NORTH YORKSHIRE COUNTY COUNCIL

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE

11 FEBRUARY 2010

WORK PROGRAMME

1.0 Purpose of Report

1.1. The Committee has agreed the attached work programme (Appendix 1).

1.2. The report gives members the opportunity to be updated on work programme items and review the shape of the work ahead.

2.0 Background

2.1. The scope of this Committee is defined as:

The needs of vulnerable adults and older people and people whose independence needs to be supported by intervention from the public or voluntary sector.

3.0 Stroke Awareness Update

3.1. Members will recall that a task group led by County Councillor Tony Hall and comprising members from the Scrutiny of Health Committee and this Committee is taking this work forward.

3.2. An informal meeting with the Regional Officer of the Stroke Association was held which informed on the completion of the initial scoping work which has now been completed.

3.3. Key issues that the task group will be examining include:

- How is stroke awareness brought to the attention of the public and how is advice made available on what they should do if a stroke is suspected?
- How is stroke awareness promoted by employers?
- What are the prompts in the triage systems used by call handlers in NHS Direct and in the Out of Hours Service to alert them to the possibility that the caller may have had a stroke?
- How do ambulance service crews assess whether or not the patient has had a stroke and how do they decide where to take the patient?

- How do staff in Accident and Emergency recognise and respond to stroke situations?

3.4. The task group is now moving into the consultation phase. Meetings have already been held with the 3 Cardiovascular Networks that cover North Yorkshire and with the Stroke Services Coordinator at the South Tees Hospitals NHS Foundation Trust.

4.0 Personalisation and Self Directed Support

4.1. Personalisation of services is becoming a key part of many Government policies, not just social care. It is a general term used to describe attempts to make sure that every person who receives care and support should be supported to shape their own lives and the type of services they receive. This should apply to both people who have support funded by councils and as well as people who pay for their own support. This should result in people having personalised, or individualised, services.

4.2. The Government is employing varying methods to make these services more personalised:

- **Self Directed Support:** a general term used to describe new approaches in the social care system that puts individual service users in control of the services they receive.

- **Direct Payments:** Social Services giving money as a direct payment instead of providing a service.

- **Personal Budgets:** Individuals knowing how much social care money has been allocated to pay for the support they receive.

- **Individual Budgets:** The further development of some aspects of Direct Payments, in that they include different sources of funding not just social care.

- **Self Assessment:** A process whereby people are enabled to assess their own care needs or to complete an assessment of someone else.

4.3. Your Chairman has agreed that a report should come to your next meeting which highlights these issues and outlines progress in relation to the various elements and the tool that the County Council is starting to use to decide how much money is allocated to pay for personalised support and how this process operates in practice.

5.0 Partnerships for Older Peoples' Projects

5.1. North Yorkshire Partnerships for Older Peoples' Project was one of 29 partnerships across the Country funded by the Department of Health. The Committee appointed a Task Group to examine the progress of the POPP and take a view on its conclusions in relation to the wider intervention agenda. The POPP Project in North Yorkshire was judged to be a large success particularly in relation to the engagement of older people in determining the progress of the project but also its evaluation. The long awaited National Final Evaluation Report and learning sources has now been published. The

Executive Summary is attached as Appendix 2.

5.2. The Health Secretary Andy Burnham was quoted when he launched the report as saying that it made "a powerful and persuasive argument for putting prevention first – not first out of the door". The National Report arguably shows that POPP projects nationally produce savings for the National Health Service to far greater extent than they did for Adult Social Care. The Local Evaluation Report undertaken by Acton Shapiro came to very much the same conclusions; however it did not convince the Primary Care Trust at the time of the validity of that evidence when the national funding ran out. Officer opinion is that the release of the National Report is unlikely to shake-up commissioning priorities, although it undoubtedly confirms what the Committee and Adult and Community Services thought locally during the North Yorkshire Pilot.

5.3. In the light of these conclusions the Chairman has agreed that the National Report, its conclusions and what impact the report might have locally will be taken to the next Mid-Cycle Briefing.

6.0 Securing the Future: A dialogue with the Third Sector in North Yorkshire

6.1. North Yorkshire Adult Community Services, together with NHS North Yorkshire and York, has entered into a dialogue with the third sector about the level of support and understanding the public sector can give to help the third sector carry out its role effectively. A recently released consultation document sets out how this relationship might change and develop. It emphasises that a strong partnership between public sector organisations and the third sector based on mutual understanding and trust is essential to making North Yorkshire a good place to live.

6.2. The consultation document addresses the relationship with third sector based organisations principally around those who provide frontline support and services to people in the community.

6.3. We are now in that part of the consultation period when the responses that are being received are being used to develop joint approaches to commissioning.

6.4. Although the Care and Independence Overview and Scrutiny Committee is taking the lead on this from a Scrutiny perspective, these issues also cut across the Safe and Sustainable Communities Overview and Scrutiny Committee's remit in terms of Social Inclusion, support for the voluntary sector, the action plan to promote a thriving voluntary sector and the progress of the Compact. Discussions between the Chairmen have led to the suggestion that it would be helpful to have a joint workshop at some point when proposals more definite are starting to emerge. I will report further when the position becomes clearer.

