is structured around these different elements of the evaluation.

Chapter 2

The Community Partnership Teams (CPTs): new ways of working for prevention

1. Data sources

Data collection for this element of the evaluation involved workshops with team members as soon as possible after their formation in order to explore their ideas about their target group, objectives, ways of working, the context in which they were working and the rationale for their approach. We then drew on two sources of evidence to consider whether the initial ideas of the CPTs about who they would work with, how, and with what effect were realised in practice: follow up interviews and focus groups with team members and data from questionnaires and interviews with individual service users. We discuss the details of results from interviews and questionnaires in Chapter 3, but here we draw briefly from that material to reflect on what happened in practice. We start by discussing the teams' thinking about their target group, ways of working and extent to which their initial ideas were realised in practice. We consider each team separately in order to highlight differences in thinking and approach as well as similarities. In the second part of the chapter we consider both internal and external factors that were considered to have impacted on what happened in practice during the evaluation period.

2. The 'target group', ways of working and the impact of this.

Chichester

The team's original thinking was that they would work primarily in local areas of deprivation and they were seeking guidance from the POPP management team about this. They identified their target group as older people who had low level needs (i.e. problems with domestic tasks and shopping that didn't meet the criteria for adult services) and who were not in receipt of statutory services; those who were starting to experience health problems – including those who may trip or fall, and those entitled to but not receiving benefits. The team suggested such people may be unaware of what services are available and service providers may find them difficult to locate – especially in rural areas.

The team's approach to prevention was described as 'nipping in the bud' any problems to prevent the need for referral to hospital or adult social care services. They aimed to achieve this by providing information, health promotion, offering health check ups and referral to rehabilitation teams and other services as appropriate. They saw 'case finding' as necessary to this approach and assumed

they would work with ‘younger older people’ in undertaking preventative work. The rural nature of the area indicated a need for outreach – attending lunch clubs and other places older people meet, and this in turn was considered likely to need good planning to avoid extensive daily travel. Contact with General Practitioners (GPs) was seen as important to ensure the team’s existence was known about, but they thought raising their profile would also require advertising in the local press and making leaflets widely available.

This team had only been complete for about five months by the end of the evaluation period and so there was limited experience on which to draw. Team members thought they were working with a rather older group than they had anticipated, although more than half were self referrals (two of the four people interviewed self referred) and much of the work the team were doing comprised the ‘little things’: practical supports such as helping them buy and use a mobile phone, or getting access to gardening, practical aids and supports, that are known to be important to older people to sustain their independence. Home visits from DWP staff were proving very important to enable people to access benefits to which they were entitled: this was confirmed by one of the four people interviewed. A 73 year old man who was caring for his wife said that he had previously been frightened to claim benefits but was now waiting to hear about entitlements. The role of the Community Link Worker (CLW) was identified as “*the outstanding success of the project.”* They thought they were seeing a number of people who may be in the early stage of Alzheimer’s, but were aware of limited services in the area to which they could refer such people. In other cases they did make referrals where the level of need was greater than they could meet. In addition to practical help and help in accessing benefits, the team considered that having the time to talk to people and being able to encourage and support them to get involved in groups was key to their approach. They were aware of older people growing in confidence as they were able to access groups and other forms of support, though the team also sought not to become engaged on a long term basis.

Arun

In the original workshop the Arun team distinguished two core areas of work:

- primary prevention i.e. preventing an injury, sickness, or disease occurring in the first place.

- in the area of functional decline i.e. where older people were starting to struggle with their activities of daily living and social activities.

As in Chichester the team assumed they would be working with people who were not in receipt of statutory services, and who were not known to these services. The majority might be viewed as ‘well’ in conventional terms, or they may just be

starting to become ‘unwell’. They anticipated working with older people 50+ who might be in a position to be active within the locality. Identification and access were considered likely to be problematic and making contact with their target group was one of their short to medium term aims. However, the team did anticipate offering health promotion sessions in sheltered housing – i.e. working with one group already in contact with services. They also anticipated a need to monitor referrals to ensure that those who required secondary or tertiary prevention were referred elsewhere.

The focus of the team also implied that managing health rather than illness was the main task and that focusing on practical issues and assistance (i.e. falls advice, social support, exercise regime, benefits advice) would also enable them to assess for other health problems. An older person led way of working (identifying what it is that older people want) was seen as contributing to encouraging independence and resourcefulness amongst older people. This in turn would lead to greater activity and fewer harmful behaviours (including risks in and around the home). The older people they worked with would be more likely to actively participate in their local communities.

What the Arun team had not anticipated was the extent to which they needed to publicise their service in order to find people who might benefit from it. Their planned focus on people who might currently be considered (or consider themselves) ‘well’ in order to adopt a preventative approach meant they had tried a number of tactics to encourage such people to come forward: including publicising on the back of the flu vaccine campaign and electric blanket testing, but they still felt they needed to do more. They noted that:

> *We’re battling with decades when the national health service has been a national **illness** service not a health service and still is, and in social care they are still dealing with crisis over there so you are battling with people’s **accurate** perceptions of what statutory services are about.*

One consequence of this was that although most of the referrals they receive are self referrals, most come when someone has reached crisis point. They thought the people they were working with were rather older than they had anticipated, although since life expectancy varied across the area by as much as 13 years, they did not consider chronological age as the most significant factor in determining appropriateness in terms of health promotion/illness prevention.

Although the team identified themselves strongly with a health promotion approach they also found the DWP link important. They thought there was a long way to go in terms of ensuring their *overall* approach was ‘older person led’, but thought this did describe their way of working with individuals. Links with the neighbourhood networks were starting to develop, but close working relationships had not yet been established with the team as a whole. The

Community Link Worker was seen as having better links because of being employed by voluntary sector agencies.

The five initial and three follow up interviews with people who used the Arun service indicated that people felt safer, more in control and able to manage knowing that if they needed some information or advice they could contact the CPT. Two people interviewed were carers – it is not clear whether they might have been entitled to a carers' assessment but no mention was made of this possibility, although in one case the man cared for was now attending a day centre. The limited evidence from these interviews does not reveal the health promotion approach in practice that the team initially emphasised.

Crawley

The population of Crawley includes many people on low incomes, there is a large Black and Minority Ethnic (BME) population, and many different languages are spoken. The team also suggested there was a lack of inter-generational support, and that both the health and social care and community/voluntary sectors were under developed. The team felt they needed to understand better what was available, what were the needs and gaps, and saw this as an important task for the first year of work. They anticipated that this would involve building bridges between the statutory and voluntary sectors. It would also involve identifying key people and organisations locally in order to benefit from their local knowledge.

The Crawley team originally described their target group as *"older people who are not accessing existing services and who may be seen as 'just about coping'".* They did not couch their approach in terms of tiers of prevention but by reference to maximising older people's ability to manage their activities of daily living and their social life (preventing social isolation), encouraging independence and avoiding the need for acute service provision i.e. hospital admission, large packages of care, or residential care. They thought they would achieve this by engaging with older people before they needed existing health and social care services, by promoting healthy diets, self care and encouraging and sustaining independence.

They described their planned approach as seeing things from the older person's point of view, adopting a pragmatic approach and going at their pace. Listening as well as responding to needs would be important. They deliberately sought to avoid 'professionalising' older people and their concerns.

They aimed to work with older people living in areas with higher levels of deprivation, although recognised that most older people did not live in the three designated Local Neighbourhood Improvement Areas. In the short to medium term they aimed to take the service where older people were, such as sheltered housing schemes, lunch clubs, community centres, and church drop-in centres.

The experience of the Crawley team in practice was that they were picking up a number of older people with mental health difficulties (including dementia) and people with learning difficulties who have substantial needs but who do not meet the criteria for other services. They are thus seeing people who are needier than they anticipated. They suggested that the numbers of people with dementia are increasing within the area, in part because as a new town the population is ageing at the same time. They had experienced a steady flow of people needing referral to DWP to increase benefit take up. Another key issue has been the necessity to ensure services are accessible to the ethnically diverse population, including elders who do not speak or read English. They have found that cultural expectations about family care for older people can lead to problems for younger family members, including difficulties in admitting to not being able to provide such support.

The team consider they have been successful in working at a pace and in ways that 'work' for the older people they come into contact with. They have had good feedback, including in relation to support in accessing help from DWP, the single point of access and providing help that people actually want, not just 'asking lots of questions.' They have not yet been able to develop health promotion work and the team felt there was still a need to clarify roles and responsibilities of the CPTs and Neighbourhood Networks.

Responses from those who have used the service at baseline and follow up interviews were mixed. For one couple the help the CPT provided had enabled them to move to a bungalow more suited to their needs and they were very happy. Some had lost touch or forgotten about the service at follow up and there were concerns about continuing isolation and the cost of services that were identified as potentially helpful. These results tend to confirm the level of need of some of those referred to the CPT and suggest continuing challenges of ensuring people are reminded about the service and that follow on services are appropriate.

Horsham

The Horsham team planned to target areas with the highest incidences of older people on lower incomes. These included both rural and urban settings. They also suggested they would target sheltered accommodation, lunch clubs, day centres and other groups/places where older people meet.

They described their target group as those who are at the start of feeling unsure about either their physical or mental capabilities in managing their everyday life, and their input as being designed to prevent things deteriorating further, to assist people before crisis point is reached. In order to do this they aimed to educate and assist older people to plan in order to enhance both their support networks

and the likelihood of them remaining in their own home for as long as possible. They saw this approach as empowering older people and linked it to the restoration of confidence.

As well as transport problems associated with the rural nature of much of the area, the team identified historical infrastructure anomalies that would affect their work. For example, some voluntary/community groups did not cover the whole of the Horsham locality, and some Worthing groups covered the southern part of the area. Five villages in the Horsham locality have their own Community Partnerships which were seen as a source of some confusion and misunderstanding. Team members thought it would be important to understand the complexities of existing voluntary and statutory infrastructure and to communicate clearly what they did and where they fit amongst other local support services.

In this context they saw themselves as filling a gap for those with low level needs and acting as a signposting service. They aimed to be relaxed, approachable and informal, encouraging information sharing whilst avoiding overload. In the future they saw health promotion, focusing on diet, exercise and medication as part of their work and aimed for older people to become self-referring in the medium to long term.

Once again the Horsham team explicitly emphasised that older people should define what they needed, rather than the service being driven by professionals' agendas. Thus 'thinking out of the box' could include connecting local older people informally, for example, to have lunch together, and the enablement of networking in communities was seen as a core aspect of their work. One consequence of this might be for older people to become volunteers. The team anticipated joining with other agencies to deliver presentations to older people, for example in relation to keeping warm.

The experience of the Horsham team was that their service did fill a gap in both National Health Service (NHS) and social care services. Some of those who use their services are not poor financially but still have complex needs. They described some as coping well in some aspects of their lives but not others. They also noted the tendency for people to try to be independent and thus being unwilling to accept the help that could avoid risk in the long run. They have sought to address this difficulty by making contact with groups where team members can talk about the help that can be offered. The team's perceived independence from social services as well as their capacity to spend time with people and not be constrained by criteria for access to social services enable them to start to break down some of these barriers. Related to this was the importance of understanding the complexities of older people's families (in some cases children in their 60s might be looking after grandchildren as well as trying to support older parents), and the fact that older people might find it easier to accept help from outside rather than inside the family.

These perceptions were supported by comments of one woman interviewed who had serious health problems and whose husband also had health problems. '*We manage'* she said and went on to explain that her husband would not want to claim anything. Knowing where to go in future if she was admitted to hospital and her husband could not cope was reassuring. This and other responses suggested that knowing the CPT was there if and when needed was valuable in its own right.

Worthing and Adur

The planned focus of this team was on those living in poverty; who live in wards identified as being the most deprived; were in a pre-crisis situation; were socially isolated; and who did not meet criteria for assistance from existing statutory services.

In order to ensure that older people who were in a pre-crisis situation received the help they need, they identified the importance of information about the services offered being widely available - in libraries, doctors' surgeries, and via local media. But they also emphasised the need to communicate a message about older people's entitlements in order to reduce their reluctance to seek help. Evidence of their success in this respect would come from an increased number of self-referrals to the POPP team and a reduction in crisis referrals elsewhere.

The team identified a number of specific foci for preventative work:

1. Falls prevention - working with older people at risk of falling in order to promote safety and avoid a crisis situation/acute hospital admission.
2. The home environment. Signposting about heating, safety/security, and fire prevention that would enhance older people's safety, confidence and well-being.
3. Practical help in or around their home i.e. house work, building/garden maintenance, and personal care. This would enhance older people's self-esteem and independence.
4. Health behaviour change. Promoting healthy lifestyles, i.e. weight loss, to enhance older people's quality of life.
5. Social isolation and loss. Reconnecting older people with their local communities and exploring loss issues was seen as likely to improve their mental and emotional well-being.
6. The identification of previously unseen risk. Working with older people in a pre-crisis situation would lead to an increase in health and social care preventative activities. Thus prevention would not be restricted to the work of the CPT.

The long term impacts of such activities were identified as an increase in older people's motivation to be active personally and within their community, to identify their own needs, and to make their own changes and choices. This in turn would lead to an observable increase in skills, knowledge, and self-esteem amongst the older people the team had worked with.

The Worthing and Adur team explicitly included carers within the definition of their target group. They proposed that they would identify carers in need of support and assistance and either provide appropriate advice and support directly or facilitate referral to an appropriate agency or service. Lessening the burden of stress on carers would result in fewer breakdowns in caring relationships and more older people remaining at home.

Advice on eligibility and maximising receipt of financial benefits would have a positive impact on the ability of older people to remain in their own homes, to increase their well-being, and to play an active part in their local communities. The team identified difficulties faced by older people in Worthing/Adur in terms of inaccessible transport, a lack of family/carer support, the variability of voluntary sector provision, and the particular needs of Black and Minority Ethnic (BME) communities. They recognised the need to work and have an impact beyond the individual level:

- Influencing public, private and voluntary transport providers so that older people can readily access good transport networks and thus be able to use available services. They planned to work with colleagues in the Worthing and Adur Neighbourhood Networks on this, but also recognised the limitations on their capacity to achieve change.

- Mapping and publicising voluntary sector provision to assist older people in accessing appropriate support and networks within their communities.

- Engaging with older people from BME communities and their organisations to work towards developing services tailored to the needs of these communities, enhancing their involvement in their local communities and enabling access to early intervention, support and advice.

- Raising their profile locally within community, voluntary, statutory services/groups and other agencies to foster joint working initiatives across sectors that can deliver 'joined up' services for older people.

The Worthing and Adur team used a similar language to other teams in relation to 'older person centred services' by which they meant enabling and empowering older people though responding to their identified concerns and needs. They saw this as offering an example to other agencies and professionals working with older people, and as contributing both to older peoples' recognition of their rights to receive help and support, and to broader perceptions about the value of older

people. In the medium to long-term, they saw the CPT as less of an intervention service and more an enabling/visionary service or resource, with older people able to be more self-directed in accessing the support and help they required.

Whilst challenging negative societal perceptions of older people in the locality was a longer-term aim, the team did plan to foster inter-generational activities in order to enhance more positive attitudes amongst younger people. In practice the experience of the Worthing and Adur team has been strongly influenced by the geographical split within the team and by the challenge of bringing different professional groups together (see below). This has impacted on the way in which they have worked with older people. One view was that the focus on prevention enabled different members of the team to come at things in different ways and that the roles complemented each other – '*they cover a person from different angles.*' There was also a view that looking ***with*** older people at the range of resources that might lessen difficulties they faced was helping to overcome a sense that they simply have to put up with things because they are old. Workers reported older people saying their contact with the team is changing their lives.

The team have also had to hold their ground in relation to inappropriate referrals coming from elsewhere – they have sought to avoid being seen as low level cover for gaps in mainstream services. They think other teams are starting to understand their focus on prevention, but there remains a danger that they will be seen as a 'dumping ground.'

In terms of their work with older people they have seen the help with practical matters that they can offer as providing a route to encouraging older people to '*look around and see what they want to do*.' The DWP input has been very significant. One team member suggested that having money to pay for someone to look after them makes older people feel better, but perversely enabling people to find out about and access means tested services (shopping, housework, bathing for example) can mean substantial parts of benefit income is immediately called upon. Responses from clients interviewed confirmed the importance of DWP in terms both of ensuring people knew what they were entitled to and help in accessing this: *'We weren't aware of what we could get. They suggested it. I think they are doing a really professional job.'* [a man supported to claim a carers' allowance and attendance allowance for his wife.]

