PSSRU

National Evaluation of Partnerships for Older People Projects

Appendices to the Final Report

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Appendices

Appendix A

Key Informant Questionnaire

National Evaluation of Partnerships for Older People Projects

Your Views

Locality Code ☐☐☐☐

Individual Code ☐☐☐☐

Dear Colleague,

Re: National Evaluation of Partnerships for Older People Projects

We are inviting you to participate in this study by completing a questionnaire, which should take approximately 40 minutes to complete. This questionnaire asks you to give your experience of being part of your Partnerships for Older People (POPP) project. The questionnaire has seven sections, none of which are particularly long. These are:

Section One: Your roles and responsibilities within the health and social care community
Section Two: Partnerships within your area
Section Three: Partnerships and the POPP Programme
Section Four: The POPP Projects
Section Five: Multi-Agency Meetings
Section Six: Sustainability
Section Seven: National Policies

We have tried to design the questionnaire to be as easy as possible to complete and, most of the questions just ask you to tick a particular box. Comment boxes have been provided should you wish to expand on your answer.

All completed questionnaires will be treated with the strictest confidence and all information provided within them will be anonymised before being included within any reports.

Thank you very much for considering taking part. Your views are important and we hope that you will take the time to complete the questionnaire. If you would like to discuss any aspect of the study, please do contact me.

Yours faithfully

Dr Richard Wagland
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Section one: Your roles and responsibilities within the health and social care community

1. Please indicate what type of organisation your work for:

- ☐ Primary Care Trust
- ☐ Local Authority
- ☐ Joint Appointment between Local Authority and PCT
- ☐ NHS Trust (Acute)
- ☐ Mental Health Trust
- ☐ Strategic Health Authority
- ☐ Voluntary/Community Organisation
- ☐ Private Organisation
- ☐ I am a Lay / User/ Carer Representative
- ☐ Other (please specify)

……

2. Please tick the job titles that best describes your role within the POPP programme (you may tick more than one if appropriate)

- ☐ Chief Executive
- ☐ Director
- ☐ Assistant Director
- ☐ Locality Manager
- ☐ Other Senior Manager
- ☐ Finance / commissioning officer
- ☐ Health or Social Care Professional
- ☐ POPP Project / scheme lead
- ☐ Project Worker
- ☐ Lay / User/ Carer Representative.
- ☐ Other (please specify)

……

3. Tick the adjective that best describes the responsibilities of your post

- ☐ Operational (if you have general management responsibilities for services)
- ☐ Strategic (if you have responsibilities for planning and development of services e.g. change management, commissioning, strategic development)
- ☐ Combination of operational and strategic responsibilities.
- ☐ Direct delivery of care or services
- ☐ Other (please specify

……

4. How long have you been within your present role?

Years / Months ……../……

5. How long have you been working within this organisation?

Years / Months ……../……

Section Two: Partnerships within your area

The following questions are intended to find out your opinions about how you feel different health and social care organisations (statutory and voluntary) work together.

6. To what extent do you agree that two or more statutory and non-statutory organisations can jointly manage services in an effective way?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree

7. To what extent do you agree that two or more statutory and non-statutory organisations can jointly share financial risks in an effective way?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree

8. To what extent do you agree that partnership working has been substantially achieved prior to POPP between the following organisations in your area?

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
The PCT and hospital Trusts	☐	☐	☐	☐	☐	☐
Social services and private organisations	☐	☐	☐	☐	☐	☐
The PCT and community and voluntary organisations	☐	☐	☐	☐	☐	☐
Hospital Trusts and community and voluntary organisations	☐	☐	☐	☐	☐	☐
The PCT and private organisations	☐	☐	☐	☐	☐	☐
Hospital Trusts and private organisations	☐	☐	☐	☐	☐	☐
Social services and hospital trusts	☐	☐	☐	☐	☐	☐
Social services and community and voluntary organisations	☐	☐	☐	☐	☐	☐
Social services and the PCT	☐	☐	☐	☐	☐	☐

Any Comments:

Section Three: Partnerships and the POPP Programme

The questions in this section relate solely to the partnership arrangements within the POPP programme in your area.