7.0 Green Paper: Funding for Social care in England

7.1. At your last meeting you agreed to contribute to the NYCC response to the green paper for Funding of Social Care in England. This you will recall marked the launch of what the Government has called "the big care debate" – a wide ranging public consultation that runs until November on the principles behind a new service.

7.2. A copy of the final response is attached as Appendix 3.

8.0 Recommendations

8.1 The Committee is recommended to:

a. Consider the attached work programme and determine whether any further amendments should be made at this stage.

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25 January 2010

Background Documents: None

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE
WORK PROGRAMME – January 2010

Social Care Outcomes

S1. Health and emotional well-being	S2. Quality of Life	S3. Making a positive contribution	S4. Exercise choice and control	S5. Freedom from discrimination and harassment	S6. Economic well-being	S7. Personal dignity

In-depth Scrutiny Projects

SUBJECT	AIMS/TERMS OF REFERENCE	ACTION/BY WHOM	PARTNERSHIP ISSUES	TIMESCALES
Access to Dementia Services	1. To assess local interpretation of the National Dementia Strategy. 2. To develop proposals for a good Dementia Service. 3. Preparation of a Joint Commissioning Strategy.	Follow Up Actions **Final Report agreed by Executive February 2009**	Network involves partners from all sectors	**Commissioning Strategy and Network Updates (January 2010)**
Valuing Employment	1. To assess and contribute to our and our partners' preparedness for the implications of Valuing Employment Now. 2. What are the numbers of people with learning disability in employment in North Yorkshire now? 3. What worked/did not work in getting these individuals into employment in North Yorkshire? 4. What are the success stories from elsewhere in the country and what lessons might be brought back to North Yorkshire? 5. How do the Committee assist the Corporate County Council understand this agenda? 6. What awareness is there among other critical partners? 7. What should be the role of ACS?	Task Group	Working with partners in all sectors to encourage a positive approach	**Final Report end of 2010**

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME – January 2010				
Extra Care Development	Report to January Committee regarding objectives of review and potential Terms of Reference	To be decided		**To be decided**
Older Peoples' Strategy Engagement	Assessment of how North Yorkshire County Council engaged with older people.	Task Group Report		**January 2010**
Early Intervention and Prevention (POPPS)	Wider prevention and early intervention agenda in the light of National POPP Evaluation.	To be considered at Mid-Cycle Briefing		**Spring 2010**

Overview Reports

SUBJECT	AIMS/TERMS OF REFERENCE	ACTION/BY WHOM	PARTNERSHIP ISSUES	TIMESCALES

S1. Health and emotional well-being	S2. Quality of Life	S3. Making a positive contribution	S4. Exercise choice and control	S5. Freedom from discrimination and harassment	S6. Economic well-being	S7. Personal dignity

	2010				
Scheduled Committee Meetings	***11 February*** *10.30am*	***8 April*** *10.30am*	***3 June*** *10.30am*	***2 September*** *10.30am*	***4 November*** *10.30am*
Scheduled Agenda Briefing	***To be arranged***	***6 April*** *10.30am*	***1 June*** *10.30am*	***31 August*** *2.00pm*	***2 November*** *10.30am*
Scheduled Mid Cycle	***4 March*** *10.30am*	***6 May*** *10.30am*	***15 July*** *10.30am*	***7 October*** *10.30am*	***23 December*** *10.30am*
Overview / Update Topics					
1. Assistive Technology/Telecare			Review Progress		
2. Personalisation/Self Directed Support		Update Review of Implementation			

3. Safeguarding	NY Board Review No Secrets				
4. Early Intervention and Prevention			Review		
5. Dignity Champion	Annual Report/Social Care				

The National Evaluation of Partnerships for Older People Projects: Executive Summary

PSSRU

The Partnership for Older People Projects (POPP) were funded by the Department of Health to develop services for older people, aimed at promoting their health, well-being and independence and preventing or delaying their need for higher intensity or institutional care. The evaluation found that a wide range of projects resulted in improved quality of life for participants and considerable savings, as well as better local working relationships.

- Twenty-nine local authorities were involved as pilot sites, working with health and voluntary sector partners to develop services, with funding of £60m
- Those projects developed ranged from low level services, such as lunch-clubs, to more formal preventive initiatives, such as hospital discharge and rapid response services
- Over a quarter of a million people (264,637) used one or more of these services
- The reduction in hospital emergency bed days resulted in considerable savings, to the extent that for every extra £1 spent on the POPP services, there has been approximately a £1.20 additional benefit in savings on emergency bed days. This is the headline estimate drawn from a statistically valid range of an £0.80 to £1.60 saving on emergency bed days for every extra £1 spent on the projects
- Overnight hospital stays were reduced by 47% and use of Accident & Emergency departments by 29%. Reductions were also seen in physiotherapy/occupational therapy and clinic or outpatient appointments with a total cost reduction of £2,166 per person
- A practical example of what works is pro-active case coordination services, where visits to A&E departments fell by 60%, hospital overnight stays were reduced by 48%, phone calls to GPs fell by 28%, visits to practice nurses reduced by 25% and GP appointments reduced by 10%
- Efficiency gains in health service use appear to have been achieved without any adverse impact on the use of social care resources
- The overwhelming majority of the POPP projects have been sustained, with only 3% being closed – either because they did not deliver the intended outcomes or because local strategic priorities had changed
- PCTs have contributed to the sustainability of the POPP projects within all 29 pilot sites. Moreover, within almost half of the sites, one or more of the projects are being entirely sustained through PCT funding – a total of 20% of POPP projects. There are a further 14% of projects for which PCTs are providing at least half of the necessary ongoing funding
- POPP services appear to have improved users' quality of life, varying with the nature of individual projects; those providing services to individuals with complex needs were particularly successful, but low-level preventive projects also had an impact
- All local projects involved older people in their design and management, although to varying degrees, including as members of steering or programme boards, in staff recruitment panels, as volunteers or in the evaluation
- Improved relationships with health agencies and the voluntary sector in the locality were generally reported as a result of partnership working, although there were some difficulties securing the involvement of GPs