Responses from older people using the service confirm the significance of social isolation: *'The whole problem is loneliness. I don't need looking after, I just need company.'* and the fact that at least some of those referred were probably beyond the primary prevention stage envisaged by team members: one person could not be followed up after the initial interview because they had been admitted to a nursing home with dementia. Transport remained a barrier to following up possible services in some cases and some people continued to assert their independence: '*We're the old school. We're independent. We don't shout,*' said

one man of 90 who cared for his 89 year old wife, had health problems himself and was no longer in touch with the CPT at follow up.

Mid Sussex

The Mid Sussex team defined their target group by reference to the large number of older people (60+) who do not meet criteria for existing statutory services, do not know where to go for help, are unclear about how to apply for assistance and have difficulty keeping appointments because of transport problems. They did not identify any geographical targets (although indicated they would start with the two more accessible areas of Burgess Hill and Haywards Heath), but said they would work with people wherever they are and thus would advertise themselves in GP surgeries, libraries, Age Concern centres, lunch clubs, and churches.

They suggested older people in the locality tend to be isolated; they may have a long term condition, low mood, and struggle with managing their conditions. Reaching those older people who do not usually access services would help them maintain their independence. The team aimed to offer holistic assessments addressing social and physical aspects of their circumstances, connecting people to practical assistance such as house work and working with older people to help them find solutions to their problems. Working at an early stage of physical decline, maintaining independence and enabling older people to do things for themselves were key to their identified approach.

They located this approach in the context of a rural locality with many close knit communities. They highlighted the importance of emphasising that the team was there to help rather than to take over. This meant working *with* local voluntary groups and enhancing the work they do. They noted important social divisions in the locality with many older people being quite affluent (although often asset rather than income rich) and others quite poor. They did not propose to distinguish in terms of economic circumstances of the older people they worked with.

Their initial planned approach was to let people know of their existence and to emphasise that people could contact them directly. Once again, team members spoke of working with older people's self-identified priorities and adopting a holistic approach and establishing positive flexible relationships. They also suggested there may be times when they would need to challenge assumptions and/or behaviour. Their objectives for older people were to maximise their ability to look after themselves and their communities, and to improve their quality of life. They saw this as helping people to remain at home and stay out of hospital. They also wanted to shift the balance in health and social care to a preventative approach.

The majority of clients they have seen have been 75+ which is older than initially suggested, but they do think they are mainly seeing people before crisis, on discharge from hospital or people with minor issues who don't know where to go for help. They have had referrals from statutory and voluntary sectors as well as self referrals. Their expectations of receiving referrals of people who have money have been confirmed and this has been a surprise from a social work perspective. They suggested they have seen people who have previously been excluded because they have money. In some cases the team have referred people for the assessment they are entitled to and then received them back from social care because they do not meet criteria.

Team members think they have been able to build trust amongst people who would be reluctant to tell social services or their GP that they are struggling to cope. This was in part because they were able to spend time with people - *'old fashioned social work'* in the view of one. Another aspect of this was helping people with paperwork that can cause a lot of worry. Their concern was that it would be difficult to measure the impact of their work in terms of number of hospital admissions prevented, for example.

They reported bringing in the fire brigade to help one couple 'de clutter' because of fire risk, of helping another couple recognise the significance of the caring roles they performed, and of spotting evidence of early stage dementia in another case. In each of these cases a combination of a holistic perspective and being able to take time to understand the situation was considered crucial. One worker expressed the person centred approach as:

> *…. they could ask us anything from I need someone to walk the dog to I've got an appointment at the dentist I'm terrified and I need someone to take me….*

Their experience was of a huge variety of requests from older people that did not always fit categories on the forms. They emphasised the importance of listening in order to understand the bigger picture of people's lives and what might help them. They felt that they were able to meet needs in 90-95% of cases, but had identified the value of a 'third level' of attendance allowance for those who do not qualify but do need help from a cleaner or gardener.

The team's attempts to publicise the service have been paying off as they have seen quite a few people from rural areas and they have used the mobile library as one way of reaching out to people in more isolated areas. This was confirmed in interviews by the number of different routes through which people heard about the team. Interviews indicated that some of those referred had quite substantial health problems and the role of the CPT had been to put people in touch with other services. One 92 year old lady was thrilled with the service that had resulted in the provision of a walking aide, a fire check by the fire brigade and accessing a housework service via Age Concern. Once again some comments

indicated the reassurance that older people felt about the service being there if they needed to call on it.

Discussion

This analysis reveals a number of ways in which the target group can and has been defined by reference to:

1. The exclusiveness of criteria for access to mainstream health and social care services.

2. Lack of knowledge of the availability of services and entitlements to help.

3. The age range (the ‘young old’).

4. Risky behaviours.

5. Types of need: practical, social, financial, psychological, relational.

6. Health status: in one case using the formal ‘tiers of prevention’ analysis, in others more informal understandings e.g. ‘’just becoming unwell’.

7. Place: specific localities which are seen to be priorities.

These are related to contextual factors, primarily:

- Rurality

- Cultural factors, including language, ethnicity, family structure and relationships.

- Older people’s values and preferences about help seeking.

- Socio-economic and health inequalities.

- Availability of statutory services.

- The nature of the voluntary and community sector.

This results in quite complex analyses of the ways in which the CPTs need to be approaching their work: both with individual older people and in relation to the broader social, and service system. However, there was a considerable degree of consistency in the need to work in a way that enabled older people to define what was important to them and to take the time to explore ways of helping them that ‘fit’: personally, culturally and in terms of what might be considered objective

needs. There is evidence that this did indeed 'work' for some of those who used the services. But there is also evidence that a significant proportion of those referred did not fit the profile of the originally envisaged target group and that teams found themselves dealing with much higher levels of need (in terms of service input) than they had expected. There was concern in some areas that it would be hard for them to sustain an emphasis on prevention in the face of stricter criteria for access to mainstream social care and evidence of substantial unmet need. Related to this was concern about the capacity of the teams and a concern about not wanting to '*wind up like statutory services with waiting lists.*'

3. Implementing a New Model

Our main focus in this evaluation has been on the experiences of older people and the impact that the POPP has had on their lives. But it is also necessary to understand factors that have affected the capacity of the project to make a difference. Here we briefly highlight issues that were raised by workers within the CPTs that have affected their ability to achieve the objectives set out for POPP as a whole and to work in the ways they planned within each locality.

We have already seen an indication that the experience of working with clients indicates the extent to which statutory services focused on high level need fail to offer the range of help and support needed by some people as they grow older. This discussion has also indicated the challenge of being able to develop a truly preventative service both because of the almost crisis nature of statutory health and social care services and the reluctance of older people to seek help. There is evidence from some of those who were interviewed for this project that older people are well schooled in the discourse of 'independence' and have learnt not to seek help except in crisis or in cases of very severe need. At the same time there was a strong sense from those working in the CPTs that this was the way they wanted to work and thought more statutory providers should be working. They faced the challenges not only of establishing new teams but of finding their place within a system that felt as if it had moved away from the values of taking the time to understand older peoples' lives and how they could best be assisted to sustain well-being and have a good quality of life in old age.

The key challenges and issues faced by the CPTs were:

Team building

All the CPTs experienced some difficulties in establishing effective working relationships amongst team members. These related to the different cultures, expectations and ways of working of the statutory and voluntary sectors; practical difficulties that varied across teams but included (in some instances) physical separation between team members and insufficient space to meet together;

recruitment spread out over a long time period, different team members being employed by different agencies with different management styles and processes and the absence of team leaders – 7 people and 5 line managers, as one person noted in her area.

The most frequently identified axis of difference was the statutory/voluntary axis, with one minority view that it would have been better to keep voluntary and statutory sector workers in different teams with good links between them. But the health and social care axis was also identified as difficult in some contexts. Social work staff experienced difficulty because of the absence of social work management and supervision, but this was being addressed toward the end of the evaluation period. Such difficulties were exacerbated by the need to 'invent' methods of working and proactively seek out those who might use and benefit from the service. Every team reported having to invest much more time and energy in the process of team building than they had anticipated.

What mitigated these difficulties was the high level of shared commitment to the objectives of POPP and a preparedness to try to make it work:

> *We are all passionate about what we do so that has brought us together well*

There was recognition of different skills and experience and the value of this not only in relation to work with older people, but in enabling shared learning within the teams.

Cross team guidance and development

All teams felt that there was a lack of clarity and/or guidance over what was expected of them and it was suggested that there would have been value in bringing teams together in the early stages to undertake development work. There was one reported example of a CPT offering guidance to another team to help them get started. This sense of having not only to 'make the job' themselves, but also to arrange their own training in one instance, reflected both the absence of team leaders and a lack of co-ordinated support at county level.

Roles and boundaries

The CPTs needed to establish their place within the overall system of health and social care, in relation to pre-existing voluntary and community sector services and develop effective working relationships and clarity over different roles and responsibilities vis a vis the Neighbourhood Networks. With respect to the latter, the comparative roles of the Community Link Workers (based in the CPTs) and the Community Engagement Workers (located in the Neighbourhood Networks)

were the most frequently cited focus for uncertainty. Broadly the view was that Community Link Workers (CLWs) worked with individuals and Community Engagement Workers (CEWs) with groups, but examples were cited where CEWs had worked with individuals and that this was not entirely successful or helpful. Within the CPTs the role of CLWs created particular uncertainty in one area where there was evidence of an approach strongly influenced by a health prevention model. This was reinforced by a sense amongst some CLWs that their work could not effectively be described or communicated by reference to the 'boxes' that had to be ticked on the internal reporting sheets needed by the centralised POPP computer system. There were different relationships with the voluntary sector in different areas, but some concern was expressed that more effort should have been put in to find out what work was already being done within this sector to avoid resistance and duplication.

We have already noted that there was concern that CPTs might be being used as 'dumping grounds' by adult social care. In the case of the local health services the concern was more about an absence of awareness or interest from the PCT. Relationships with GPs were identified as important for case finding and referrals. The Unique Care model of working being piloted in Worthing with a view then to being rolled out across the county was seen to facilitate such relationships. This model based around a GP surgery seeks to enable all practitioners involved in a 'case' to have an involvement in discussion and decisions.

4. Conclusion

We have noted in other parts of this report that the implementation of the POPP took longer than had been anticipated and the experiences reported here demonstrated that even when the teams were recruited considerable effort was required to enable them to operate effectively. The teams were very aware of the pilot nature of the project and also of the long time frame necessary to demonstrate a real impact from the preventative work that they were starting to develop. They were all highly committed to the continuation of the work and anxious that this should not be curtailed. It is also clear from the interviews with those using the service that it will take some time to overcome a sense that older people should not seek help unless they are desperate and that the trust that is necessary for the delivery of sensitive support services can only be sustained if the teams are able to continue giving time and working in ways that make sense to older people themselves.

Chapter 3

Improving quality of life? - the impact of POPP on older people.

1. Introduction

In this chapter we discuss evidence from questionnaires and interviews conducted with a sample of older people referred to the CPTs. In the introduction we noted the need to use the Quality of Life questionnaire developed by the National Evaluation Team in order to feed in to the overall evaluation of the POPP. For use in West Sussex this questionnaire was shortened and the personal data section amended in line with the Department of Health categories for marital status and ethnicity. A copy of the questionnaire used is included at Appendix 2. This was sent to a sample of those referred to the CPTs in the first three months of operation. Those who returned the questionnaire could also opt to participate in an interview by returning an enclosed form with their contact details. The interviews aimed to provide more qualitative data, reveal the experience of those referred to the service and consider the outcomes and personal impact of the service on individuals.

Follow up questionnaires were sent to those who had returned a questionnaire at baseline in Adur and Worthing, Arun and Crawley, and follow up interviews were requested via a covering letter. Because of implementation delays there was insufficient time to follow up at 6 months in Chichester, Horsham and Mid-Sussex with questionnaires and interviews.

2. Quality of Life questionnaires and interviews

Summary of responses

Three hundred and fifty-eight baseline questionnaires were sent out and ninety-three of these were returned. This represents a response rate of about 26%.

Number of questionnaires:

	Sent out		**Sent out**	
	Baseline:	**Returned**	**Follow up:**	**Returned**
Worthing and Adur	126	23 (18%)	22	12 (55%)
Arun	61	19 (31%)	19	7 (37%)

Crawley	33	6 (18%)	6	2 (6.5%)
Chichester	21	9 (43%)	n/a	n/a
Horsham	46	13 (28%)	n/a	n/a
Mid-Sussex	71	23 (32%)	n/a	n/a
Total:	358	93 (26%)	47	21 (45%)

At baseline, forty-four interviews were carried out; sixteen people were interviewed after six months at follow up.

Number of interviews:

	Baseline:	**Follow-up:**
Worthing and Adur	10	8
Arun	5	3
Crawley	10	5
Chichester	4	n/a
Horsham	6	n/a
Mid-Sussex	9	n/a
Total:	44	16

Baseline questionnaires

Of the 93 people returning a questionnaire, 53 completed the questionnaire themselves, 3 people didn't report how the questionnaire was completed, 31 completed the questionnaire with help from family or a friend; all these were returned by post. Six questionnaires were completed with the help of a researcher in a face to face interview.

Characteristics of respondents:

- 73% (68) of respondents were female and of these, 29 (42%) were aged 85 or over
- 52.7% (49) were widowed
- 53.8% (50) lived alone
- 86.0% (80) said they were retired
- 12.9% (12) were caring for a family member
- 13.9% (13) said they were long term sick or disabled
- The majority of respondents, 88.2% (82) said they were white British
- 82.8% (77) said they were Christian

Health state

Compared with their general level of health over the past 12 months, 48 (51.6%) respondents said their health state is 'much the same', 38 respondents (40.9%) said their health is worse, 6 respondents (6.5%) said their health is better and one person did not answer this question.

- 74.2 % of respondents had some problems walking about
- 47.3% of respondents had some problems washing and dressing
- 63.4% of respondents had some problems performing usual activities
- 64.6% of respondents had moderate pain or discomfort
- 10% had of respondents had extreme pain or discomfort
- 41.9% of respondents were moderately anxious or depressed
- 8.6% of respondents were extremely anxious or depressed
-

Health state today

On a scale of 0 to 100, with 100 being the best imaginable health state, 44 (47.3%) reported their health state was 50 or below; 47 (50%) reported their health state was above 50. Two people did not respond.

Quality of Life

Twenty respondents (21.5%) said their quality of life is 'bad', 'very bad' or 'so bad it could not be worse'; 29 respondents (31.2%) said their quality of life is 'good' or 'very good'; 44 (47.3%) respondents said their quality of life is 'alright'

Service Use in the last 3 months

In respect of visits to hospital, 26.9% (25) had been to A&E, 20.4% (19) had had an overnight stay and 40.9% (38) had had a clinic or out-patient appointment.

Use of services at local surgery or health centre:

- 54.8% (51) saw their GP at the surgery
- 24.7% (23) saw their GP at home
- 36.6% (34) telephoned their surgery for advice
- 47.3% (44) saw their practice nurse
- 25.8% (24) saw a chiropodist
- 6.5% (6) saw a physiotherapist

Services at home

- 16.1% (15) received meals on wheels
- 20.4% (19) received home care/home help
- 29.0% (27) said a social worker or care manager had visited
- 24.7% (23) said a nurse had visited
- 42.0% (39) said a physiotherapist had visited
- 41.9% (39) had a personal alarm
- 11.8% (11) had used the alarm
- 16.1% (15) had received changes to their home e.g. a stair lift, downstairs bathroom etc.

Leisure and transport

Eight people (8.6%) go to a day/drop-in/resource centre, 12 (12.9%) go to a lunch club and 15.1% (14) have transport to health care. These figures appear low with few people participating in organised social activities outside their network of family and friends.

Help from friends or relatives

- 51.6% (48) have help with housework and laundry
- 49.5% (46) have transport/get taken out
- 45.2% (42) have help with gardening
- 58.1% (54) have help with shopping
- 53.8% (50) have general support

Activities/involvement

Respondents were asked a framed question about what activities they had been involved in during the last 3 months. A range of activities were described including church, bridge, UNISON, cards, talking, clubs, coffee, Sunday lunch, meals, a barbeque, shopping, and outings. Many people described regular contact e.g. weekly, twice a week, and twice a month.

Church or faith based activities were mentioned by 23 (24.7%) respondents and gardening and outside activities were mentioned by 19 (20.4%) respondents. The most frequent and popular activity mentioned was socialising with family friends or neighbours. Sixty-three (67.7%) respondents described visits to and from their family and neighbours.

Twenty-five respondents gave no mention of activities, involvement or socialising. This is reflected in comments made during interviews where some respondents admitted they felt lonely and socially isolated.