9. To what extent do you agree that partnership working between the following organisations has been strengthened by the POPP programme?

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
Social services and private organisations	☐	☐	☐	☐	☐	☐
The PCT and community and voluntary organisations	☐	☐	☐	☐	☐	☐
Social services and community and voluntary organisations	☐	☐	☐	☐	☐	☐
Social services and the PCT	☐	☐	☐	☐	☐	☐
Social services and the Hospital Trusts.	☐	☐	☐	☐	☐	☐
The PCT and private organisations	☐	☐	☐	☐	☐	☐
Hospital Trusts and community organisations	☐	☐	☐	☐	☐	☐
Hospital Trusts and private organisations	☐	☐	☐	☐	☐	☐
The PCT and Hospital Trusts	☐	☐	☐	☐	☐	☐

Any Comments:

10. To what extent do you agree that the following barriers to partnership working exist within your area's POPP programme partnership?

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
The complicated governance structures make it difficult for lay representatives and older people to be fully involved.	☐	☐	☐	☐	☐	☐
Uncertainty surrounding the ongoing funding of the POPP projects acts as an disincentive for partners to work together	☐	☐	☐	☐	☐	☐
The reconfiguration of the PCTs has created some difficulties in the short term due to a change in staff	☐	☐	☐	☐	☐	☐
A lack of trust and confidence exists between the partner agencies	☐	☐	☐	☐	☐	☐
The different cultures of the partner organisations means there cannot be a true partnership between them	☐	☐	☐	☐	☐	☐

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't Know
The POPP partnership incorporates too many organisations which make effective decision making difficult	☐	☐	☐	☐	☐	☐
GPs are not fully 'on board' within the POPP programme	☐	☐	☐	☐	☐	☐
There is a lack of commitment from one or more POPP partner agencies	☐	☐	☐	☐	☐	☐
The partner agencies lack a shared vision around the POPP programme	☐	☐	☐	☐	☐	☐
Too few older people are involved within the POPP governance arrangements	☐	☐	☐	☐	☐	☐
The current financial constraints within the health and social care economy is not conductive to partnership working	☐	☐	☐	☐	☐	☐
There is insufficient executive leadership over the strategic direction of the partnership	☐	☐	☐	☐	☐	☐
Community and voluntary organisations have too little decision-making responsibility within the POPP programme	☐	☐	☐	☐	☐	☐
The dominance of the lead social services organisation does not allow equal partnership	☐	☐	☐	☐	☐	☐

11. Please specify any further barriers that you think exist in your area but which are not listed above:

Section Four: POPP projects

The first question in this section relates to the conception of 'prevention' and how you feel 'prevention' could be best defined. The questions that follow it explore the interventions and projects that make up the POPP programme in your area

12. Please indicate how closely each of the following statements describes your understanding of 'Prevention' on a scale of 1 to 5 (5 being the most closely)

	(Most closely) 5	4	3	2	(Least closely) 1
Prevention of admission of older people to acute secondary sector care	☐	☐	☐	☐	☐
Prevention of admission of older people to institutional residential/ nursing care	☐	☐	☐	☐	☐
Delaying or preventing the need of older people for more expensive / intensive social and health care services	☐	☐	☐	☐	☐
Promotion of 'successful' aging	☐	☐	☐	☐	☐
Facilitating older people to achieve their goals	☐	☐	☐	☐	☐

	(Most closely) 5	4	3	2	(Least closely) 1
Preventing disease	☐	☐	☐	☐	☐
Delaying or preventing the loss of independence of older people	☐	☐	☐	☐	☐
Preventing or delaying the decline of well-being of older people	☐	☐	☐	☐	☐
Promoting greater engagement of older people with their local community	☐	☐	☐	☐	☐

Any Comments:

13. Please indicate the level of influence that the following factors had on the design of the projects / interventions that make up the POPP programme in your area