BACKGROUND

The Partnership for Older People Projects (POPP) were funded by the Department of Health to develop services for older people, aimed at promoting their health, well-being and independence and preventing or delaying their need for higher intensity or institutional care.

The POPP initiative was set up to provide improved health and well-being for older people via a series of individual projects providing local services. These services were to be person-centred and integrated, to promote health, well-being and independence, and to prevent or delay the need for higher intensity or institutional care. There was an expectation that strong partnerships would be forged with local providers of health care, as well as with many other local organisations, particularly local voluntary and community organisations (VCOs). A greater involvement of older people themselves was also an objective of the initiative.

The Department of Health designated 29 pilot sites (19 in a first round and ten in a second round), running from May 2006 through March 2009. Each pilot site was a local authority in England. The Department also commissioned a national evaluation of the programme as a whole.

This summary is drawn from the full report submitted by the National Evaluation Team in October 2009.

FINDINGS

The projects

the 29 sites set up 146 core local services, with a further 530 small 'upstream' projects commissioned from the third sector

In total, the 29 sites set up 146 core local projects, comprising many more individual services, aimed at improving health and well-being among older people and reducing social exclusion and isolation. The individual projects were determined according to local priorities. Of the 146 projects, two-thirds were primarily directed at reducing social isolation and exclusion or promoting healthy living among older people ('community facing'). The remaining one-third focused primarily on avoiding hospital admission or facilitating early discharge from acute or institutional care ('hospital facing'). Some addressed the full spectrum of needs. In addition to these 'core' projects, a further 530 small 'upstream' projects were commissioned from the third sector.

older people, working as volunteers, made a significant contribution to the projects

Altogether, 522 organisations were involved with projects across the POPP programme, including health bodies, such as PCTs, secondary care trusts and ambulance trusts; other bodies, such as the fire service, police, and housing associations; national and local voluntary organisations; and private sector organisations. Volunteers, including many older people themselves, also made an important contribution, becoming increasingly significant over the period of the project.

The services used by those engaged with POPP services were not limited to those within the programme. Just over a quarter of service users were referred on to other services, with a higher referral rate in the second round of ten pilot sites. Of the individuals referred, one

fifth (21%) were referred on to voluntary organisations and over a quarter (27%) to some form of health care, including hospital (6%), GP (6%), other health professional (9%) or mental health provision (6%). Over one in ten (13%) of the referrals were to social care and the same proportion (13%) were to other POPP projects. The latter was particularly strong (17%) in the second year of operation, suggesting that the individual local projects had formed a sense of an overall programme of work.

Service users

over a quarter of a million people used the services of POPP projects over three years

Well over one quarter of a million people (264,000) used the services of POPP projects over the three years, with particularly heavy use in the third year.

The clearest information on the demographic characteristics of users comes from the standardised questionnaire. The average (mean) age of these service users was 75, with a range of 40 to 101. Two-thirds were women. Roughly one-third were married, with the remainder widowed, divorced or single. The great majority (81%) lived in their own homes (or that of a relative), but some lived in sheltered housing, residential or nursing care homes. Roughly two-thirds lived in areas designated as deprived. There was some variation in all these characteristics according to the nature of the projects.

two-thirds of service users were aged 75 and over

Of those users receiving a service, almost one-third (30%) were aged 85 and over, with almost two-thirds (63%) aged 75 and over, with some variation with the focus of the service. A high proportion (60%) of those aged 85 and over accessed projects providing tertiary care, but one-third (34%) also accessed services offering primary prevention. This suggests that services focused toward early intervention are being used by the total older person population, not simply those in younger age groups.

OUTCOMES

Impact on older people

POPP projects were widely thought by staff to have delivered better services for older people in terms of their quality of life and well-being

The POPP projects were widely thought by staff to have delivered better services for older people in terms of their quality of life and well-being. A greater range of services was said to be offered and there was a greater awareness among older people of the services available, coupled with easier access to them. In addition to obtaining new services, many individuals were also referred on to other services via the projects, for instance to social services, health care professionals or other POPP services. Some difficulties were experienced however, in providing access to 'hard to reach' people and some services were felt to be insufficiently responsive to the needs of black and minority ethnic (BME) groups, despite

considerable efforts on the part of staff to ensure that services were relevant and culturally sensitive. Where services were dedicated expressly to BME groups, engagement was much more successful.