Benefits and finances

- 60.2% (56) of respondents were claiming Attendance Allowance
- Of those 77 claiming a range of benefits, 27 (35%) said they received up to £100 per week.
- 17.2% (16) said they were not claiming any benefits
- 45% (42) said their household income was £249 per week or less

Additional comments

Comments added to the questionnaire included mention of health issues such as Alzheimer's, frequent falls, dementia, visual impairment, caring for a partner, and mobility problems. Loneliness and mental well-being were raised as significant issues:

- *There is no-one to turn to when I am low (Female 76 years)*

- *Having recently been widowed (and very depressed) I was looking to what future existed for me (Male 77 years)*

One person was not impressed with the length or content of the questionnaire suggesting it would not contribute to understanding how services for the elderly can be improved.

Others offered positive responses regarding the help they had received:

- *When I needed help I found that it was quickly forthcoming and I appreciated the kindness of spirit.* (Adur & Worthing, female 79 years)

- *Thank you for caring about the older citizens……...Being under stress I was able to talk to someone and felt so much better.* (Arun, female 85 years)

- *I have been looking after my husband for nearly 4 years. We have recently received Attendance Allowance. I have a few weeks ago got help one and a half hours a day. I am unstable and cannot go shopping now. I am grateful for the Attendance Allowance!* (Mid Sussex, female 89 years)

- Person who cares for his wife: *I cannot speak too highly of the way she [my wife] and I have been treated by all concerned, specialists, social*

workers, nurses, occupational therapists and physiotherapists. They have, without exception, been most helpful, pleasant and considerate to us both. And: *One of the factors which has eased our problems has been the fact most have come to our home rather than us having to travel to appointments when can be difficult and tiring when disabled* (Mid – Sussex, male 82 years)

- *I have had a visit from the CPT scheme and am very impressed……within a day or two I received meals on wheels, the fire service fitted new smoke alarms and the young lady brought a zimmer to use upstairs. I have a 3 wheeler downstairs. It is a great idea. More so for people who have no family at all* (Mid Sussex, female 92 years)

Follow-up questionnaires

The follow up Quality of Life questionnaire was sent to 22 people in Worthing and Adur in August 2008, 19 people in Arun in December 2008 and 6 people in Crawley in December 2008, 6 months after the baseline questionnaire. In total 21 follow up questionnaires were returned – a 45% response rate.

Characteristics of respondents

- Most respondents are female: 17 (81.0%). Of these, 8 (47%) are aged 85 or over.
- A high proportion are widowed; at follow up stage 61.9% (13) .
- Most respondents live in domestic housing: 18 (85.7%); the same number at follow up compared to baseline. One more person has moved into sheltered housing since the baseline interview, a total of 2 (9.5%), and one person was in respite care at follow up.
- At follow up 13 (61.9%) respondents lived alone.
- At follow up 18 (90.4%) respondents said they were receiving benefits
- At follow up, 11 (52.4%) were receiving Attendance Allowance, 6 (28.5%) were receiving pension credit and 2 (9.5%) were receiving council tax benefit for example.
- At follow up, household income per week was between £0 - £249 for 13 respondents and between £250 - £449 for one respondent. The remaining 7 respondents did not answer this question.
- 20 (95.2%) of respondents were White British
- 17 (81.0%) of respondents said they were Christian

Current Health and quality of life – comparisons baseline and follow-up

Taking baseline and follow up data for individual cases it is possible to compare current health and quality of life as stated by each person. Respondents were asked to rate their own health state on a scale 0 to 100, where 0 is the worst imaginable health state and 100 is the best health state imaginable. In respect of quality of life, respondents were asked to rate their quality of life as a whole.

Case reference	Baseline health scale	Follow-up health Scale	Change	Baseline QoL	Follow-Up QoL	Change
7	60	60	=	Good	Alright	-
15	30	35	+	Alright	Alright	=
36	40	50	+	Bad	Bad	=
49	25	Not ans.	?	Bad	Bad	=
72	60	55	-	Alright	Alright	=
83	65	60	-	Good	Good	=
86	60	60	=	Good	Good	=
87	30	35	+	Bad	Bad	=
90	75	60	-	Good	Good	=
91	0	0	=	So bad..	So bad..	=
113	90	90	=	V.good	V.good	=
123	25	40	+	Bad	Alright	+
141	60	60	=	Alright	Good	+
143	70	70	=	Good	Good	=
150	70	70	=	Alright	Not ans.	?
168	30	50	+	Alright	Alright	=
172	90	80	-	V.good	V.good	=
182	80	75	-	Alright	Good	+
183	50	50	=	Alright	Alright	=
201	50	40	-	Alright	Bad	-
219	90	90	=	Good	Good	=

Key: + improved
- worse
= the same

The responses to position on the health scale ranged from 0 to 90; at baseline 14 (66.6%) respondents rated their health at 50 or more on the scale and at follow up 15 (71.4%) respondents rated their health at 50 or more on the scale. At the other extreme one respondent rated health at zero, for baseline and follow up.

In respect of the health scale, 14 (66.6%) respondents reported their health was the same or better at baseline compared to follow up and 18 (85.7%)

respondents reported their quality of life was the same or better baseline compared to follow up.

In respect of quality of life, 16 (76.1%) respondents reported their quality of life was alright, good or very good at baseline and 14 (66.6%) respondents reported their quality of life was alright, good or very good at follow up. Again one person reported the worst possible quality of life both baseline and follow up.

Summary of health scale and quality of life:

	Health Scale	**Quality of life**
Improved (+)	5	3
Worse (-)	5	2
The same (=)	9	15
Not answered	1	1
Total	21	21

"Your Health Today" – comparisons baseline and follow up

Mobility

	Baseline:	**Follow up:**
I have no problems in walking about	5 (23.8%)	5 (23.8%)
I have some problems in walking about	15 (71.4%)	16 (76.2%)
I am confined to bed	1 (4.8%)	0
Not answered	0	0
	21 (100.00)	21 (100.00%)

Self-care

	Baseline:	**Follow up:**
I have no problems with self-care	9 (42.9%)	8 (38.1%)
I have some problems washing and dressing myself	11 (52.4%)	11 (52.4%)
I am unable to wash or dress myself	0	1 (4.2%)
Not answered	1 (4.2%)	1 (4.2%)
	21 (100.00)	21 (100.00%)

Usual activities (e.g. work, study, housework, family or leisure activities)

	Baseline:	**Follow up:**
I have no problems with performing my usual activities	5 (23.8%)	4 (19.0%)
I have some problems with performing my usual activities	11 (52.4%)	11 (52.4%)

I am unable to perform my usual activities	5 (23.8%)	6 (28.6%)
	21 (100.00)	21 (100.00%)

Pain/Discomfort

	Baseline:	**Follow up:**
I have no pain or discomfort	4 (19.0%)	6 (28.6%)
I have moderate pain or discomfort	13 (61.9%)	11 (52.4%)
I have extreme pain or discomfort	3 (14.3%)	4 (19.0%)
Not answered	1 (4.8%)	0
	21 (100.00)	21 (100.00%)

Anxiety/Depression

	Baseline:	**Follow up:**
I am not anxious or depressed	10 (47.6%)	12 (57.1%)
I am moderately anxious or depressed	8 (38.1%)	6 (28.6%)
I am extremely anxious or depressed	2 (9.5%)	1 (4.8%)
Not answered	1 (4.8%)	2 (9.5%)
	21 (100.00)	21 (100.00%)

These results show little difference between self-assessed health status at baseline and follow up. The main difference in respect of these aspects of health is ‘anxiety/depression’ where less people show signs of this at the follow up stage, and show signs to a lesser degree. However, the numbers of people for whom we have comparative data at baseline and follow up is small and thus we are unable to say whether these results are statistically significant.

Service Use in the last 3 months

Visits to hospital and use of services at the local surgery or health centre remained similar baseline compared to follow up with one exception. At baseline, only one respondent reported seeing a chiropodist at the local surgery or health centre; 4.8% (At follow up, this rose to 66.7% (14).

In respect of services at home:

- 6 people (28.6%) of respondents received meals on wheels at follow up compared to baseline; 1 (4.8%)
- Less respondents reported receiving homecare/home help at follow up; 2 (9.5%), compared to baseline; 5 (23.8%)
- Many more respondents reported having physiotherapy at home at follow up; 16 (76.1%) compared to baseline; 3 (14.3%).

- More people used the home library or mobile library service at follow up; 6 (28.6%) compared to baseline; 1 (4.8%).
- One more respondent had a personal alarm.

Although the numbers are small and it is difficult to draw conclusions, it appears that more people are receiving meals on wheels and social work support at the time of the follow up. More people are using services at home such as a mobile library and the services of a physiotherapist.

A few people were disgruntled about having to pay for certain services, including a lonely and depressed 86 year old woman who had to pay for meals on wheels, and another woman who was advised by the CPT that she would have to pay for help at home *"They [social services/CPT] are a waste of time. I need some support".* (Female 78 years).

In respect of *leisure and transport,* it would appear that less people are using day services and lunch clubs at follow up compared to baseline. This may be partly explained by the problem of transport mentioned by people during the interviews. However, more people are using organised transport to health services and hospital appointments.

Help from friends or relatives

- Less respondents received help from friends or relatives with housework and laundry at follow up; 7 (33.3%), compared to baseline: 12 (57.1%). This may be due to the greater take up of benefits such as Attendance Allowance, whereby people are able to purchase help at home.
- Fewer respondents have had friends or relatives stay off work to help them at follow up; 2 (9.5%) compared to baseline; 4 (19.0%).
- More respondents have had friends or relatives help them prepare meals at follow up; 9 (42.9%) compared to baseline; 7 (33.3%).
- More respondents have had friends or relatives help them with personal care at follow up; 5 (23.8%) compared to baseline; 2 (9.5%).

Activities/involvement

Activities and involvement have largely remained the same at baseline and follow up with people still involved in activities they were involved in at the time of the baseline questionnaire, including church related activities, gardening and socialising with family, friends and neighbours.

Additional comments made on the follow up questionnaires indicate that mobility problems and transport are a significant issue for some people, for example:

Being partially sighted it has not been easy for me to complete this questionnaire. Even posting this presents a problem. Walking to the pillar box is a challenge!

I have found great difficulty in finding an outlet which will provide transport. Commercial transport and other drivers are not often co-operative in leaving vehicle to mount two flights of stairs to transport my walking frame and stay with me while I descend. My opportunities to leave the flat are therefore very limited.

Interviews – Baseline and Follow up

This table summarises the age and gender characteristics of the 44 people interviewed at *baseline*:

	Under 60years		**60-64 years**		**65-74 years**		**75-84 years**		**85+**		**Total**		**Total:**
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	
A&W	-	-	1	-	-	1	1	2	1	4	3	7	10
Arun	-	-	-	-	-	1	-	2	-	2	-	5	5
Crawley	-	-	-	-	1	1	1	4	1	2	3	7	10
Chichester		1	1	-	1	-	-	1	-	-	2	2	4
Horsham	-	-	-	-	1	-	1	3	-	1	2	4	6
Mid-Sussex	-	-	-	-	-	-	1	4	-	4	1	8	9
Total:	-	1	2	-	3	3	4	16	2	13	10	34	44

Please note: the age given is that recorded at baseline.

This table summarises the age and gender characteristics of the 16 people interviewed at *follow up:*

	Under 60years		**60-64 years**		**65-74 years**		**75-84 years**		**85+**		**Total**		**Total:**
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	
A&W	-	-	1	-	-	1	1	1	1	3	3	5	8
Arun	-	-	-	-	-	1	-	1	-	1	-	3	3
Crawley	-	-	-	-	-	1	-	2	1	1	1	4	5
Total:	-	-	1	-	-	3	1	4	2	5	4	12	16

Please note: the age given is that recorded at baseline.

Contact with the Community Partnership Team (CPT)

Interviewees described positive experiences of contact with the CPTs. For example:

> *I thought it was a good idea. Particularly having somebody to sort of show you the works kind of business.* (Female 84 years)

The son of one 86 year old woman said "*I was very impressed. Really impressed that the service had come into being and Mum could benefit from it".* This carer added that new smoke detectors, a key safe and personal alarm had been organised via the social worker on the CPT whom he was very impressed with.

One person (Female aged 92) said her son rang the CPT for her on a Saturday and left a message. They called back on Monday and visited her. They brought a walking frame for her, organised for the Fire Service to do a safety check and did the smoke detectors. The CPT also put her in touch with an agency to do some housework for her: *"I get it done for £10 an hour".* She is thrilled with the agency and the information the CPT gave her. *"There are lots of things I can't do at 92! They were really wonderful. I wouldn't be without them. It has made a difference to me".*

Many people were unaware of the service until they came out of hospital or their GP or District Nurse referred them or persuaded them to contact their local CPT. They were also impressed that contact with the CPT also meant they were 'signposted' to a whole range of other services as well. This has improved access to other services and encouraged people to apply for Carers Allowance and Attendance Allowance. The input from DWP workers was very well received by a number of people. Some responses indicated surprise at the help that was available:

"Well we were surprised because the whole thing had opened up a big window to help that we knew nothing about. We just carried on, at our time of life; we didn't expect to get help from anybody you see. We thought…. if help was coming it would be routed through the doctor you see" (Male 88 years). *"We weren't aware of what we could get. They suggested it. [The CPT] I think they are doing a really professional job."* This person was supported to claim a Carers Allowance and Attendance Allowance for his wife.

> *I was gob smacked that the whole force of the surgery got going and this other lovely section [CPT] got going and I really was being cared for.*
>
> *I can't believe that when I needed help it was 'voomp', right there.* (Female 88 years)
>
> *It was all a learning curve. All unexpected. I didn't know what I would receive.* (Female 95 years)

Although we have limited statistical evidence of health improvement the accounts of some older people indicate the value of the service to them and the impact this

has on their well-being. *"It makes you feel much safer and now I can just pick up the phone"* (Female 88 years). With a little bit of help, advice or information people feel 'safer' and able to cope and maintain a level of independence. They are reassured because they know they can contact their CPT when they need to and that the CPT staff are kind and supportive.

One couple were afraid they would not be able to manage at home because of their health problems. *"We didn't know what we were going to do. They were fantastic. We now have a nice little bungalow and we are so happy. The CPT gave information and advice about finances and moving home and put them in touch with the local council."* (Female 68 years) At follow up she added: *"Yes! We are still in touch with the service. We are happier each day. Super!"* This couple were given advice and information and signposted to housing services to help them move to more suitable accommodation. This has enabled them to cope. In addition to this, she now gets a carers allowance and her husband (70 years) gets Attendance Allowance.

One 84 year old woman was referred when she left hospital. She was depressed and needed some help at home which the CPT organised for her. She also cares for her partner and commented about the service: *"It's a godsend. If I need anything they are there. I don't feel so isolated"* . She also commented that she is lucky to have a supportive family but is quite sure the service is vital for people who have no-one else to help them or advise them.

Other responses demonstrated the reluctance of older people to seek help:

"We're the old school. We're independent. We don't shout" (Male 90 years) The man cares for his wife (89 years) and has health issues himself. He has the CPT telephone number if he needs it.

"We manage" (Female 77 years). *"They [the CPT] were extremely helpful. Wanted to visit us".* She explained to them that her husband would not want to claim anything, but she needed transport to get to hospital.

Perhaps one reason that older people do not know where to go for help is that the main problem they experience is loneliness:

> *The whole problem is loneliness. I don't need looking after I just need company* (Female, 89 years)
>
> *My main problem is I need more contact with people. I'm living in isolation.* (Male, 64 years)

In a number of cases the problem was about knowing who to go to for help and being very uncertain about what kind of help might be available. One 81 year old woman described the problems she faced at home everyday as ones that could

not be covered by one service. She said she was getting confused about which medicines to take and was feeling lonely. She wanted the kind of companionship that was hard to describe to a stranger. She summed it up by saying: *"I get low on my own".*

3. Conclusions

It is difficult to draw quantitative conclusions from the questionnaire and the interview responses because the individual stories and experiences are unique and the overall numbers are small. In view of this, comparisons have not been made between CPT areas. The comments made by individuals are important and demonstrate the range of experiences and the range of ways the POPP project and the work of the individual CPTs has had a positive impact on older people.

Evidence concerning the age and circumstances of those referred to the CPTs confirm observations that they constitute a much needier group than had been anticipated. By and large they were older and more likely to be in receipt of services than members of the CPTs had originally anticipated. A majority reported health and/or mobility problems and problems of self care. In this context, there was little evidence of improvement in health status or quality of life amongst those competing questionnaires. However, individual interviews suggest the positive impacts of the service were insufficiently captured by this questionnaire. Similarly, although there was limited evidence of increased service use from questionnaires, interviews identified a number of ways in which people had been put into contact with services they had not known about before. But there was little evidence from this data that older people were being enabled to take a more active part in their local communities.