	Strongly influential	Influential	Not influential	Don't know
Gaps identified within existing service provision	☐	☐	☐	☐
Financial recovery plans	☐	☐	☐	☐
Previous research commissioned within primary healthcare	☐	☐	☐	☐
Local government policies	☐	☐	☐	☐
The views of staff from statutory organisations (LA/PCT)	☐	☐	☐	☐
Ongoing service developments initiated prior to POPP funding	☐	☐	☐	☐

	Strongly influential	Influential	Not influential	Don't know
The learning from other non-POPP projects within your area	☐	☐	☐	☐
Previous academic research commissioned elsewhere	☐	☐	☐	☐
Reducing health and social care inequalities	☐	☐	☐	☐
Previous research commissioned within the local authority	☐	☐	☐	☐
Issues concerning rurality	☐	☐	☐	☐
National government policies	☐	☐	☐	☐
The views of older people	☐	☐	☐	☐
The level at which the Fair Access to Care (FAC) criteria are set for the accessing of social care services	☐	☐	☐	☐

Any Comments:

14. To what extent do you agree that the following issues were key challenges to the setting up and initiation of the POPP projects/interventions?

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
Recruitment of POPP projects leads	☐	☐	☐	☐	☐	☐
Tendering processes or the delivery of POPP services	☐	☐	☐	☐	☐	☐
Setting up arrangements for monitoring the performance of the local POPP programme	☐	☐	☐	☐	☐	☐
Recruitment of older people as POPP volunteers as service providers	☐	☐	☐	☐	☐	☐
Defining local evaluation proposals	☐	☐	☐	☐	☐	☐
Working with the National Evaluation Team	☐	☐	☐	☐	☐	☐
Setting key POPP service outcomes	☐	☐	☐	☐	☐	☐
Developing arrangements by which to secure the sustainability of the POPP programme	☐	☐	☐	☐	☐	☐
Working with the Department of Health Project Management Team	☐	☐	☐	☐	☐	☐
Negotiating premises from which POPP project management could be provided	☐	☐	☐	☐	☐	☐

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
Recruitment of POPP operational staff	☐	☐	☐	☐	☐	☐
Greater response than expected from community and voluntary sector organisations in bidding for POPP funds	☐	☐	☐	☐	☐	☐
Negotiations with trade unions	☐	☐	☐	☐	☐	☐
Poor response from community and voluntary sector organisations in bidding for POPP funds to provide services	☐	☐	☐	☐	☐	☐
Negotiating premises which POPP services will be provided	☐	☐	☐	☐	☐	☐
Recruitment of older people as POPP steering group members	☐	☐	☐	☐	☐	☐
Agreeing risk sharing arrangements between POPP partner agencies	☐	☐	☐	☐	☐	☐
Working out realistic expected financial savings to be achieved by the local POPP programme	☐	☐	☐	☐	☐	☐
Reluctance of GPs to become involved with the POPP programme	☐	☐	☐	☐	☐	☐
Setting job descriptions for POPP personnel	☐	☐	☐	☐	☐	☐

Any Comments:

15. To what extent do you agree with the following statements with regards to the progress of your POPP programme to date?

The progress of the POPP programme to date has:

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
Ensured older people are more readily referred to appropriate specialist services	☐	☐	☐	☐	☐	☐
Made older people more aware of the services available to them	☐	☐	☐	☐	☐	☐
Increased the responsiveness of services to the needs of older people from black and minority ethnic communities and other hard to reach groups	☐	☐	☐	☐	☐	☐
Improved the accessibility of services to older people as they are easier to reach	☐	☐	☐	☐	☐	☐
Made the delivery of services more accountable to older people	☐	☐	☐	☐	☐	☐
Brought greater job satisfaction for staff	☐	☐	☐	☐	☐	☐
Delivered a fairer geographical distribution of services than previously existed (i.e. people with the same needs receive the same services across the pilot site areas)	☐	☐	☐	☐	☐	☐
Delivered improvements in the quality of life and well-being of service users	☐	☐	☐	☐	☐	☐

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
Delivered services that provide greater continuity of care to older people for as long as necessary	☐	☐	☐	☐	☐	☐
Enhanced the experience of carers	☐	☐	☐	☐	☐	☐
Provided a wider range of choice of services to older people	☐	☐	☐	☐	☐	☐
Improved the accessibility of services to older people owing to a quicker response from service providers	☐	☐	☐	☐	☐	☐

16. To what extent do you agree that the projects / interventions being developed by the POPP programme in your area adequately provide access for older people from the following communities?