POPP services improved users' quality of life, varying with the nature of individual projects. Those providing services to individuals with complex needs were particularly successful, but low level services also had an impact.

Assessing the impact of these projects on users' health-related quality of life, as well as overall quality of life, is difficult, because many users were very old and frail and likely to experience deteriorating well-being in any case. Indeed, those in the POPP sample initially reported between one fifth and one quarter lower levels of quality of life, compared to the 'normal population'. Moreover, a number of services, although providing valuable help to people, were unlikely to have a striking impact on their overall quality of life, as other factors, such as poverty, illness or bereavement, were more likely to be critical here.

The evaluation addressed the issue of the Programme's impact in two ways. A standardised questionnaire, administered both before and after the POPP intervention, measured the health-related quality of life (HRQoL) of a sample of 1,529 older people, and recorded their perception of any changes in their overall quality of life. A sample drawn from the British Household Panel Survey was used as a comparison. First, attention was given to changes in HRQoL. These varied with the type of project, but improvements were found in nine of the 11 types, compared to the comparison group. Those receiving practical help appeared to report a notable improvement (12% increase), as simple aids or services could affect well-being – such as a grab-rail making washing easier or minor repairs reducing anxiety. An equivalent improvement (12% increase) was also reported following interventions providing exercise, presumably due to increased strength and flexibility and a positive effect on mood. Smaller improvements were found in those involved with projects offering community support, proactive case coordination and specialist falls programmes (3%–4%). A very slight deterioration was found in those people in projects offering hospital discharge and complex care (lower than 2% decline), but these individuals still fared better than the comparative sample. Moreover, when these latter categories were further analysed, it was found that some types of intervention 'bucked the trend'; if an intervention was multi-disciplinary, better outcomes were recorded.

a 12% increase in health-related quality of life was found for those individuals receiving practical help

The projects were further divided into the wider groupings by needs levels and 'community-facing' and 'hospital-facing'. People using community-facing services appeared to experience improved HRQoL compared to the comparison group drawn from the BHPS. Those using tertiary services had an improved HRQoL of 25% and even those involved with low-level preventative projects reported a 2% improvement.

All these findings must be treated with caution, as the variance in the data made it impossible to attribute statistical significance across the wider groupings. Nevertheless, when individual services were examined as representatives of the whole, changes in HRQoL were found to be significant.

Second, a single question asked individuals to rate their quality of life as a whole, ranging from 'my life is so bad, it could not be worse', through to 'my life is so good, it could not be better'. Such a question is by necessity multi-factorial, with each participant interpreting it according to their own circumstances, preferences and beliefs. It may not be appropriate to expect low-level and short-term services to have an impact on such a wide measure, especially within a short time span (median administration time was six months). Overall, individuals reported a small deterioration in their quality of life, using these questions, following the POPP intervention, with some variation according to the nature of the area in which people lived and with age. Fewer individuals in the most deprived areas reported that their quality of life had remained the same, while younger individuals reported the greatest deterioration (but it should be noted that their level of disability was likely to be high, given their involvement with services).

older people using POPP programmes reported increased receipt of state benefits

Older people further benefited from the POPP programme through a reported increase in the receipt of state benefits. More people were receiving attendance allowance following the programme than before, with information and advice services increasing benefits by £23,000 per annum. The overall increase was £53,768 per year.

Impact on joint working

The projects were reasonably successful in developing good working relations with the wide range of partner organisations, with some variation across areas and organisations. In most areas, service delivery teams comprised staff employed by more than one agency; several had multi-agency multi-disciplinary teams. Such teams facilitated easy discussion, mutual respect and, on a practical level, advice and referrals across agencies; this was particularly notable where staff worked together in the same location, in contrast to 'virtual' teams. In some areas, new posts developed expressly to overcome organisational barriers were introduced and found to enhance good working relations. Link roles were also helpful in this respect.

'Older people told us the sort of services they wanted the money invested in – and that affected what we spent the money on. The real test to me of engagement is that you have to affect one of the two important things: what you do or what you spend your money on…The involvement of older people in the programme has affected both things directly.'
(Project manager, local pilot site)

Many local VCOs provided and received benefit from participation in the POPP programme. Local authority and health partners were able to benefit from their local knowledge of communities and voluntary services. Where commissioned to provide services, VCOs were able to strengthen their skills and abilities, for instance in their capacity to obtain funding. Good networking and support between such organisations was also noted.

The direct involvement of older people in the design and implementation of the POPP projects, an underlying principle of the programme, was said to strengthen over time, with increasing commitment amongst project staff.

In most sites, there was an effort to go beyond tokenism to involve

'When I retired, I sat there for a month and then thought 'well is this me for the rest of my life? And I thought, 'no way!' I joined the pensioner group and it's evolved from that. I get a lot of pleasure out of it.'
(Volunteer provider, local pilot site)

older people fully. The nature of this involvement varied across sites, however, and was generally stronger in the design (77% of the projects) and governance (93% had older people on a steering committee) of projects, compared to service delivery. Fewer than one-third (29%) involved older people as volunteers. The older people involved tended to be newly retired (the 'young old'), healthy and well-educated.