Some of the stories told suggest that access to these services may also have an impact on their families and carers who had previously provided a lot of support. Increased take up of Attendance Allowance is starting to enable people to get some domestic help at home and thus relieve carers from undertaking this work. Issues such as loneliness, social isolation, professional bereavement support, transport to social activities and health appointments, and transport with an escort remain important issues for people. This may reveal either access problems or potential gaps in services in some areas.

Chapter 4

The Neighbourhood Networks: working with communities

1. Background

The Neighbourhood Networks became operational between March and September 2008 with most starting in March/April. Not all Neighbourhood Network staff were in place at this stage and in some areas staff were still being appointed in the late autumn of 2008. The evaluation was funded for two years from June 2007 and was concluded by the end of June 2009. At the time of writing POPP funding has been extended to March 2010 but the follow up stage interviews for the evaluation were conducted between February and June 2009. This gave a limited period of time for some of the Networks to be in full operation before the final stages of the evaluation were conducted and this impacts on findings.

2. The evaluation process

Our approach to an analysis of the Neighbourhood Networks (NNs) was again based on theory of change evaluation. We drew on two main sources of evidence: individual interviews with neighbourhood network member organisations and co-ordinators and group interviews with community engagement worker teams. We did not consider the role of other staff who were part of the networks primarily the business development officers, fundraisers and the publicity staff although their role and involvement were referred to in interviews with neighbourhood network members and community engagement staff.

We undertook a baseline set of interviews with Neighbourhood Network members in all seven areas as the networks came on line. We were able to interview more people in some areas than others at this stage but since key individuals and organisations were involved in more than one network we were able to develop a broad view of what was happening across the county.

At follow up stage (6-12 months after implementation) we followed up network members in Worthing, Crawley and Chichester. In Chichester due to the lateness of implementation we were only able to conduct one set of interviews.

We worked with all but one of the Community Engagement Worker teams at baseline stage and developed a theory of change statement with them which documented how they planned to work and what their aims were. We followed up

with the Community Engagement Workers (CEWs) in Worthing, Crawley and Chichester. Time did not allow us to make contact with individuals that the CEWs had worked with in the community.

The complexity of the commissioning and implementation process resulted in delays in staff recruitment in some areas. This, plus limits on evaluation resources, meant we were not able to undertake detailed data collection in all seven areas. In discussion with the commissioners of the evaluation it was decided to concentrate the follow up stage on Worthing, Crawley and Chichester, which included urban, rural and coastal area experiences. Efforts were made to ensure the inclusion of key organisations involved in a number of networks to explore differences in operation across the county.

The first section of this chapter presents findings relating to the Neighbourhood Networks as a whole, including reflections on implementing a new model. This is followed by a section where we consider the work of the Community Engagement Workers. In order to protect the anonymity of participants we present findings thematically rather than by NN. Where quotes are used they may therefore relate to a post, a kind of organisation or an area but not to an individual. The views expressed are those of organisations involved in the networks and the staff employed to develop the network, they are not the views of older people involved in the network or receiving services.

3. The Neighbourhood Networks

In some areas the Neighbourhood Network Co-ordinator (NNC) post is divided between two and even three staff. Most but not all of those organisations interviewed were also contracted to employ POPP staff including Neighbourhood Network Co-ordinators, Business Development Officers, Fundraisers, Publicity officers , administrators, Community Engagement Workers and in some cases CPT Community Link Workers as well. (Some of the organisations are also involved in the Health Trainers initiative and employ staff including those dedicated to working with older people.) Where organisations were employing staff in more than one area some had also recruited staff within their own organisation to support and manage the POPP staff employed across the county.

Interview findings are presented in sections covering the aims and expectations that organisations had of their involvement in POPP, what they were doing to implement the model, how they saw the benefits and challenges to their organisations and the outcomes they envisaged for themselves and for older people.

Aims and expectations

Organisational

There were common reasons for wanting to be involved in POPP across all organisations. Those with general interests in older people like Age Concern, with interests in specific issues affecting older people such as the Alzheimer's Society or 4Sight, as well as more 'generalist' organisations such as Councils for Voluntary Service (CVS), Citizens Advice Bureaux (CAB) and issue specific organisations such as Anchor Staying Put all saw a clear fit between the aims of POPP and the aims and objectives of their organisation.

All voiced a commitment to ensuring the needs of older people were correctly identified and to developing services to meet those needs. Organisations were aware of gaps in existing services and some had previously provided services that had met those needs for which funding had now ceased. They wished to make their own services more available to more older people, and where appropriate to promote their own presence as a specialist organisation. Thus, many hoped that POPP would add value or increase the effectiveness of work they were already engaged in or that they had already identified as development targets. It was an opportunity to increase the funds coming into the sector and provided opportunities to generate long term work and funding for the organisations concerned.

Being part of the POPP partnership was seen as an opportunity to raise the profile, value and influence of their organisations and the communities they were part of and for county wide, regional and national organisations as a way to increase local involvement.

Services and Voice for Older People

The organisations were seeking to achieve the following benefits for older people;

- To increase the numbers of older people being helped
- To meet low level and practical needs on a day to day basis
- To increase older people's knowledge of what is available

  I think it is that older people have more resources to tap into and know where to go and that they know there is a body out there who can help them individually or as groups.

- To increase financial help
- To provide access to a comprehensive service through joined up working around neighbourhood and individual work

Older people need to be able to get a comprehensive service somebody with a low level need that might be answered by a volunteer popping in once a week may also need a chiropodist or have an issue with a pension

- To be able to access more help than POPP can provide speedily and effectively
- To facilitate the voice of older people and develop a variety of mechanisms for them to make their voice heard

Partnership

Organisations anticipated that working in partnership with others would build strong local relationships and networking. They hoped it would bring voluntary sector services together, making them easier to understand, avoiding duplication and enabling them to complement rather than compete with each other. They wanted to share knowledge and expertise and be in a forum where they could hear about and be able to disseminate information and knowledge to their own client base.

Improved partnership working with others was seen as a way to facilitate the voices of local organisations to be heard and for their particular contribution to the health and well-being of older people to be recognised and valued, particularly where it did not relate directly to provision of health or social care services. They hoped it would develop links between large and small organisations in the neighbourhood and strengthen and develop the really good organisations that already existed.

They also saw it as an opportunity to build relations with the statutory sector and to highlight the voluntary sector contribution to partnership working:

to give statutory agencies particularly ones we are not engaged with a really positive experience of working with the voluntary sector... an opportunity to break down those barriers and help people get an understanding of the benefits to their clients of us working together

Follow up interviews

At follow up there was a feeling amongst most organisations that these aims were being met. Voluntary organisations were experiencing better partnership working and were very positive about how the Neighbourhood Networks were developing and their involvement in them. They saw evidence of enhanced services for older people, increasing engagement of older people in community

activities and new older people becoming involved in the Older People's Reference Groups (OPRGs).

In two of the three areas partnership development seemed to be more advanced and more broadly inclusive of the range of interested organisations. In both these areas the development of the POPP partnership had been facilitated by existing partnership working around older people's issues.

Specialist organisations who had contracted to employ POPP staff felt that they had improved their ability to develop their services and skills and to integrate more with other providers to mutual benefit.

However, some organisations had been disappointed. A few felt that their own services were not benefitting from increased usage. In some cases they felt sidelined within the partnership, in others they felt that too much was being developed 'new' without sufficient reference to what was already being done or to existing knowledge. Some concern was also expressed about the needs of individual communities and how that was not being fully recognised or responded to appropriately. But there was also evidence that both these areas of concern were being addressed and thus these dissatisfactions might be anticipated to reduce.

Implementing the model

In the early stage interviews it was clear that organisations were focused on the operational tasks of tendering, recruiting and employing staff and ensuring they were properly supported and inducted into the POPP framework. They were negotiating appropriate community based locations for community engagement and other staff and developing operational structures within their organisations and across the contracting organisations.

Work was also underway developing the NNs either out of the bidding partnerships or working with an existing network. Neighbourhood Network Co-ordinators in particular were recruiting, setting up and supporting the development of the Older People's Reference Groups.

All areas were undertaking a Gap Analysis mapping exercise to establish a base line of what was already available within their network areas and seeking older people's views on gaps in services and activities.

Neighbourhood based staff in post at this stage were making contact with groups, starting to recruit volunteers and starting to develop new groups and activities within their communities.

Follow up interviews

Although most of the Networks were fully operational at the follow up stage significant issues were still being worked on.

The contracting organisations had all their staff in post, but sorting out how staff were managed and supported where there were multiple employers had been complicated. Those interviewed felt that it had taken significant time to develop ways of working, line management structures, and to ensure that teams could develop. In the areas where most of the NN staff were employed by one organisation and in particular where the NNC managed the CEWs there was evidence that the work was developing faster. Organisations had struggled with some of these issues but had come to some good resolutions between themselves. They felt that this had delayed implementation and given them less time to show real results.

Some of those who employed a number of staff either within their own organisations or across a number of areas had had to create infrastructure posts to support the POPP staff and these were starting to become effective. Organisations who were employing a number of different POPP staff including neighbourhood staff, business and fundraising staff and CPT staff were finding that they were developing a much better understanding of how the overall POPP model was intended to work.

The partnerships were developing, but in the post tendering stage were having to address some real working issues. There was the disappointment of unsuccessful bidders to deal with but also the different ethos and aims of organisations involved. Some organisations were focused on the empowerment agenda whilst others wanted to focus on services and partnerships and were working hard to try and keep their overall aims in mind whilst meeting the targets that were set. There were concerns about the unrealistic timetable and what they would be able to show as achievement by the end of the pilot.

There were examples of how organisations were developing linkages into organisations they had had no contact with before, particularly Black and Minority Ethnic (BME) organisations and with other structures within the broader health and well-being agenda, particularly the Local Strategic Partnerships (LSPs) and their sub groups including Healthy Area Partnerships.

Benefits and Challenges

Organisational

Even at the first interviews organisations could see benefits to being involved in POPP. They had seen some skills development both through the tendering process and in the workers they had taken on or existing staff involved in the

project. The experience of tendering had been a steep learning curve but had generated transferable skills for future tendering processes. One organisation had successfully applied for a quality mark on the basis of work done for the tendering process.

There was an excitement in being involved in a collaborative way of working with new partners or with existing partners in a more focused way. Organisations were learning about issues faced by both large and small organisations and those who were from county wide or regional or national organisations were finding a route to keep up to date with what was happening in each POPP area.

Organisations that had previously undertaken the type of work being developed by POPP were seeing what they had worked for gaining a higher profile and become more valued. Key staff were developing operational links and the Gap Analysis was providing a way of mapping what was happening and considered likely to reduce duplication of effort.

However, interviewees were concerned by the complexity of the model and how the employing arrangements were working out in practice. Different employing organisations had different ethos, priorities and ways of working. Some key roles were shared between a number of individuals in different organisations and some across geographical boundaries. This created difficulties for the management and direction of staff and, where they were not co-located, for their development as a team. There was some difficulty understanding how all the roles in the model fitted together and some of the community based staff found the lack of clarity around roles difficult to deal with.

The varied backgrounds of staff were seen as positive but meant that it took time for them to settle into working groups and understand each other's ethos and ways of working *"not all talking the same language"*. There were high expectations of the community based roles (CEW and CLW). They were not considered to be well paid but people were expected to bring a lot and deliver a lot. The issue of training for community based staff was considered to be important.

Interviewees felt that issues to do with Health and Safety, Insurance and Criminal Records Bureau (CRB) checks had not been fully thought through. Organisations reported that insufficient funding to meet these requirements was holding up staff and volunteer recruitment. The process of CRB checks in particular was causing long delays and there was a feeling that this could have been better supported by the County Council.

There were management issues where organisations had capacity problems covering all the work and in some cases having to increase the infrastructure within their own organisation to support the POPP staff.

For those organisations that had been unsuccessful in the tendering process there was uncertainty about how to ensure they were still included in the bigger process if they were not employing POPP staff.

Services and Voice for Older People

Where the networks had been operational longest organisations had a sense that they were starting to improve existing services, to expand services and to extend their reach to older people. Some gaps in low level prevention work were being recognised in a way that facilitated action:

> *It's been a catalyst to help people understand the idea of prevention, actually much better to do something now before you have to.*

Whilst Older People's Reference Groups were setting up and in some areas existing forums were seeing new older people beginning to get involved interviewees expressed some uncertainty about how to develop effective OPRGs and whether older people would see the value and want to take the lead in the groups. Some organisations hoped to see benefits to their users becoming more involved with mainstream community activities via developing support services. But there was also concern about raising expectations and interest in volunteering and services and the challenge of supporting increased demand at the end of the pilot. There were limited numbers of volunteers in evidence at the early stages and organisations were questioning whether it was realistic to look for a lot of older volunteers.

Partnership

Interviewees anticipated a better understanding of the roles and interests of key players in the sector and raised awareness of the needs of specific communities. Those organisations that specialised in particular needs like dementia or sight problems felt that they had an opportunity to bring their understanding and expertise and contribute to the other organisations, both by working with them within the Neighbourhood Network, and by employing POPP staff who could bring that expertise into the operational staff teams both in the NN and the CPT.

Relationships were developing and some of the smaller organisations felt that being part of the Network increased their capacity to have an influence on developments.

> *POPP is about making meaningful relationships and links on whatever level*

But interviewees also felt there had been a significant lack of understanding of the voluntary sector as an existing service provider that could adversely affect collaborative working:

> *they (*those developing POPP*) needed to consult the service providers who are already out there to see what people need, I know they did ask the older people but then did they ask the voluntary sector what they could provide and then say okay so that's what you're providing but this is what we want, now can we come to some negotiation about what you can provide or how you might adapt your services to meet our need. There is this misconception that the voluntary sector is living in the past and it's absolutely not true we are changing and improving our services all the time*

> *maybe if they* (those developing POPP) *had done a bit more research they could have seen what organisations were doing already and it wasn't actually necessary to set up a whole new structure*

However, most interviewees felt that the Networks had made a positive start and all had enthusiasm for the work. Some very good working relationships already existed between organisations and some new ones were being developed. It was commented in one area that the Network had enabled historic breaches between voluntary organisations to be healed and that organisations were now committed to working together.

The early stages of the partnerships had demonstrated that there was a lot to learn about each other as organisations *"different backgrounds, different expectations, a bit of competition"* and how to ensure that partnership working was equal between potentially competing organisations. Many smaller organisations had not wanted to take on responsibility for tendering and there was work to be done to ensure that smaller organisations would get involved and could see a benefit of being involved.

Interviewees reflected on the need to ensure that the NN had a broad base, was inclusive and developed its own identity. Some of the larger organisations acknowledged that they spoke the *"statutory language"* to some extent and that the Network needed to represent all voices in the sector. There was an early recognition that the size of organisations had an impact on how much involvement they would be able to sustain in the Network, and that the larger organisations and those employing staff would have more information, time and influence. However the importance and benefit to the smaller organisations of being involved at an appropriate level and being kept informed was significant.

The tendering process had created problems in the early phase of partnership working. It was suggested that the County Council had been insufficiently aware of the divisiveness of a competitive tendering process in terms of impact on

voluntary sector organisations: *"They are wanting us to work in partnership but putting us in a position of direct competition".* Tendering was a new process to many organisations that had previously been funded through grants:

> *grant funding never felt competitive because everybody put their bids in isolation and the powers that be made the decision with tendering it's much clearer that this is a competitive process and within the sector we may not necessarily have the skills to manage that process properly*

The tendering process required a lot of time and hard work from organisations. It was a lengthy process with a number of delays. There were concerns about the way tenders had been advertised and tendering for posts at different stages in different areas was difficult for organisations bidding in more than one area. Many felt that if a simpler process had been used they could have been up and running much earlier and spent more of the money on delivery. Not everyone felt that the awarding of contracts had been fair and some questioned why contracts could not have been directly commissioned rather than competitively tendered. County wide organisations bidding in more than one area had to tender for each post in each area and negotiate through a number of consortiums.

It was clear that many interviewees felt that not enough time or understanding had been given to the benefits and problems of developing effective bidding partnerships. Comments were made about the tensions between developing partnerships to bid that gave strength in numbers and how to keep a balance between strong partners and between county wide and local interests. There was an expectation that consortium bids would be accepted in total and where only some parts of the bid were accepted this had fractured partnerships that had otherwise started to develop.

Follow up interviews

At follow up there had been significant learning opportunities for the organisations involved. They valued what they had learnt although the process of learning had not always been easy. Being a pilot had given a sense that they could try things and experiment, although many were mindful that any future model might be more prescriptive. A number of organisations felt that the learning had strengthened them through the development of improved structures, systems and policies. This was specifically true for organisations that had contracted for a significant number of staff.