A number represented local voluntary organisations for older people. Some of the professionals employed by the sites noted that they found it difficult to fully involve older people, in part because of reluctance to hand over power, but also because of tight timetables and administrative constraints.

Expenditure and savings

The 29 pilot sites spent £50.7m on the projects developed over the period of the initiative. Of this, two-thirds (64%) was spent on 'community-facing' projects and one-third (36%) on 'hospital-facing' projects. Breaking down the spend across the types of prevention, one-third (35%) was spent on projects addressing tertiary prevention, one-third (31%) on primary prevention projects, one quarter (24%) on secondary prevention projects and the remainder on underpinning projects.

The costs of the POPP programme were examined by four different means. The first assessed the cost of the individual projects per user. These varied considerably with the focus of projects: those aimed at primary prevention cost £4 per user per week, compared to £7 for projects aimed at secondary prevention. These costs are low compared with other social and health care interventions. Such findings must be treated with caution, due to some probable inaccuracies in reporting and a high level of missing data.

emergency hospital admissions were reduced, resulting in considerable savings – an additional £1 spent on POPP services is estimated to produce approximately a £1.20 saving on emergency bed days

The second analysis focused on the impact of the POPP projects on the use of hospital emergency beds, using areas without a POPP programme as a comparison. It was found that POPP projects appeared to have a significant effect on emergency bed days, and this has stabilised over time. The effect was such that an additional investment of £1 in POPP services would produce greater than £1 savings on emergency bed days. The projected figure varies with assumptions about management overhead costs: under an assumption of 10% management costs, a £1 additional spend on POPP projects would lead to approximately a £1.20 reduction in required spending on emergency bed occupants at the mean. This is the headline estimate drawn from a statistically valid range of an £0.80 to £1.60 saving on emergency bed days for every extra £1 spent on the projects.

Differences were found here according to the nature of the projects, with 'hospital-facing' projects showing signs of diminishing effect, not economies of scale. That is, larger projects seemingly produced

lower potential savings on emergency bed days. This may be partially due to the limit in the number of people who can be easily diverted from hospital by such projects. In contrast, 'community-facing' projects showed increasing returns against economies of scale, such that the larger the project, the greater the saving. These may require a 'critical mass', but once they are large enough, can seemingly reduce the need for emergency secondary care. Moreover, funding these services to a sufficient degree would be cost-effective in saving £1 for every £1 spent.

As with any analysis of this type, there are inherent limitations to the certainty which can be placed on the analysis, but within the context of this research, POPP projects can be recommended as a cost-effective policy option.

within the context of this research, POPP projects can be recommended as a cost-effective policy option

The third analysis explored whether the quality of life benefits delivered by the projects were cost-effective or more expensive than 'usual care'. Projects were analysed using the cost-effectiveness acceptability curve (CEAC), compared to outcomes in areas with no POPP projects, using the 'willingness to pay' cut-off figure of £30K for a point increase in QALY employed by the National Institute for Health and Clinical Excellence (NICE). It was found that, considering the POPP projects as a whole, there was a very high probability (86%) that the overarching POPP programme was cost-effective, compared with usual care. Decisions will need to be made as to whether the cost-effectiveness probability levels are high enough to support commissioning decisions. For example, commissioners would need to ask themselves if a 14% area of risk in setting up projects (that 1.4 projects in ten may not be cost-effective as compared with usual care) is too great.

In exploring the different types of project (e.g., practical help, social/emotional support, pro-active case finding) variations as to the probability of cost-effectiveness were found. Nevertheless, there was high probability in all cases and, within three categories, there was greater than a 98% probability that at £10,000 or less per point increase in QALY, such projects were cost-effective if compared with 'usual care'.

One operational example concerns those projects focused on improving well-being through the provision of practical help, small housing repairs, gardening, limited assistive technology or shopping. For an extra spend of £5,000 per person – £96.15 per week – there is a 98% probability that such projects are cost-effective compared with 'usual care'. Commissioners putting in place such projects could be reasonably confident that only around 0.2 projects in ten would not be cost-effective.

Finally, individuals' use of health and social care services was analysed, to address whether there was a change in costs arising from changes in the type and extent of services used before and after the POPP project. This information was based on 1,529 service users who completed the standardised questionnaire before

overnight hospital stays reduced by 47% and use of A&E Departments by 29%. There were also fewer physiotherapy/occupational therapy and clinic or outpatient appointments, with a cost reduction of £2166 per person.

and after their involvement in the POPP programme. Overall, hospital overnight stays appeared to be reduced by almost half (47%) and use of Accident & Emergency departments by almost a third (29%). Reductions were seen in physiotherapy/occupational therapy and clinic or outpatient appointments by almost one in ten. Such change had a notable impact on costs with a cost reduction of £2,166 per person reported. There was, of course, considerable variation depending on the type of projects in which the older people were involved; the highest reductions were for projects focusing on hospital discharge and the lowest was for specialist falls services.

This evidence of the POPP projects leading to cost-reductions in secondary, primary and social care was similarly demonstrated by many of the local evaluations. The main difficulty for sites was translating the evidenced cost-reduction into a cost saving. Moving monies around the health and social care system was a huge challenge, and proved an insurmountable one where budgets were the responsibility of more than one organisation. For instance, monies could be moved from residential care budgets to home care budgets within a local authority, but a claim for monies by a local authority from either primary or secondary health care budgets did not prove possible.

Key learning points

As with any new programme, the POPP pilot projects experienced a number of challenges in their implementation. Problems arose around the short duration of the POPP projects, as this inevitably meant hasty initial decision-making and staff concerns about their own future employment toward the end of the project. Recruitment of staff, particularly project managers, proved difficult, and it took time for them to clarify exactly what they should be doing. Similar problems were found with volunteers, who could be difficult to retain. The amount of administration time required for projects was often under-estimated. Second round projects were able to benefit, however, from the experience of the first round projects.

The involvement of older people could prove difficult, due to their own ill health or that of people for whom they were caring, as well as transport difficulties; people from BME communities were found to be difficult to recruit.

improved relationships with health agencies and the voluntary sector in the locality were generally reported as a result of partnership working, although there were some difficulties securing the involvement of GPs

Difficulties in organisational partnerships are notorious and the POPP projects reported some problems, including the sheer time and commitment needed across agencies and considerable cultural boundaries between professions. Inter-organisational referrals were found to be complex. An inherent tension was noted in policies which promoted partnership across agencies on the one hand and competition on the other. There were also both practical and ethical problems in data-sharing. Those managing multi-agency teams experienced particular problems in coping with differing

organisational arrangements, for instance with respect to pay, holiday and pension systems. It was found that GPs were difficult to engage, although playing a central role with service users. In addition, problems arose from specific developments at the time, such as the major reconfiguration of PCTs, which meant that PCT staff were preoccupied with the demands of their own jobs, together with considerable turnover of personnel.

Sustainability

the ovewhelming majority of the POPP projects have been sustained, with only 3% closing – either because they did not deliver the intended outcomes or because local strategic priorities changed

The ability of projects like POPP to endure beyond their initial funding period is clearly important to their long-term impact. The overwhelming majority (85%) of POPP projects secured funding to continue in one form or another, in many cases through their local PCT. In addition, the 'transformation agenda' for social care, incorporated in *Our Health, Our Care, Our Say* (2006), closely mirrored the focus of POPP and was influential on decisions to sustain projects via the Social Care Reform Grant. Only 3% of the projects 'closed', either because they did not deliver the intended outcomes or because local strategic priorities had changed.

Sustainability was often achieved through early attention to the issue. Local Area Agreements, for instance, proved an important mechanism for embedding and sustaining programmes. In many sites, final decisions concerning funding were not made until late in the final year; in contrast, where early agreements were made with agencies regarding their respective responsibilities for sustaining projects – and written into initial bids – the process of ensuring sustainability appeared to be timelier.

PCTs have contributed to the sustainability of the POPP projects within all 29 pilot sites. Moreover, within almost half of the sites, one or more of the projects are being entirely sustained through PCT funding – a total of 20% of POPP projects being entirely sustained through PCT funding. There are a further 14% of projects for which PCTs are providing at least half of the necessary ongoing funding.

PCTs contributed to the sustainability of the POPP projects within all 29 sites. Moreover, within almost half of the sites one or more projects were entirely sustained through PCT funding – giving a total of 20% of POPP projects entirely sustained through PCT funding. In a number of other projects (14%), PCTs provided at least half the necessary ongoing funding.

Key factors in bringing about continued enthusiasm and funding were the involvement of local councillors and older people as representatives, which raised the profile of POPP programmes both among strategic managers and the wider public. Local evaluations were also important, with early findings shaping the development of projects. But recognition was necessary of the inherently long-term impact of some of the services, where short-term changes could not be demonstrated. It was particularly difficult to provide robust evidence of service cost-effectiveness within the two-year funding period.

IMPLICATIONS FOR POLICY AND PRACTICE

Achieving desired outcomes

older people with high levels of need experienced improved outcomes

The POPP programme, set up to test preventive approaches, demonstrated that prevention and early intervention can 'work' for older people. Local authority-led partnerships, working within the context of Local Strategic Partnership and Local Area Agreements, can help to reduce demand on secondary services, providing they are appropriately funded and performance managed. Moreover, it has shown that small services providing practical help and emotional support to older people can significantly affect their health and well-being, alongside more sizeable services expressly directed to avoiding their need for hospital. Most of the older people using POPP services had relatively high levels of need, but they nonetheless experienced improved outcomes and reported greater satisfaction than the comparison group, as a result of using these services.

Indeed, it is possible that the evaluation results understate the benefits which can potentially be derived from such a programme. The POPP projects were, by definition, largely untested and some were necessarily more effective than others. If those seeking to introduce similar programmes were to focus on those projects that were found to be most effective and those older people found most likely to benefit from them, the returns from similar levels of investment is likely to be greater. Moreover, the POPP projects took time both to bed in and to become embedded within local health and social care systems. It is possible that even greater value could be secured over the longer term, as new projects learn from their experience, and general expertise and confidence grow.

if cashable savings are to be released some degree of financial systems reform is likely to be necessary

These gains were secured by pump-priming prevention and early intervention projects. Their cost-effectiveness gains cannot be fully realised unless cashable savings can be released and re-invested in such projects. Initially, only marginal savings may be identified. Some degree of financial systems reform is likely to be necessary to support the decommissioning of services in one part of the health and local government system alongside the re-investment of resources elsewhere.