They could see some benefits coming from raised profiles for their organisations and the work they specialised in. Their staff groups in many cases had expanded and there was a general recognition of the positive contribution that the varied skills of POPP staff across the board was making to the whole project. Some organisations had identified a need for community based workers and this was

being met. Many felt that they were gaining a much clearer picture of grass roots activity and how they might support this as a result of these posts. Organisations working with more specialised areas like dementia reported an increase in requests for the training they offered.

There were still a number of challenges in relation to developing teams where workers were not employed by the same organisation, and ensuring effective lines of co-ordination and communication. In some areas the operation was still a bit disjointed but where staff had been in post longer it was improving. There was particular feedback about the importance of the NNC role as a key link role between the community and the Network and how that link did not function as successfully where the management of these two groups of staff was not within the same organisation.

In terms of partnership development there was a sense that new layers of relationships were developing. There were the existing strategic level relationships but management and operational level relationships were also developing between organisations which were helping to identify shared client groups and interests. In Worthing a network within the Network was developing of organisations involved in working with dementia. This was proving an excellent forum for a range of organisations to meet and discuss their work and aims around this client group. Individual relationships and connections were developing between network member organisations where there was a shared interest in a particular project or area of work. The involvement of significant BME organisations in the Crawley network was enabling access to their communities for some key organisations that had not been possible before. The BME organisations also cited benefits of having dedicated neighbourhood workers with responsibility for their communities who were developing strong relationships and building trust.

But working in real partnership rather than competition continued to be a challenge *"Partnership working is not to be underestimated"*. Organisations still felt work was necessary to ensure that decisions and discussions were open to all who wished to be part of them and that smaller groups were encouraged to stay involved. And interviewees also reflected on the importance of ensuring that the role of NNs was understood in a broader context as well as in the context of POPP.

From the NN perspective there had been operational problems in developing the links between the two elements of the POPP model: the CPTs and the NNs. There had been difficulty in some areas getting to grips with the difference between the CLW and CEW role. Where one group of staff had started quite a while before the other there were instances of staff having moved into areas of work that were not 'theirs' as there was no one else to do it and then having to withdraw. This had caused some confusion for older people in the community and some unhappiness amongst staff. Steps had been taken in a number of

areas to clarify these roles and make strong working connections between the two groups of staff and these were showing benefits. One area had a buddy scheme between the two groups where the workers kept each other informed about promotional activities and shared visits to groups.

The strength of the links between CPTs and NNs varied across areas. The main role connecting the two within the POPP model is the NNC and where this individual had a good and regular working relationship with the CPT links were developing well and problems were able to be resolved. Two key issues affecting these relationships were raised by both CPT and NN staff: firstly, a sense that the voluntary sector was not seen as an equal partner in the CPT teams, and secondly, that CPTs do not have a 'lead' through whom links might be facilitated.

A number of interviewees felt that as time had gone on and more activity was happening on the ground, real challenges were starting to become evident in ensuring that existing services were not being ignored, duplicated or left vulnerable as new service developments were being considered. We have noted that a number of the posts in the POPP model overlapped with posts and projects already in operation in parts of the county and there was strong concern about whether voluntary organisations would end up losing community based resources as a result of the pilot. Connected to this was an issue of standards where existing services had quality marks and where a similar service was being set up and run differently. There was concern that if standards were not similar then any failure could reflect badly on existing services.

Outcomes

Despite what seemed like some major challenges getting POPP operational, NN interviewees identified significant outcomes that were starting to emerge.

POPP was seen to have created a context in which additional resources had enabled not just the support of more groups, but also a start to tackling some big issues. For example, there was evidence that voluntary organisations were working together and even creatively pooling resources around issues like transport, and a Conference on Dementia was about to take place which was generating considerable excitement.

Some felt that older people's issues were achieving a higher priority, although it was uncertain whether this would be sustained:

> *actually it has changed the landscape of older people's services in the town whether we sustain that if there was no more money it probably wouldn't take long to revert to what it was but it has changed the landscape*

Work in the community was engaging with older people who had not been seen before. Interviewees felt that more older people were accessing services provided by their organisations, although there was still a long way to go. Work with BME communities was offering older people from these communities access to different kinds of services. The dedicated staff working with these communities were also building an understanding of how those communities were ageing and of the impact of cultural priorities around care within families within these communities.

Across all the areas there had been good promotional events where the POPP teams had enabled smaller organisations to come together to promote and publicise their groups and there was evidence that a small amount of help from neighbourhood staff was impacting on the sustainability of existing groups.

There was evidence that more voices were being heard through the development of the Older People's Reference Groups and by linking these with existing or developing forums. In Chichester the network was looking at how it might use technology to enable people in more rural areas to take part in meetings through video conferencing.

There were many examples of different ways that the networks were supporting the development of services and opportunities for older people. There were some that stood out as an illustration of the creative thinking that was going on and how networks were responding to the needs they were becoming aware of, for example:

- ideas for developing an intergenerational playground
- working with Chichester University to support older people to learn research skills and then asking them to evaluate network events
- responding to specific needs of more isolated older men around developing cooking skills
- encouraging different kinds and levels of volunteering, including matching up older people with existing skills and interests like cooking and reading aloud with other older people for whom these were no longer possible
- discovering what people had enjoyed when they were more active, e.g. rambling, and then putting together a series of supported town walks where people could enjoy a previous interest at a level that suited their age and mobility.

The contracting organisations in particular were seeing the development of skills in their organisations from having new kinds of staff, undertaking work they had not previously been involved in and having more levels of their operational staff involved with neighbourhood networks and organisations. Having new staff had also brought opportunities to develop policies around lone working and Identity Cards and that learning could be passed on to other organisations.

Those who were directly involved with CPT staff were also clear that the CPTs were providing a service that had not been available to older people before.

There were fewer perceptions of positive outcomes amongst those who thought the services they offered were being negatively affected by POPP and by other newer developments. Despite this there was a strong commitment to staying within the network and working with others to achieve the best results for older people.

All felt that there was still some way to go before it was possible to say that the needs of older people were being met but it did already seem that there would be significant benefits to older people coming from the co-ordination of services.

> *I think it's too early to assess whether it is meeting the needs of older people. What it is doing well is co-ordinating voluntary organisations to look at addressing those needs.*

Overall most had valued their involvement in the pilot despite the challenges;

> *I think the whole exercise has been quite positive and I think the learning curve that everybody has been through has been challenging but brilliant because there have actually been steps forward*

> *I think a lot of valuable work has been done, and it's been worth it, and the money put into it has been well spent. It seems a shame that those people who are so good at their jobs have only got the job for a limited time*

Reflections on implementing a new model

Some issues were raised that concerned the POPP model and how it was working more broadly.

The seven network areas include urban, rural and coastal areas, some encompass both urban and rural areas and Chichester has all three types. Those in the more rural areas emphasised the need to recognise that rural and more remote areas might have required a different approach to what was seen as an essentially urban POPP model which everyone understood as having been developed out of work in Worthing. There were also comments about the need to recognise what older people see as their local community and how the presence of a number of smaller town or village communities within a larger area would impact on the development and delivery of services and engagement.

There were concerns that using the same model in each area did not necessarily fit with existing ways of working. In some areas there were already well developed partnerships and organisations with existing roles and projects funded

to do work similar to some of the POPP roles, particularly the community based and fundraising posts. It was felt that more attention should have been given to what already existed. In some areas partnerships had to rename and organisations had to curtail services in order to allow the POPP model to be developed without duplication or confusion. This overlap with existing structures delayed process while people decided whether they were prepared to work with it. Some very independent groups took time to buy into POPP and to see the benefits of being involved particularly if they saw it as taking what they considered to be their work or if they thought everything was working well already.

There was acknowledgement that the POPP model was a good idea but many were not sure that enough thought had been put into how it would be implemented

> *a lot of blue sky thinking was done when the bid was written but not actually reality or expert or experience of doing it*

Many were also concerned about how much older people would understand it and the need to ensure that they did not feel part of an experiment

> *you have to be careful in how you approach people they can feel they are being bombarded with people knocking on the door saying are you alright?*

Many commented on the lack of involvement of the District and Borough Councils and suggested the model made little reference to how it fitted with their local services and initiatives. Many organisations had existing relationships with District and Borough Councils and a number worked alongside them in Local Strategic Partnerships and Healthy Area Partnerships. Interviewees were aware that most District and Borough Councils had some community development resources and other services designed to support older people staying in their own homes. Crawley Borough Council in particular as a New Town council had historically committed substantial funding to the voluntary sector and had substantial involvement in development work. The lack of involvement of the District and Borough Councils was seen as a missed opportunity to develop partnership working, not helping delivery on the ground and causing confusion amongst partners.

The Neighbourhood Network Co-ordinator role was singled out as key to the development of POPP. The role was seen as crucial in being a source of information and support to smaller groups in the Network, and in being a key link between organisations within the network, between the Network and the Older People's Reference Group and between the Network and the CPT. It was felt that this role was not usefully shared between different organisations as it reduced the ability to act as this link. In areas where there was a close

relationship with the CEWs this role was at its most effective and whilst people did not disagree with different organisations employing staff they did feel there needed to be a clear relationship between the neighbourhood based staff and the NNC since they created more impact as a group acting together.

Interviewees suggested that the fundraising support was meeting an important need for smaller organisations who could not afford to provide it for themselves. Most saw this role as one that fitted most closely with CVS responsibilities and in some areas it overlapped with the existing community based fundraisers.

The CLW role was seen as *"the missing link"* and a role that the voluntary sector had previously played *"the voluntary sector can do this role so well in fact the CLW is going back some of the roles the voluntary sector used to have".* There were concerns about the confusion between the CLW and the CEW roles but as teams on both sides of the model became better established these confusions were being sorted out. As people became more familiar with the model as a whole they understood that the roles were substantially different but some felt that there should have been better guidance in the early stages of the pilot as to how these two posts would complement each other. Concerns were expressed about the lack of valuing of the voluntary sector contribution to the CPT and a lack of equality between the partners within the teams. Many also felt that the approaches and ways of working were very different, *"so we come with 'what can we do?' and others come with 'what's the reason why we shouldn't see that person?'"*

4. Community Engagement Workers (CEWs)

A theory of change statement (ToC) was developed with four of the CEW teams in Worthing, Adur, Arun and Crawley and an initial meeting took place with the team from Mid Sussex. No initial work was done with Horsham or Chichester due to the time constraints of the evaluation and because staff were not in post. The ToC summarised how the staff wanted to work and what they thought were going to be their activities and challenges. The groups were followed up in Worthing, Crawley and Chichester although the whole group was only present in Crawley. The reflective diaries completed by some of the workers in Worthing and Crawley added context to the interviews and indicated the kind of work they were doing and what they saw as their achievements.

Theory of change statements

There was a lot of commonality between the theory of change statements indicating that the Community Engagement Workers shared understanding of the task ahead of them and how they wanted to go about it.

They saw as their main objectives;

- Identifying gaps in services and working with expressed needs of older people
- Developing new groups and opportunities for older people to interact
- Networking existing groups and helping them promote themselves
- Increasing volunteering amongst older people
- Promoting intergenerational work
- Accessing and working with the more lonely and isolated older people
- Creating a profile for themselves and their work

All the teams were aware that there would be different stages to achieving these objectives.

In the early stages they saw themselves mapping what was already available and getting to know the groups that were out there. They saw themselves asking about needs through questionnaires, talking to groups of older people and through linking up with other community based workers like Police Community Support Officers (PCSOs). Developing their profile was also important and they had looked at how they might use publicity and community events not just to seek views but to develop an understanding of their role. They also expected to start some new groups and to encourage some volunteering.

As the work developed they expected to have to consider more complex issues relating to the area in order to develop awareness of the nature of the area and how this impacted on what older people might need and want to do. This would include understanding the geography: were areas split by rivers or major roads? were there distinct small town communities? and how did having a large rural area impact on the development of groups and whether people could easily move around their area? They would be considering how to access the more isolated older people and how to support minority communities in their areas. In some areas the workers were aware of quite clear economic splits in the community and were considering how to support groups to develop in the areas of greater deprivation.

The challenges they saw included ensuring sustainability for new and existing groups and the fundraisers and publicity staff were seen as part of the team for making this happen. They also wanted to ensure they worked in a way that enabled older people themselves to define what they wanted to do and how and in what capacity they wanted to volunteer. Some teams wanted to encourage a variety of ways for older people to engage in community life that were not just about joining a group. This seemed to allow for much smaller interventions where older people could be linked together for something like tea and a chat or to play a shared game together like chess. There was also a recognition of the need to understand the changing needs of older people and the pressures to do with health and family that might prevent them engaging in activities.

There was awareness of the roles of the other staff involved in POPP and how it was intended that work would split between them. However at this stage there was little feedback on how those relationships were working in practice.

Follow up

We were able to follow up with Community Engagement Workers in Worthing, Crawley and Chichester although the full group were only seen in Crawley.

The teams in Worthing and Crawley had been fully operational for 7-8 months. The full team in Chichester had only been operational for six months. In Worthing and Crawley the staff were all directly supervised by the respective CVS which also employed the Neighbourhood Network Co-ordinator. In Crawley although the staff were supervised as a team within CVS the contracts for the CEWs were spread between a significant number of the Neighbourhood Network organisations and staff were closely connected to the organisations they had been recruited for in terms of the development work they were doing. In Chichester the three CEWs were employed by three separate neighbourhood network member organisations and the two NNC posts were employed by Chichester CVS and Age Concern West Sussex (ACWS).

In the follow up interviews we asked the CEWs to consider if their role had developed as they had expected and what they had been doing, what challenges they had experienced, whether they had reached the objectives they set themselves in the ToC statements and what had helped them meet those objectives.

Was the role as they expected?

Workers felt that the role was as they had expected but all acknowledged that it continued to develop. In each of the teams there had been early decisions to allocate workers a geographical patch and to locate them physically in community based organisations. In addition to a geographic patch workers had area wide responsibilities for a particular client group like those with sight problems or a specific BME community or for a specific interest area like health or intergenerational work.

What were they doing?

The CEWs in all three areas were generating a huge amount of work. The initial work that they had seen for themselves of mapping, getting to know their areas and promoting their service had got under way relatively quickly and in all cases

they were able to give many examples of new groups and initiatives that had been started. They were for example involved in setting up community walks for people who had previously been walkers, a support group for older BME women including carers, a hard of hearing group to complement a deaf club and intergenerational projects with local schools around technology and arts and music.

They were developing knowledge about the older people in their areas and the kind of support they had. One area was struck by how many people had moved there for retirement and though they were still active in the community many of them had no family nearby or even at all.

They were responding to identified gaps in services. For example in one area work was underway with 4Sight to develop deaf blind centres to meet an unmet need and in a couple of the areas the need for activities for men were being recognised. Where groups existed but would provide additional benefit if they could run for longer or over the weekend (such as lunch clubs) staff were working with them to try and find ways to help them expand their service.

In all areas the CEWs were getting themselves known to key local organisations and networks. They were working with the organisations who were part of the neighbourhood networks and with other locally based staff to develop linkages and to do joint promotional work. They were getting to know existing groups and services and developing linkages where they saw them. One example of this was organising a visit to a local hospice for representatives from a BME community to develop a better understanding of the services that could be provided there for their community.

In Crawley the contact with the BME communities was developing significantly and a number of the workers were involved with groups and initiatives. Where CEWs had been recruited to work directly with some of the BME communities they were taking the time to get to know those communities, build trust and work with them to establish the needs of their older people.

In one area the CEWs spoke about the high numbers of befriending enquiries they were getting and how a significant number of people were seeking to be active with other people rather than to have someone visit them at home. The CEWs commented that they had been challenged a bit by the very much older people coming forward who were still very active into their 90s.

> *I think personally that's what has fuelled this project that someone has realised that older people have still got a lot of things that they want to do and the ability to do it they just need that little bit of support*

The response from this team to these enquiries had been to try and develop activity based groups which had included the town walks and an exercise class called POPPMO whose tutor was an active 70 year old well known in the area.

What were the challenges?

Making contact with the more isolated older people was a challenge and a number of CEWs acknowledged how important it was to use a variety of methods of communication.

> *It is one of the challenges of the job lonely isolated people by definition are the hardest people to contact. You have got to keep publicising yourself in as many different avenues as you can because you never know which method of advertising yourself will filter through and get to those lonely and isolated people*

Most of those being engaged with were much older people and there was a challenge in engaging the 'younger old' who perhaps did not see themselves as being there yet. Enabling these people to be involved in forums where their experience and knowledge could be used was one way of tackling this *"it is a way of them feeding their soul and feeling useful in their community".*

Accessing individuals into groups was taking time. It involved not only finding out what they really wanted but then matching them with something suitable. Not everyone felt confident to try what was suggested and the workers might have to work with them a few times to encourage them to take up an opportunity.