From the results of this evaluation, it can be argued that the approach piloted by the POPP programme should be sustained, using the programme's learning to target investment to maximise individual and systems benefits. The realisation of the cost-effectiveness gains will be dependent, however, on the introduction of systems to support decommissioning and reinvestment.

Improving processes and management arrangements

Complex new programmes are inherently challenging to get off the ground, especially where they involve a range of agencies. Because it can be difficult to anticipate the particular problems likely to arise, time and resources for the implementation period should be built in from the start. It needs to be recognised – by both commissioners and programme managers – that recruitment, training and staff preparation is likely to take at least six months and local project managers should be in place to ensure appropriate implementation.

It should be expected that both project structures and processes will, quite rightly, evolve over time. Such changes will need to be mirrored by changes in project targets and monitoring tools. Good staff supervision should be ensured to support staff through such changes.

Multi-disciplinary projects benefit from the co-location of staff from different agencies and professions in one place, rather than seeking to develop a 'virtual' team, as well as from single line management. Co-located teams enable people to work more effectively together and achieve better outcomes, although they do not function without difficulties.

Where large programmes involve tendering for projects, attention should be given to the development of flexible commissioning processes appropriate to the scale of the exercise. Tendering must be arranged to assure an equitable process, particularly where small voluntary organisations are involved. Support and assistance with capacity-building should be available early on, together with clear information concerning requirements for monitoring and targets.

Where there is to be a programme evaluation, project leads should work with all stakeholders (providers, commissioners, programme clients) to think through their desired outcomes from the programme, rather than simple outputs. These outcomes should be used to develop a framework for evaluation, prior to commissioning external evaluators. Monitoring and measurement should then be embedded in any project recording systems prior to the start of any project. Baseline measurements must be established early on.

Involving consumers effectively in the design and direction of programmes is well known to be difficult and may be particularly problematic in the case of older people. Time and resources to assist this process must be built into the implementation programme, including for the provision of appropriate training and the establishment of systems for such practical issues as payment arrangements and transport. There also needs to be a balance of understanding between the necessary 'safe-guarding' procedures (through Criminal Records Bureau checks) and the level of support older people are providing. Management of risk may need to be undertaken and underwritten across the authority if the contribution of volunteers and representatives is to be optimised.

METHODS

The National Evaluation of the POPP Programme involved 15 different methods of data collection and analysis. These were concerned to address questions focused both on outcomes, such as the extent to which projects improved the quality of life of older people or were cost effective, as well as process, such as the nature of the opportunities and challenges experienced in the course of implementing the programme. A first phase involved the collection of baseline information, including documentary analysis and a key informant questionnaire across the 29 pilot sites; a second phase involved substantial data collection via interviews and focus groups with both local staff and older people across five case study sites; and the third involved further interviews across the 29 sites.

Older people – and to some extent their carers – were involved throughout the evaluation. They helped with the design of key study tools, sat on a steering group and commented on the early findings. It is hoped that they will also be involved in dissemination activities.

FURTHER INFORMATION

The evaluation of the Partnerships for Older People Projects was funded by the Policy Research Programme at the Department of Health. The findings presented and views expressed in this report are those of the researchers and not necessarily those of the Department of Health or any other government department.

Summary and full reports of the evaluation can be downloaded from the PSSRU website, www.pssru.ac.uk.

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The **PERSONAL SOCIAL SERVICES RESEARCH UNIT** undertakes social and health care research, supported mainly by the Department of Health, and focusing particularly on policy research and analysis of equity and efficiency in community care, long-term care and related areas — including services for elderly people, people with mental health problems and children in care. Views expressed in PSSRU publications do not necessarily reflect those of funding organisations. The PSSRU was established at the University of Kent at Canterbury in 1974, and from 1996 it has operated from three branches:

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Dear Colleague

Re the Big Care Debate and Shaping the Future of Social Care

North Yorkshire County Council took the care debate very seriously. Representatives from Adult Care Services attended the DH event in Darlington, the Senior Management Team of the Corporate Council considered and debated the matter and the Care and Independence Overview and Scrutiny Committee, under the Chairmanship of Cllr. Tony Hall held a special committee meeting to debate the topic. Representatives from a range of agencies were called as witnesses.

Overall there was a strong support for the debate and individuals, agencies and committees welcomed the opportunity to participate.

On the reason for the debate and why change is needed North Yorkshire County Council acknowledges and recognises the scenarios highlighted early in the debate document. We are facing a 68% increase in the number of people with dementia by 2020 and two years ago the Corporate Director of Adult Social Care predicted a £43m shortfall at 2007 prices for North Yorkshire alone by 2017. The present model is not sustainable.

On the principles underpinning the debate we acknowledges these as valid principles on which to base a national debate on the future of social care. However while there was some support for a national care model there strong view was of the need to drive forward the integration agenda across health and social care rather than develop a new social care

national system. There has been much encouragement for more integrated approaches but no real national lead or a requirement to deliver on integration.

While there is support in principle for a national entitlement such as a portable assessment of need, unless there is a national template and methodology for allocation of resources according to need there will continue to be local interpretation and variation of service delivery. North Yorkshire is one of the largest counties geographically and understands the challenges of ensuring consistency of approaches across its own wide county. To achieve this nationally will prove to be a major challenge.

On how to fund the future of social care there is recognition that funding is a primary issue in this debate and does need addressing. It will need all party consensus and possibly a national referendum. However this does need to be an honest and open debate and focus on wider government and national expenditure. The time has come for us as a nation to discuss and agree our priorities at large. So rather than discussing the £1.5billion available to social care the discussion should be on the £621billion of national investment.

However funding is not the only issue and system reform must also be driven forward. This should include integration of NHS Community Services with Social Care under a public accountability framework. The major investment of the Department of Health itself is in the NHS. North Yorkshire is minded of the Wanless Report which suggested that every £1 invested in social care saves the NHS £1.30. Failure to address the balance of investment in social is costing the NHS and the Department of Health vast amounts. Nationally we continue to fund the growing demand for acute care, which is primarily an acute provider driven demand, rather than invest an increased percentage in community services as part of health promotion and prevention. Councils are in a key position to turn this around for the NHS.

The ambition of the vision outlined in ‘Shaping the Future of Social Care’ is laudable and welcomed. However the gaps in the document are clear. There is almost complete absence of financial figures and modelling. There is no clear indication what a national care service and the extra demands of our ageing population might cost; how much would be paid by the government; and critically what individuals would get for their contribution. The bottom line is that we believe we need to find substantial extra money to pay for social care in the future - who pays, how much, when and how represent really hard choices but this is one issue that cannot be fudged and the concern is that with an election pending the delay in addressing this places social care in an even more vulnerable position. The under estimation of the growth in dementia and the numbers needing services and the national failure to fund the ever increasing high cost of care is but one example area where there is increased pressure to address funding.

On the six key aspects of a national care system:

- the North Yorkshire view is we are already committed to early intervention and prevention and understand it makes care ands economic sense. There should be further ring fenced investment in the area.
- National assessment concept is support but getting consistency of approach requires retraining many staff, a bespoke assessment tool with minimised room for professional discretion and the introduction of the idea of a national tariff or fixed price for care.

- While supportive of a joined up service we believe it should not be optional and be local authority led and be public accountable
- Information and advice: we see this as a given and therefore see our Library Services as playing a key role.
- Personalised care and support. Fully supported. But this should not be about who has the money but how it is used.
- Fair Funding: this is commented upon below.

On making the vision a reality:

- as a two tier authority we are fully supportive of more joined up working and we are constantly seeking ways forward with Seven District Councils partners and our local NHS North Yorkshire and York.
- Partnership working consumes a lot of time when performance frameworks are not joined up and the allocation of funding is not allocated on joint efficiency delivery programmes. Our view is there is need for more incentives to deliver joined up working and penalties for failure to address the needs of communities in a collective manner. Our view is that more public accountable authorities are more partnership and integrated orientated. World Class Commissioning Framework has yet to deliver this drive within the NHS.
- We are fully supportive of the widest range reasonable choices for people.
- We believe the present inspection regime of social care with its outdated input measurement approach acts as a barrier to innovation and its minimum standards in care approach acts as a perverse incentive to quality delivery.

On National consistency versus local flexibility:

- We are supportive of the comments of Councillor David Rogers ,chair of the Local Government Association Community Wellbeing Board:
    - ‘whatever system is implemented we can be sure that councils will continue to play a crucial role in supporting people to receive good quality financial advice, and incentivise financial products which enable people to make their personal contribution.
    - Of the two models proposed …we believe there is a sound rationale for the part local/part national model, which will deliver better outcomes for people.
    - More than that we believe a fully national system could undermine councils' flexibility in commissioning and designing care services around the needs of the user.’

On Funding care and support:

- As one of the lowest funded authorities in the country with a minimum tax burden on our local community we still deliver a highly rated Council agenda with a three star performance in social care.
- We are therefore supportive of Government tacking both authorities and NHS systems which do not deliver VFM.
- Government itself must lead a rational debate about the use of public purse and not focus on social care in isolation. And we are supportive of the LGA position that a fairer funding system must consider the totality of money available in the current system, in particular health.
- We believe in and support a partnership approach between the state and its people.

- There must be a major communication and education programme on the need for insurance. There are too many perverse incentives to approach this on a voluntary basis and opting out should not be an option or most will do so!
- The most vulnerable must also be protected.

Other views included:

- The need to pay attention to the voices of people with dementia and to carers;
- The lack of attention to the role of the third sector and community development approaches
- The need to ensure safeguarding vulnerable adults under pins any proposed system;
- The need to give recognition to those who have taken personal responsibility in planning for later life through good financial planning and healthy lifestyles.
- People with skills and abilities should not be barred from work because of age

In summary we welcomed the debate but believe the debate should be in the context of a much wider debate on public expenditure. While funding is a critical issue it is not the only issue and much more could be gained by driving more integrated approaches in public service delivery. The funding of social care is now at a critical level and the debate and its conclusions must be quickly concluded. Failure to address the appropriate funding of social care now will result in a greater national funding burden further down the line.

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