In the early stages of each team there had been some confusion and overlapping with the CLWs and in one area where the CEWs had been in post a long while before the CLWs they had had to withdraw a bit from some situations. This withdrawal had been challenging as even though their remit was to work with groups, groups are made up of individuals and there were some situations in which the boundaries between the two roles became quite unclear. That confusion was rapidly disappearing as both staff teams became fully functional and there were joint meetings and buddy links being developed across the areas. Some staff were critical that there had not been enough clarity when the project had started but the evidence in this section and in other parts of this report suggested that confusion was more in evidence where different parts of the model were implemented at different times and where the relationships between the CPT and the NN team were not as well developed. Some workers felt that there had been over engagement with the community and that there was not enough connection between the different parts of the POPP model.

The workers in some areas also felt challenged by long established groups who clearly did not want contact with them and by groups who when they had been

involved in assisting them for a while felt confident to go on by themselves and didn't want their involvement anymore. There was a learning process going on for all staff about the boundaries to their role and understanding that not everyone would want the help they wished to offer or would need it for long. There was also a need to recognise that some people chose to be part of a group because it was their interest not because they were an older person. In those groups people resented what they saw as an intrusion to seek volunteers or to tell people about services because they were a captive audience.

Recruiting volunteers had been challenging for the teams. Finding the right volunteers could sometimes be an issue as people might be willing but not suitable. One team commented on how it takes time to sort out whether someone is suitable for one to one work, or whether they have a need themselves and perhaps would work better in a different kind of setting. The complexity of the volunteering relationship was being recognised *"It's a fine line between needing help and offering help and people can do both".* The process of securing CRB checks was also time consuming and staff had lost some people because they did not want to deal with the paperwork. There was also an awareness of the needs of smaller groups for volunteers and how the changing nature of the volunteer workforce was challenging them to think differently about who might be a suitable volunteer for them. Once found, keeping volunteers was also an issue and in one area having found some 'community champions' they were linking them together as a group and providing them with training as a way of encouraging them to feel valued and stay involved.

Ensuring the sustainability of new groups was also a challenge. Staff were clear that with a pilot they should endeavour to ensure that a group would be able to carry on without reliance on them as a team and were aware that this would take time and might not in all cases be possible as their contribution was part of what kept the group functioning.

There was a challenge particular to Chichester around the nature of the area. Both Crawley and Worthing presented mostly urban geography whilst Chichester included rural, urban and coastal. To try to look at the differences and to deal with the overall size of the District the CEWs had been allocated one of these areas each as patches. They had then been asked to target their work further to look at the impact they could have across three parts of their patch from a well developed community to a less well developed. It was hoped that this would prove a good way of dealing with the workload and providing good evidence to the pilot.

What helped?

What had really helped many of them to get to know their communities had been physically walking their area either alone or with other local community based

staff like Police Community Support Officers or with Local Authority Councillors. These and other locally based staff had been prepared to share knowledge and perspectives with them. The Neighbourhood Network membership had also provided a route into the community and helped spread the knowledge of what they were there to do.

It was recognised that working with faith communities could be complex but making relationships with churches, mosques and other places of worship was a route to get information out to isolated people particularly within minority communities. One team talked about the need to be very aware of who is out there before you go in

> *you've got to respect that a lot of groups and services have been running a long time and we're the new kids*

'Word of mouth' was proving extremely useful and as they talked with groups the word got around about what they were doing. It was noted by one CEW that their work had an indirect outcome of building community

> *almost none of what we do is directly aimed at building up community but everything we do has that as a secondary effect just by publicising and letting people know what we do creates those connections within the community*

In all areas schools had been very willing to get involved with intergenerational work. This fit with their interest and commitments to citizenship work with their pupils and to developing work around green issues through gardening and allotment projects.

Being part of an organisation with community based staff and knowledge was also extremely useful as was having supervisors and managers who were well networked already.

Were they meeting the objectives they had set themselves?

All those interviewed in this stage felt that they were definitely meeting their early objectives although they recognised that they would get further given more time. For the limited time they had been operational they could see that they were meeting a need for grass roots staff who were able to network people and smaller organisations together and who could provide an information and support link through to other services. They were clear that many of the people they were dealing with had not previously been involved or been getting the kind of support to get involved in positive activities and friendships that they had wanted.

There was active engagement in some areas with BME communities that had not been happening before although it was recognised that where these communities were small it was more difficult to make contacts and support them.

Most of the workers recognised the longer term challenge that was still before them to access more isolated older people in the more socially deprived areas and that the process of setting up and supporting new groups in these areas would take more time, patience and support.

What had helped them meet their objectives?

All the CEWs were highly committed and enthusiastic about the work they were doing. They accepted that the job was not the best paid, not all were full time and they were very aware of the short term nature of their contracts. However they felt that in some way these constraints had brought people into the role who had really wanted to do the job and wanted to achieve what they could to make the pilot a success.

They came from a variety of backgrounds and their interest in the job ranged from wanting to work in a useful job to seeing an opportunity to bring skills they had learnt in another sector to work with a client group they cared about. They all had individual qualities and a range of interests and skills. They enjoyed the autonomy of the role and felt valued and trusted. They recognised the need to be self motivated and organised but in most cases were also benefitting from having clear direction from well connected managers and supervisors. They were all networkers and recognised this as the key skill they needed for the job. Some commented that they thought those who had recruited them had had a good idea of the kinds of people and skills they thought would work well in the role.

Being part of a team was very important. They saw the team as a support mechanism for them as autonomous workers but also as somewhere they could pool their skills and make the best use of their collective skills, knowledge and connections.

Finally the positive response they were getting from older people themselves and seeing what they were helping to put in place working well was enabling them to see the effect they were having and encouraging them in their work.

One of the reflective diary entries showed the key components of what the CEW saw as their impact and how it made them feel.

> *it was seeing the potential of their kitchen, acting on it and making contact with someone I had previously met that could help. The most rewarding thing is to know that now all those people will be out at a lunch club each week talking and interacting with others instead of being on their own*

5. Conclusion

There had been some significant delays in the implementation phase for the organisations involved in the Neighbourhood Networks. These were largely attributed to the complexity of the competitive tendering process and the problems of recruiting staff and sorting out management arrangements.

Despite the delays most organisations could see their aims for POPP beginning to be met. The development of better partnership working between themselves, a growing understanding of what was already happening in the areas, the networking developing between groups and the raised profiles for organisations were all seen as positive outcomes.

The development of groups and activities to meet the expressed needs of older people was happening and there was more involvement of older people themselves both in the OPRGs and through volunteering.

There were still challenges in making the linkages work between the CPTs and the NN staff and in ensuring that existing services and developments were not duplicated.

Despite the difficulties that had been experienced the interviewees acknowledged the huge learning opportunity POPP had presented for their staff and their organisations and recognised the new skills and systems that were now in place.

Chapter 5

A view from statutory stakeholders

1. Background

In this section of the evaluation we drew on data from two sets of interviews with key stakeholders interviewed twice during the course of the evaluation. The first interviews took place in March /April of 2008 and the final interviews about 12 months later between March and May 2009. There were 12 original interviewees two of whom had moved to other jobs within this period. One of these posts was partly replaced thus follow up interviews were with 10 of the original group and one new person. The group represented strategic level staff from Adult Social Care and the West Sussex PCT (PCT) and key development and implementation staff from the POPP team. Half of the group were WSCC staff and half PCT staff.

The issues coming from the first interviews covered four main areas; their aims for POPP, the limitations they saw to achieving them, what longer term outcomes they were looking for and evident and anticipated challenges. At the initial interview stage the implementation was underway but only in one or two areas was there anything close to the full structure in place and operating.

2. First interviews

Aims for POPP

Collectively interviewees defined the following aims:

- To improve the quality of life for older people recognising that the county has an increasing ageing population and that the criteria for acute services and the lack of more low level options for support limit their access to the help that would benefit them.

- To make an investment in prevention services that would impact now to improve the health and well-being of older people and reduce their need for more acute services.

- To develop more locally responsive integrated services and ensure that POPP complements the many developing initiatives around health and social care that are currently in place or coming on stream.

- To develop the capacity of local communities and individuals to help and support themselves by nurturing neighbourhood support and volunteering and by involving older people in defining what would work for them.

- To develop a concept and pilot a new way of delivering joined up services that promotes a person centred multi agency approach and to demonstrate outcomes.

- To develop the capacity of the voluntary sector to be involved in providing more community based services and to change and develop the way the sectors work together.

They also identified a number of factors likely to constrain the achievement of these objectives. Some of these have already been discussed as front line workers had experienced these *in practice*.

One such was the competitive tendering process. Interviewees recognised that the process was complex and long and there were limits to the capacity and skills of voluntary sector organisations to engage with it. In some areas there were not enough organisations to bid for the tenders. Some questioned whether there would have been a simpler way to identify organisations to take on the work. They recognised that there was a need for work to develop voluntary sector capacity and sustainability for future initiatives.

The POPP model *per se* was considered to be ambitious and complex and might not translate as effectively in each area. There was significant complexity in the number and nature of the organisations involved on a local level and in the challenges of a large, geographically varied county. At this early stage interviewees identified difficulties recruiting all the staff needed and the availability of the right skills.

Interviewees suggested that the task of implementation had been underestimated. They recognised what we have learnt from those working at the front line: team development, ensuring good local working relationships with existing services, working across professional boundaries, dealing with negativity and concern about potential threats to existing services and organisations, all take considerable time and effort. They felt this had not sufficiently been allowed for.

There was also concern about the bureaucracy and complexity of the two statutory organisations. The reconfiguring of the PCT and the shifting of people around in jobs put the County Council in the driving seat and led to less involvement from the PCT than they had wished for. External factors and pressures on both organisations also created tensions. The existence of different tiers of local government, plus the work of Local Strategic Partnerships and their

sub groups meant POPP was being developed in the context of a complex system of governance and service delivery.

These more strategic interviewees also anticipated what we have demonstrated in practice: that POPP staff would pick up much older, frailer and more needy people than anticipated and as a result would be dealing with more acute and less preventative work. They were concerned that POPP should not become another layer of Adult Social Care doing more one to one work and less group and issue based prevention work. They were concerned about whether POPP would be able to achieve the right reach into the more socially and economically deprived communities and respond to the growing numbers of older people within BME communities. They acknowledged there were huge gaps in services to meet older people's needs and recognised once expectations were raised clarity would be needed about how such services would be continued.

Longer term outcomes

In the long term stakeholders hoped for outcomes relating both to the lives of older people and to ways of working within and across sectors and organisations. They anticipated that:

- individuals and families would be able to access what they needed much earlier, and that problems would be resolved quickly;
- integration between health and social care would provide a comprehensive prevention service with speedy access into more acute services where required;
- there would be more integrated working at a strategic level between Health and Social Care through the development of a Joint Commissioning Board;
- more strategic work with other partners included in POPP like the Benefits Agency, the voluntary sector and housing agencies;
- and more appropriate services for a growing and diverse population.

From an Adult Social Care perspective there was a hope that the nature and seriousness of referrals for services would change and there would be less hospitalisation as a result of falls and issues resulting from lack of self care. They hoped to be able to target their mainstream services more effectively at a higher level of need and as result of preventative work see more people keeping well and staying in their own homes for longer. The PCT wished to be able to see some improvements in health for people over 75 and in particular in economically deprived areas.

Statutory partners also hoped that POPP would facilitate a more integrated, coherent, and stable voluntary sector as well as more effective cross sector working around the provision of local services. Some stakeholders hoped to be

able to see more community cohesion and broader community benefits coming from increased neighbourliness and local volunteering.

Finally there was a hope that the learning from the pilot would have the effect of facilitating broader collaborations in achieving government targets for improving health and well-being within the older population.

Evident and anticipated challenges

Interviewees saw the two year timescale as a very short period in which to achieve the ambitious and long term outcomes for the POPP. An early and continuing challenge was to communicate the model to a number of audiences; those who were employed; those who would use services; those who were working as partners and those who were significant existing deliverers of locally based services.

These stakeholders reflected the demands associated with establishing operational teams we have discussed earlier in this report. This was considered to be a particular problem in the context of the local NHS which was undergoing significant redevelopment of community based services at the same time as POPP was being implemented.

Both statutory agencies felt they were strapped for cash and facing reduced national settlements. They were uncertain of implications for the continuation of the POPP model beyond the pilot. Added to this was the need to prove the success of POPP quite quickly in order to compete with other local initiatives for what longer term funding was available to the agencies.

The view of the voluntary sector was that there were difficulties in developing collaborative partnerships to tender for contracts. The perceived stress that the lack of capacity for taking part in competitive processes was putting on them was considered to be both a short term challenge for the delivery of POPP and a long term challenge for developing commissioner/provider relationships between the sectors.

In the longer term a number of the stakeholders saw the challenge of needing to keep a strategic view of the pilot and to maintain the coherence of the model to ensure that the value of it as a different way of working could be properly assessed.

3. Follow up interviews

Some 12 months later we invited interviewees to reflect on the above issues. At the time of these second interviews all the areas were operational but some had only been fully operational for a few months.

Had aims been met and how did they know?

Many of the stakeholders saw that their short and medium term aims were being met to some great extent but it was more difficult at this stage to assess whether long term or strategic aims had been met.

Short and medium term aims

Referrals data showed that POPP was delivering services to more people than before and that a significant proportion of these were previously unknown to services. There were higher than expected levels of self referral in some areas and a significant take up of welfare benefits across all areas. POPP was being seen as a multi agency and community based initiative and the partnership with the voluntary sector was considered crucial in developing the image of the service and in attracting older people to feel it was for them.

The strengthening of community networks was enabling contributions by individuals to the community and to helping themselves, and involvement in groups and volunteering was giving older people knowledge and understanding of the service that was available to them should they chose to access it. Older People's Reference Groups (OPRGs) were seen as increasing opportunities for older people to hear about and look at issues involved in developing services and the web sites were providing information and encouraging involvement. POPP was beginning to reach out to the BME communities and by recruiting community members as staff was achieving better access into the needs of the communities.

> *POPP can use the local population to help the local population so you get the flavour and needs of that population*

Interviewees saw POPP in practice as an umbrella under which a range of agencies and communities were being pulled together to develop a seamless service for prevention. Integrated working was developing within the CPTs and the inclusion of the voluntary sector in the mix of staff was seen as providing a positive bridge to the community.

Despite significant delays in the early stages all areas were operational. The dedicated implementation team was considered to include a good mix of roles and skills and was recognised as key in delivering the implementation and

ensuring key operational and monitoring outcomes. The implementation team themselves felt that clear co-ordination across the county had enabled demonstration of the potential use of the model. They thought that having to meet Department of Health (DoH) requirements had helped them focus on delivery despite difficulties in gaining full support for the model. POPP was building a sound evidence base of needs, take up and impact of prevention services and a shared understanding was developing with the voluntary sector of the need to evidence what they were achieving.

Statutory stakeholders welcomed the developing relationship with the voluntary sector as a provider and saw the voluntary sector collaborating more as a sector. The development of performance systems with the voluntary sector was seen as assisting them to develop more robust systems for monitoring and accountability that would benefit them as organisations.

Long term aims

Whilst a number of successful developments in relationships between health and social care at an operational level were evident, there was acknowledgment by all stakeholders that the longer term aim had to be more integration with community based health care initiatives and with GP and other primary care services. POPP had historically sat in the public health arena but all stakeholders recognised the influence of acute care services and how they needed to be able to see the value of POPP to them. It was hoped that the rolling out of the joint work around the Unique Care pilot would assist this.

Relationships were developing on a strategic level with the Joint Commissioning Board and stakeholders could see that in the longer term the ongoing development of POPP and the relationship to other initiatives would be supported there. All sides recognised that the PCT had not been as engaged with the POPP pilot as it could have been, not least because of organisational reconfiguration during the POPP pilot. The Joint Commissioning Board was seen to be much more evenly balanced between health and social care and would become the forum for consideration of broader commissioning issues around services for older people including prevention. But the inability of the PCT to engage to the extent they might have wished was considered to create difficulties in ensuring future commitment from the NHS locally to support for POPP.

Adult Social Care interviewees thought the pilot had successfully enabled them to deliver the DoH requirements and also provided an opportunity to test out a model with different organisations working together that would enable them to meet the requirements of the national ‘Putting People First’ agenda. POPP was identified by Adult Social Care as part of how they would meet the broader transformation agenda and the move to self directed support.

Stakeholders felt there was now a better understanding from the voluntary sector of the future landscape for services and that they would be better placed to respond to it as a result of the POPP experience.

The positives and limitations to the POPP pilot

Positives

Stakeholders saw positive outcomes for the population through delivering what people had said they wanted. Different services were being developed to offer support and new groups and activities for older people were in evidence. Gaps in services were being identified and met through the work of the neighbourhood networks.

> *all these years we've asked older people what they want and we haven't been able to deliver but now especially with older people's forums that we are involved with we are actually delivering what they want for a change*

The value of a holistic approach was increasingly recognised:

> *much better understanding of the inter connectedness between healthy communities and individual health and well-being in that healthy individuals make for healthy communities*

Bringing low level care to the fore in a way that was not seen as 'medicalised' was giving people better ownership of their own issues and health and a better understanding that social care needs can become health needs.

New health roles like Health Advisers (HAs) and Health Trainers (HTs) had developed quicker than might otherwise have been possible. The existing examples of the Neighbourhood Care Alliance and the Link Worker roles already developed in Worthing had been rolled up into the bigger POPP model alongside the Health Enhancement Programme for Older People (HEPOP). The combination of the CLW role in the CPT and the NNC role in co-ordinating the OPRGs meant that individual voices were being heard alongside the voice of the community of interest so that group as well as individual needs could be understood.

Interviewees felt there had been progress in reaching more excluded communities and whilst there was still a long way to go the pilot had enabled agencies to know where those communities were and what the issues might be in reaching them.

Better working relationships on the ground, the developing understanding of team and partnership approaches and the contribution of all sectors were increasingly valued. Despite the complexity of the model it was seen that the pilot had provided an opportunity to do things in a different way and that learning from the experience for all partners would be enormously useful for future ways of working.

Statutory stakeholders felt the development of partnership working in the voluntary sector was breaking down historic barriers between organisations and creating a better base for future collaboration.

The development of tight performance management systems was seen as enabling demonstration of impact and ensuring accountability.

Limitations

Time and money constituted major limitations. Stakeholders felt the DoH did not understand that it would be difficult to prove effectiveness and long term impact within the timescale.

More local factors also impacted on what had been achieved. Again, some of these have been identified earlier in this report:

- issues around the co-location of staff and the inappropriateness of some buildings;
- boundaries to be sorted out about ways of working and management of staff from different sectors.

Interviewees also identified difficulties linking staff from different agencies into one IT system, and problems for social services recruiting suitably qualified staff to replace the experienced staff they were seconding to the CPTs and the resulting pressure this put on acute services in the localities.

Despite the huge amount of data being produced the higher level performance indicators required by government from the statutory agencies did not adequately reflect the performance of the pilot. Stakeholders felt this limited their ability to prove the case for the work to a variety of audiences.

There was significant pressure from other health based initiatives being developed and from the reorganisation of community based health services. It was clear that stronger links needed to be made with GPs and with the broader health economy. *“I think we are missing a trick by not knitting together all the initiatives”*

NHS interviewees suggested different understandings within the PCT (across primary care and health improvement) of the need to work collaboratively in relation to prevention. Some front line health services demonstrated a lack of tolerance of new systems that they did not control, and interviewees suggested it was necessary to show operational staff the clear benefits of working with non health staff to meet prevention targets. There was also an acknowledgment of the potential clash of the different approaches to categorising services between the health and social care

> *we don't make the distinction between older people and working age people in the same way that social care would I think that's a bit of a problem for us*

More strategic interviewees reiterated evidence of confusion and overlap on the ground in some areas with District and Borough Councils, particularly around community development and the linkages with Local Strategic Partnerships.

They also suggested that POPP constituted a huge culture change for the voluntary sector as they had to deliver in a different way and keep information about impact in a different way. There was also an acceptance that putting organisations into a competitive relationship and then requiring them to work in partnership had given mixed signals.

Finally interviewees re-emphasised the complexity of the model and implementation process. The lack of a joint commissioning strategy and the built in inertia of big organisations delayed decisions on contracting processes and strategic support. Some saw the model as too centralised and not necessarily likely to work in different contexts to the one in which it had developed, while others considered this the best way to implement a whole system approach.

Lasting outcomes?

Case studies and stories of individual positive experiences of POPP have been documented in other reports (Moir 2009) For some it was these experiences that would determine the legacy of POPP – in particular the awareness of how 'that little bit of help' could make a difference for older people.

> *Nobody dealt with it before because local authority stuff is all done on FACS criteria, these are too small they're not crisis nobody's going to die but they're going to lead a pretty crappy life what's left of it and it changes people's lives. When (name) stands up and speaks about it people weep as they should do and we should weep with the humiliation that we haven't been able to sort this out before*

More strategically the development of the OPRGs was seen as having changed the way the County Council liaised with the community and this would continue.

POPP was considered to have changed the way the local authority was working with the voluntary sector. The voluntary sector was seen as best placed to develop and support local groups and that was likely to influence future commissioning decisions. There was also recognition that the voluntary sector has a lot to offer as a provider partner from their ways of working to the different kinds of people they were able to attract into jobs. Whilst the tendering process had been difficult, this was seen to have developed the knowledge and skill of the organisations that took part. The needs analysis and monitoring systems would be of use to them in the future both in their own services and in bidding for funding. It was acknowledged that the voluntary sector involvement had taken longer to achieve in the short term but in the longer term would ensure that the service would reach more people. The particular voluntary sector contribution to the development of partnership working and the overall outcomes of POPP was acknowledged:

> *I think there has been a big benefit for the client group in them being involved because I think the influence that they have they moderate the way the public sector behaves quite a lot they have much more of a client focus than a bureaucratic focus shall we say. The way they talk and think is different and it's very good that we share that thinking isn't it. I think sometimes they need to be a bit more bureaucratic and we need to be a bit more focused on the outcomes and the people so I think that kind of debate is useful and getting a shared understanding of what we are trying to do.*

Some stakeholders saw a better understanding developing of the value of prevention

> *we have established an understanding of the value of preventative services in improving health and well-being and that message has been understood across the whole system at a very senior level as well as at a practitioner level*

Others saw POPP as having provided a vehicle to bring people round the table to work more closely together for the future:

> *relationships would probably have moved on to some extent but once you have got everyone round the table then you can have a proper conversation about where should we go from here. Before people weren't really engaged and it was quite hard to have that conversation so the County Council may have taken this over but they have made that happen they have got people round the table so we can take the next step now*

Working more successfully with BME communities to recognise their needs was seen as a significant move towards understanding and supporting all communities:

> *In Crawley we are now reaching BME communities that you would never have reached before. We have CLWs and CEWs from those communities and we are reaching them it's like roots of a tree getting through everywhere and if over the years we can sustain it it's going to get through to all those hard to reach people*

The universality of the model was of interest to all stakeholders for the future, particularly how it might be used with other client groups and bearing in mind the changing face and needs of the older client group and the development of more integrated services across broader age groupings.

The development of a performance framework across the sectors was seen as a legacy of the pilot by showing a way to map need and monitor achievement that would assist future commissioning decisions.

Not all of these outcomes had been anticipated and some of the outcomes looked for had not been achieved. Proving long term benefit to older people would take much longer. Interventions may be complex and as people aged the cost effectiveness of those interventions might be questioned. There was also a recognition that there was still a way to go to ensure more integration of services and less duplication particularly around new initiatives:

> *we do have a tendency don't we when anyone sees a gap they'll set up a new service because they won't know the people down the road are already doing something similar and we need to stop doing that and the only way to do that is to get the key people round the table and make sure everyone is talking to everyone else*

Overall implementation was seen to have been largely successful despite the delays and difficult issues that had arisen. The DoH expectation was seen as too high but it was also accepted that the model was ambitious within the pilot time scale. Implementation was challenged by practical and systems issues and by the need to develop awareness and skills within partners. Significant delays in the tendering and recruitment process and the support needed for those processes limited the amount of time the project was operational before the end of the pilot funding.

4. Conclusion

Overall stakeholders were very positive about what the pilot had been able to achieve to date although well aware that the work was not as advanced as they

had hoped. They recognised the many limitations of the pilot in the early stages but thought huge progress with local operational issues had been made. Significant immediate benefits for older people were being seen but concern was expressed about the difficulty in proving long term prevention outcomes in such a short timescale.

The stakeholders were largely positive about the developing partnership working across the sectors and the integration within local teams. They recognised that more work was required to ensure effective linkages between POPP and community based acute health provision. They were also aware of the need to build better relationships with other local providers and developments, including District and Borough Councils and other local strategic structures around health and well-being like the LSPs.

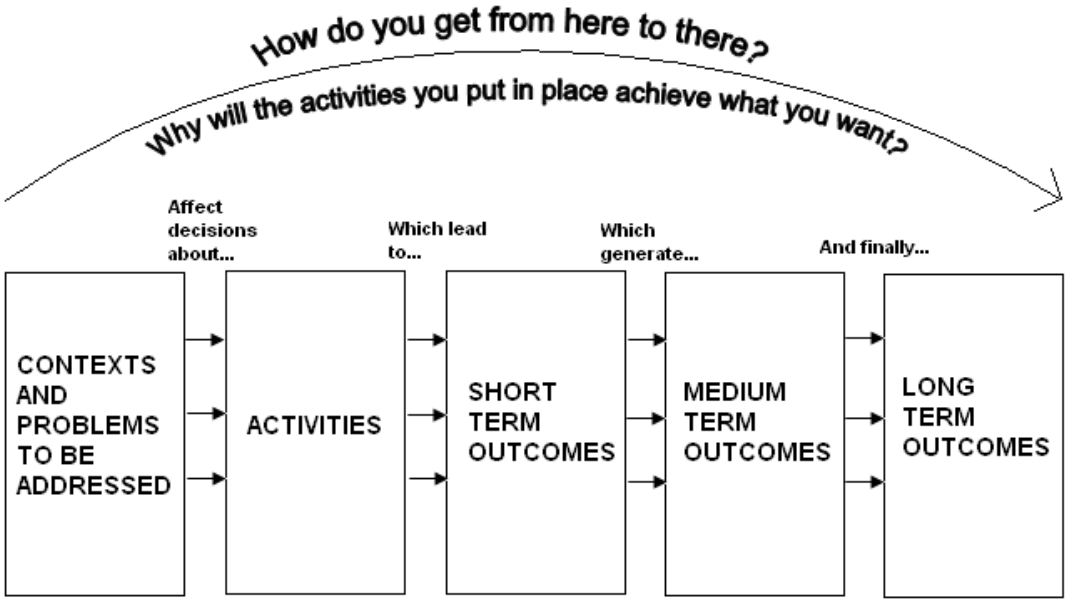
Stakeholders emphasised the contribution of the voluntary sector to the success to date for POPP and how their presence in the mix was changing and developing awareness on both sides.

Chapter 6

Conclusion

In this final chapter we summarise key learning arising from the evaluation of the West Sussex POPP. In order to do so we utilise a version of the Theory of Change framework that helps structure the material we have gathered from the different elements of the evaluation. We then offer some final reflections on what has been achieved and where the POPP has got to.

The figure below represents the basic building blocks for a Theory of Change. It sets out the context in which the project or programme is working, specifies the long term outcomes objectives to be achieved, and then fills in the middle: what activities need to be put in place to start to make short term changes, that will build to or enable medium term outcomes that will eventually deliver the long term objectives sought. The other key element – the 'theory' – is an articulation of why the proposed activities will lead to the desired changes. This approach was developed because of observations that those involved in social change programmes were often good at defining the problems, context and long term outcomes, but not very good at specifying what needed to be done and why in order to make the desired changes.



One limitation of this model is that it suggests a one directional, linear approach to change. As will become evident below, the POPP experience emphasises the importance of reflection that may lead to change or development in the activities being undertaken as the context in which people are working changes.

Context and problems

The POPP was developed in the context of an increasing number of people living into old age in the county who were likely to need input from social and health care services. Access to social care services had become limited and it was considered not possible for mainstream adult social care services to provide the low level, preventive support that would reduce the likelihood of intensive input further down the road. At the same time, social care services were increasingly being encouraged to adopt a 'person centred' approach deriving from the personalisation agenda.

Older people in the county lacked information about what help might be available, were often fiercely independent and reluctant to seek help except in emergencies. They were often being cared for by partners of a similar age who experienced health problems themselves. Others had no family in the area and/or were reluctant to look to them for help. They were also fearful that contact with adult social care would inevitably lead to admission to residential care.

The county encompasses a diverse population with pockets of affluence and deprivation within and across areas. The rural nature of much of the county makes transport and access to services difficult in many cases, and creates a situation in which people may identify with areas that are different from those defined by administrative boundaries. The needs, circumstances and cultural expectations of BME groups in Crawley and elsewhere are often different from, for example, those of affluent but isolated older people in Horsham. It is not only poverty that creates complex needs amongst older people in the area.

The county had an active but rather uncoordinated voluntary sector with a number of organisations providing services that had similar objectives to POPP. Relevant services were also provided by District and Borough Councils as well as the County Council. The PCT locally was undergoing substantial internal change during this period and was also involved in a number of service development initiatives that competed with POPP for attention.

Long term outcomes

In this context the long term outcomes sought related to services, systems, individual older people and communities. These can briefly be summarised as:

1. Better health and improved quality of life for older people.
2. Communities that supported the active engagement of older people.
3. A shift in focus across statutory services to embrace early intervention, prevention and health promotion.
4. Better collaboration across both statutory and voluntary sectors.

5. A better co-ordinated voluntary sector that was also better placed to respond to tenders.
6. Reduced demand on acute/intensive health and social care services.

Our analysis of what happened in practice during the two years of the evaluation enables us to fill in the middle boxes of the ToC model and to suggest what might be learnt from this for the future development of strategies which continue to seek the POPP objectives.

Activities

The first task is one that was completed before the evaluation started: to determine the overall model through which POPP in West Sussex would work. The broad assumptions underpinning this model were that both individually and community focused activities were necessary to enable early intervention/prevention and to support community development that was inclusive of older people. The overall strategy did not directly address the need to 'bend the mainstream' in terms of a shift towards prevention, but rather established new multi-disciplinary teams, the CPTs, to implement more preventative work, and created resources to support community based networks to pursue the community development aspect of the strategy (NNs).

Thus early activities focused on the establishment of new teams of workers from different agencies, and the commissioning of services from the voluntary sector to deliver the community focused aspect of the work. There was broad agreement that both of these implementation tasks took much more time than had been anticipated, that detailed aspects of the approach were not always helpful (absence of a lead person in CPTs, encouraging competition rather than collaboration amongst voluntary organisations etc), and that this had adversely affected the ability to achieve outcomes for older people within this time period.

Alongside these processes early activities focused on:

- Finding out what others were doing in the area, reviewing needs and undertaking gap analyses.
- Promoting the work of the new teams and services to individual older people, specific groups of older people and to other service providers in the area.
- Locating older people who might benefit from the services and encouraging them to access these.
- Reviewing and developing working practices in the light of early experiences. In some instances this meant that early ideas about the ways in which teams would work needed to be revised, e.g. because the level of need of those referred was higher than anticipated.

Short term outcomes

Short term outcomes primarily relate to the achievement of what might be considered the building blocks necessary to start to achieve the objectives sought through POPP. In view of the substantial implementation challenges faced, it is important to recognise the significance of these as outcomes in their own right. The key elements of this are:

1. CPTs that had developed ways of working that made the most of the different individual skills of team members, and which were sensitive and responsive to older people's wishes and concerns.
2. Understanding amongst other service providers, in particular those referring people to the CPTs, of the nature of the role they were to play and the services they could offer. There remained concern that this was not fully understood in all quarters.
3. Appropriate referrals coming to CPTs from other agencies and, increasingly, direct referrals from older people themselves. Again, there was some question of the extent to which all referrals were 'appropriate' in relation to the prevention focus of the project. This had necessitated some rethinking of the ways of working necessary to respond to the needs and circumstances of those referred.
4. Neighbourhood networks in which roles and management arrangements had been clarified.
5. Active engagement from voluntary organisations in the locality in the work of NNs.
6. Improved understanding and collaboration between voluntary organisations.

Medium Term Outcomes

This is the point that was being reached by the end of the evaluation period. As a result of the work being done by CPTs and NNs, for at least some older people and their carers there was evidence of:

- Lessening anxiety about the availability and nature of help that could be available.
- The receipt of practical help that was of immediate benefit.
- Enhanced income via access to welfare benefits.
- Participation in informal group activities.
- Greater opportunity for their voices to be heard in OPRGs.

For at least some parts of the voluntary and community sector medium term outcomes included:

- Increased use of their services.
- Respect and recognition from the statutory sector.
- Enhanced resources, skills and capacity.
- More groups and support networks had been developed.

At this point POPP was being seen to be impacting on the processes of collaboration and joint working in which statutory sector agencies were involved. They had recognised that these had not been entirely helpful to the early implementation of the POPP, but there was a feeling that the necessity to work through issues associated with POPP was having a generally positive impact on inter-agency relationships.

The time scale is too short to suggest whether the long term outcomes specified are likely to be achieved. But we conclude by reflecting on the rationale underpinning the approach adopted and whether this appears to be a robust basis on which to take forward the work of POPP.

Rationale for the approach used

Evidence so far suggests that the two pronged model was an appropriate approach to adopt in the West Sussex context. The ways of working that the CPTs have been able to develop are starting to enable access to services and supports amongst those who fall below the threshold for access to mainstream social care services and/or who would be reluctant to seek help from this quarter. At the same time the NNs are starting to enable more collective work to develop that can facilitate more engagement with the community for older people. Links between the two are proving important and it is unlikely that either approach on its own would be able to achieve the objectives set for POPP.

Experiences suggest there is a need to consider the precise way in which the model is implemented in different types of areas. For example, the number of community based staff may need to be greater in dispersed rural areas and a ‘one point of access’ policy in relation to CPTs may be less appropriate in those areas in which population centres are more dispersed.

What is less clear at this stage is whether the model is sufficiently robust to withstand the pressure that all prevention initiatives face from mainstream services that prioritise high levels of need. Arguably the need for POPP is as much to do with a tightening of criteria for social care services as it is to do with changing population needs (although the two are themselves linked). In view of this it may be necessary to give more explicit attention to ways in which ‘POPP ways of working’ might inform mainstream practice across a range of service and policy areas in order to realise the long term objective of shifting the focus towards prevention. POPP workers have developed a better understanding of what preventative work means in practice as well as how to work in a way that

starts from the perspectives and wishes of older people. These skills could usefully be brought to bear to feed in to developing policy and practice within mainstream services.

Another key assumption underpinning the model was that the voluntary sector would have an important part to play in view of their existing experiences both of community development and of providing services that older people find sensitive and supportive. This assumption is proving correct, but so far it is the larger voluntary organisations who have been best placed to respond to the opportunities POPP has created. The sustainability of the model and the voluntary sector's role within this will require broadly based capacity building across the sector.

Finally, what has been very evident from the work we have undertaken is the high level of commitment being made by staff seconded and recruited to POPP. Recognising and valuing this commitment will be vital to ensuring the sustainability of the model.

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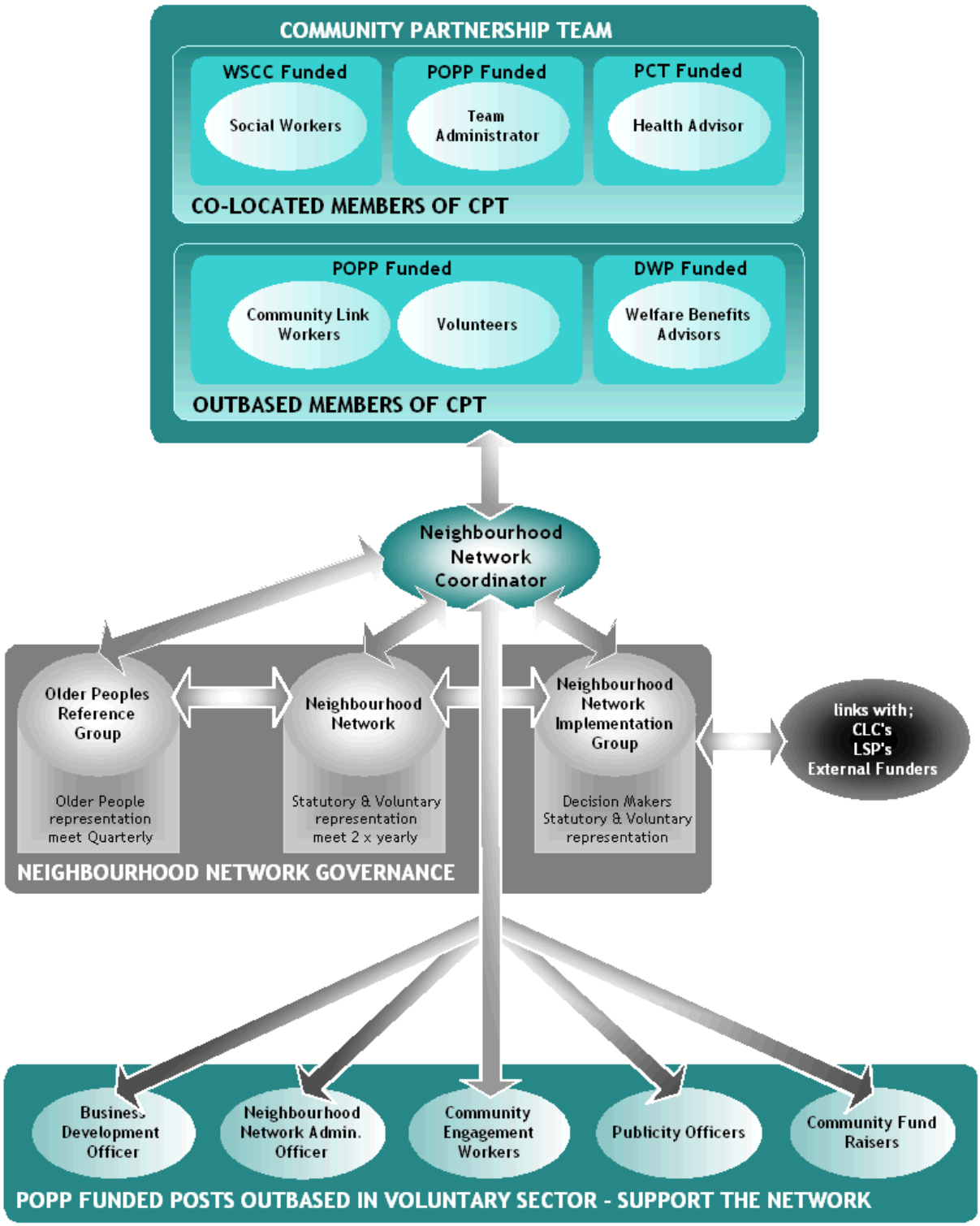
Appendix 1: POPP Structure/Model



Appendix 2: Quality of Life Questionnaire

University of Brighton

west sussex county council

Local Evaluation of the West Sussex Partnerships for Older People Project (POPP)

Monitoring Quality of Life for Older Citizens

Individual Code ☐☐☐☐

How is this questionnaire being completed?

I am completing this questionnaire myself ☐

I am completing this questionnaire with help from a member of my family/ friend ☐

I am completing this questionnaire with one of the POPP team ☐

How do I complete the questionnaire?

Please answer the questions by:

Ticking the box, like this ☑

Writing a number in a box like this 7 6 **years old**

If you have any queries about this questionnaire, please phone:
Di Hughes on (01243) 752015
or Susan Davies on (01243) 752163
Email: di.hughes@westsussex.gov.uk
or susan.davies@westsussex.gov.uk

Administration Only:

The questionnaire is being completed as part of a telephone interview ☐

The questionnaire is being completed as part of an interview ☐

Your health today

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

1 **Mobility**

I have no problems in walking about ❑
I have some problems in walking about ❑
I am confined to bed ❑

2 **Self-Care**

I have no problems with self-care ❑
I have some problems washing or dressing myself ❑
I am unable to wash or dress myself ❑

3 **Usual Activities** (*e.g. work, study, housework, family or leisure activities)*

I have no problems with performing my usual activities ❑
I have some problems with performing my usual activities ❑
I am unable to perform my usual activities ❑

4 **Pain/Discomfort**

I have no pain or discomfort ❑
I have moderate pain or discomfort ❑
I have extreme pain or discomfort ❑

5 **Anxiety/Depression**

I am not anxious or depressed ❑
I am moderately anxious or depressed ❑
I am extremely anxious or depressed ❑

---

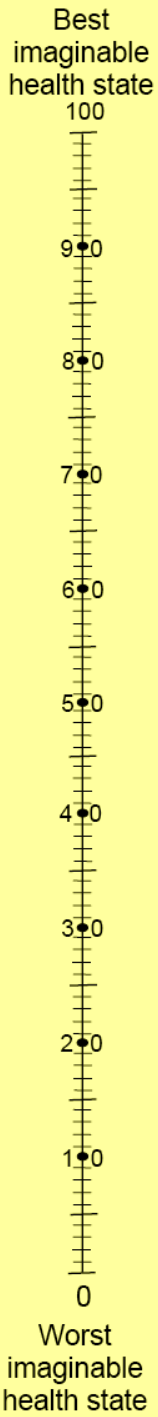
6 Compared with my general level of health over the past 12 months, my health state today is:

Better ❑ PLEASE TICK
Much the same ❑ ONE
Worse ❑ BOX

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

Your own health state today



What is your quality of life?

7 Thinking about the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole?

(Please tick the box next to the answer that best describes the quality of your life:)

(1) So good, it could not be better ☐

(2) Very good ☐

(3) Good ☐

(4) Alright ☐

(5) Bad ☐

(6) Very bad ☐

(7) So bad, it could not be worse ☐

Service Use

8 In the last 3 (three) months, have you been to hospital?

Please tick 'Yes' or 'No' for each line. If you answer 'Yes' to any of them, please tell us how many times you used the service.

	No	Yes	Total number of
For physiotherapy or occupational therapy appointment	☐	☐	visits ……..
Went to accident and emergency (casualty)	☐	☐	visits ……
Stayed in hospital overnight	☐	☐	nights ……..
Had a clinic or outpatient appointment	☐	☐	appointments ……..

9 In the last 3 (three) months, have you used any of the services below?

Your local surgery or health centre	**No**	**Yes**	**Number of times you saw the individual in the last 3 months**
Saw GP at the surgery	☐	☐	……
Saw GP at home	☐	☐	……
Phoned surgery for advice	☐	☐	……
Saw practice nurse	☐	☐	……
Saw other staff (e.g. physiotherapist, counsellor, chiropodist) – please specify			……
……	☐	☐	……
……	☐	☐	……
……	☐	☐	……
Services in your home	**No**	**Yes**	
Received "Meals on Wheels"	☐	☐	Number of times per week……
Received "Home Care/ Home Help"	☐	☐	Number of visits per day…… / Length of each visit (eg 15 minutes, 30 minutes etc) …..
Social worker/care manager visited	☐	☐	Number of times visited in the last 3 months……
Nurse visited	☐	☐	Number of times visited in the last 3 months……
Saw other staff (e.g. therapist, health visitor) – please specify			
……	☐	☐	Number of times visited in the last 3 months…….
……	☐	☐	Number of times visited in the last 3 months…….
……	☐	☐	Number of times visited in the last 3 months…….

Services in your home cont/…	No	Yes	
Home library/mobile library visited	☐	☐	
Do you have a Community alarm/personal alarm?	☐	☐	
Did you use Community alarm/ personal alarm in last 3 months?	☐	☐	Number of times used……
Received changes to your home (eg Moving bathroom downstairs, stairlift).	☐	☐	
Leisure and transport	**No**	**Yes**	**Number of times you used service in the last 3 months:**
Bus pass	☐	☐	……
Dial-a-ride	☐	☐	……
Library	☐	☐	……
Day/drop-in/resource centre	☐	☐	……
Lunch club	☐	☐	……
Community/leisure centre	☐	☐	……
Transport to Health Care (eg Hospital Car	☐	☐	……
Other services *(please specify)*	**No**	**Yes**	**Number of times you used the service in the last 3 months**
……	☐	☐	……
……	☐	☐	……

10 **<u>In the last 3 (three) months</u>, have friends and relatives helped you with tasks at home which you had difficulty with or couldn't do?**

Please tick 'Yes' or 'No' for each line. If you answer 'Yes' to any of them, please tell us how many hours per week they help you.

Did anyone help you with the following task(s)?	No	Yes	Typically, how many hours per week?
Personal care (e.g. bathing, dressing)	☐	☐	……
Housework / laundry	☐	☐	……
Providing transport / taking you out	☐	☐	……
Preparing meals	☐	☐	……
Gardening	☐	☐	……
Shopping	☐	☐	……
Looking after pets	☐	☐	……
Generally providing support	☐	☐	……
Other *(please describe below)*			
……..	☐	☐	……
……..	☐	☐	……

11 **In the last 3 (three) months, have friends and relatives stayed off work to help you?** Yes ☐ No ☐

If Yes, How many days did they take off work in the last 3 months?

.....

Activities/Involvement

In the last 3 (three) months, have you been active or involved in any of the following areas?

12 **Voluntary activities -** Yes ☐ No ☐

If yes, please describe what it was and how often you did it.

.....

13 **Local groups/organisations involved with campaigning or local issues -** Yes ☐ No ☐

If yes, please describe what it was and how often you did it.

.....

14 **Community or user groups -** Yes ☐ No ☐

If yes, please describe what it was and how often you did it.

.....

15 **Sports and/or exercise -** Yes ☐ No ☐

If yes, please describe what it was and how often you did it.

.....

16 **Arts and/or culture -** Yes ☐ No ☐

If yes, please describe what it was and how often you did it.

.....

17 **Gardening or outside activities -**

Yes ☐ No ☐

If yes, please describe what it was and how often you did it.

.....

18 **Church or faith based activities -**

Yes ☐ No ☐

If yes, please describe what it was and how often you did it.

.....

19 **Education -**

Yes ☐ No ☐

If yes, please describe what it was and how often you did it.

.....

20 **Socialising with family, friends or neighbours -**

Yes ☐ No ☐

If yes, please describe what it was and how often you did it.

.....

About yourself

Because all replies are anonymous, it will help us to understand your answers better if we have a little background data from everyone, as covered in the following questions.

***21* What is your age in years?**

(Please write in the boxes e.g., 6 then 7 if you are 67)

☐ ☐

***22* Are you:**

Male ☐ Female ☐

***23* What is your marital status?**

(Please tick the box that applies to you)

- Single ☐
- Married ☐
- Living with Partner ☐
- Widowed ☐
- Divorced or Separated ☐
- Civil Partnership ☐

***24* What kind of accommodation do you live in at the moment?**

Please tick one

- ☐ Domestic housing
- ☐ Sheltered housing
- ☐ Residential home
- ☐ Nursing home

***25* If you live in domestic housing, how many people are there in your household?**

Number of adults (including yourself) ……..

Number of children under the age of 16 ……

26 What is your current employment situation?

(Please tick as many boxes that apply to you. For example, you may have retired, but be undertaking further study, or, you may be retired, but caring for a relative or looking after your grandchildren)

- ☐ In employment
- ☐ Unemployed
- ☐ Retired
- ☐ Student
- ☐ Other *(Please specify)* .....
- ☐ Caring for a relative or friend
- ☐ Temporarily sick or disabled
- ☐ Long term sick or disabled
- ☐ Looking after family member(s)

27 Do you receive any state benefits?

Please tick below which benefits you get and tell us how much you get altogether.

- ☐ Income support
- ☐ Family credit
- ☐ Jobseeker's allowance
- ☐ Housing benefit
- ☐ Statutory sick pay
- ☐ Others *(please describe)* .....
- ☐ Invalidity allowance
- ☐ Disability working allowance
- ☐ Disability living allowance
- ☐ Incapacity benefit
- ☐ Attendance allowance

How much do you receive altogether in benefits each week?

£ .....

28 What is the total income of your household per week from all sources before taxes and deductions? (excluding housing benefit and council tax rebate)

Note: a household is either one person living alone, or a group of people (who may or may not be related) living, or staying temporarily, at the same address, with common housekeeping).

- ☐ £0 - £249 (£0 - £12,999 per year)
- ☐ £250 - £449 (£13,000 - £23,399 per year)
- ☐ £450 - £749 (£23,400 - £38,999 per year)
- ☐ £750 or more (£39,000 or more per year)

29 What ethnic group do you consider yourself to belong to?
(Please tick one)

- ☐ White - British
- ☐ White – Irish
- ☐ White – Other
- ☐ Chinese or other
- ☐ Other (please specify ……..)
- ☐ Black or Black British
- ☐ Asian or Asian British
- ☐ Mixed Other

30. What is your religion or belief?

- ☐ None
- ☐ Christian
- ☐ Jewish
- ☐ Sikh
- ☐ Buddhist
- ☐ Hindu
- ☐ Muslim
- ☐ Other

31. Are there any other comments you would like to make?

THANK YOU

FOR COMPLETING OUR QUESTIONNAIRE

Please return to the local project team in the pre paid envelope provided

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