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
Older people from hard to reach groups	☐	☐	☐	☐	☐	☐
Older people from black and minority ethnic (BME) groups	☐	☐	☐	☐	☐	☐
All older people	☐	☐	☐	☐	☐	☐
Older people with functional mental illness (e.g. depression)	☐	☐	☐	☐	☐	☐
Older people with organic mental illness (e.g. dementia)	☐	☐	☐	☐	☐	☐
Older people from socially deprived groups	☐	☐	☐	☐	☐	☐

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
Older people with learning difficulties	☐	☐	☐	☐	☐	☐
Older people from the travelling community	☐	☐	☐	☐	☐	☐
Older people from refugee groups	☐	☐	☐	☐	☐	☐
The carers of older people	☐	☐	☐	☐	☐	☐

Section Five: Multi-agency meetings

The questions in this section are about POPP groups or meetings that have representatives from different agencies or organisations. If you are not a member of any such multi-agency groups, simply tick the 'No' box and turn to Section Six, question 28 on page 23.

17. I attend a multi-agency group/meeting/forum in my local area that has a role in the POPP programme.

☐ Yes

☐ No

18. How would you classify this group/meeting/forum?

	Yes	No	Not sure
Strategic – responsible for planning the POPP programme service delivery	☐	☐	☐
Operational – responsible for executing strategic planning around the POPP projects and interventions	☐	☐	☐
Both strategic and operational	☐	☐	☐

19. Which organisations have representatives on this group?

- ☐ Social Services
- ☐ Primary Care Trust
- ☐ NHS Trusts (Acute)
- ☐ Mental Health NHS Trust
- ☐ Voluntary/Community sector organisations
- ☐ Local authority
- ☐ Private Provider
- ☐ Don't know
- ☐ Other (Please specify)……

20. Is the chair an employee of:

- ☐ Primary Care Trust
- ☐ NHS Trust (Acute)
- ☐ Mental Health NHS Trust
- ☐ Voluntary/Community sector organisations

- ☐ Local authority
- ☐ Private Provider
- ☐ Don't know
- ☐ Other (Please specify)…….

21. Does the chair rotate?

Yes	No	Don't Know
☐	☐	☐

22. If so, between which organisations? (please tick all boxes that apply)

- ☐ Primary Care Trust
- ☐ NHS Trusts (Acute)
- ☐ Mental Health NHS Trust
- ☐ Voluntary/Community sector organisations
- ☐ Local authority
- ☐ Private Provider
- ☐ Don't know
- ☐ Other (Please specify)…….

23. How often does the group meet? (Tick one)

- ☐ Weekly
- ☐ Monthly
- ☐ Every two months
- ☐ Every three months
- ☐ Every four months

☐ Every six months

☐ Annually

☐ Ad hoc/ as required

☐ Other (Please specify)……

24. Please answer yes or no to the following (if the answer is not 'yes', please remember to tick the 'no' box)

	Yes	No	Don't know
The group has consistently met as scheduled	☐	☐	☐
Nominated representatives have attended consistently	☐	☐	☐
Group attendance has been low	☐	☐	☐
There is adequate service user presentation within the group	☐	☐	☐
Issues are usually resolved without repeated discussion	☐	☐	☐
One particular organisation tends to dominate the meeting	☐	☐	☐
During the last year there has been disagreements between the member organisations	☐	☐	☐
The meetings are open to the public	☐	☐	☐
There is adequate representation from black and minority ethnic (BME) communities	☐	☐	☐

Any Comments:

25. From your perspective, how much of a contribution has each type of organisation made to the meeting? (please tick one box per organisational type)

	Has played no part	Has played a small part	Has contributed consistently	Has taken the lead	Don't know
Primary Care Trust	☐	☐	☐	☐	☐
NHS (Acute) Trust	☐	☐	☐	☐	☐
Mental Health NHS Trust	☐	☐	☐	☐	☐
Local Authority	☐	☐	☐	☐	☐
Community / Voluntary sector	☐	☐	☐	☐	☐
Private Sector	☐	☐	☐	☐	☐

Any Comments:

26. Does the group have a commissioning responsibility within the POPP programme?

Yes	No	Don't Know
☐	☐	☐

27. Can the group allocate funds without recourse to the Chief Executive Offices (CEOs) or other bodies?

Yes	No	Don't Know
☐	☐	☐

Section Six: Sustainability

The three questions in this section concern whether POPP projects can be sustained once the POPP grant has expired.

28. To what extent do you agree with the following statements?

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
The POPP programme is fully integrated within the overarching services delivered across the health and social care economy	☐	☐	☐	☐	☐	☐
The POPP programme is operating as a 'bolt on' extra to service delivery within the health and social care economy	☐	☐	☐	☐	☐	☐

29. To what extent do you agree that the following factors are important if the POPP projects are to be sustained.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
Incorporating the POPP aims and objectives within the LAA	☐	☐	☐	☐	☐	☐
Mainstream funding	☐	☐	☐	☐	☐	☐
Financial contributions from POPP partners	☐	☐	☐	☐	☐	☐
The development of practice based commissioning (PBC)	☐	☐	☐	☐	☐	☐
Support from other grants	☐	☐	☐	☐	☐	☐
Monies to be released from secondary care	☐	☐	☐	☐	☐	☐

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
The development of a social enterprise organisation	☐	☐	☐	☐	☐	☐
The development of capacity within the community and voluntary sector	☐	☐	☐	☐	☐	☐

Any Comments:

30. Which of the following do you perceive to be the barriers to sustainability?

	No threat	Low threat	Medium threat	High threat	Don't know
A lack of commitment from one or more POPP partner agencies	☐	☐	☐	☐	☐
Charges to the user for social care	☐	☐	☐	☐	☐
Financial constraints within one or more partner agencies	☐	☐	☐	☐	☐
Demonstrating little evidence of project effectiveness	☐	☐	☐	☐	☐
Changes in Central Government policy	☐	☐	☐	☐	☐
Existing contracts for services that 'tie up' funds	☐	☐	☐	☐	☐

	No threat	Low threat	Medium threat	High threat	Don't know
Unexpected consequences of the changes to service delivery created by the POPP programme	☐	☐	☐	☐	☐
Poor take up of services amongst target groups	☐	☐	☐	☐	☐
Unexpectedly high take up amongst target groups	☐	☐	☐	☐	☐
Inability to maintain recruitment of volunteers	☐	☐	☐	☐	☐
Practice based commissioning	☐	☐	☐	☐	☐
Payment by results	☐	☐	☐	☐	☐

Any Comments:

Section Seven: National Policies

This last question relates to the impact that various national policies have had on your POPP programme.

31. Which policies do you perceive as impacting upon your POPP programme

	Positive impact	No impact	Negative impact	Don't know
National Service Framework for Older People	☐	☐	☐	☐
National Service Framework for Long Term Conditions	☐	☐	☐	☐
Fair Access to Care Scheme (FACS)	☐	☐	☐	☐
Payment by Results	☐	☐	☐	☐
Proactive based commissioning	☐	☐	☐	☐
Foundation Trusts	☐	☐	☐	☐
'Our health, our care, our say' White paper	☐	☐	☐	☐
'Independence, Well-Being and Choice' Green paper	☐	☐	☐	☐
New GP Contract	☐	☐	☐	☐
Mental Health Act 2007	☐	☐	☐	☐
Specific targets, please specify (e.g. four hour wait in A&E, 18 week pathway)	☐	☐	☐	☐

……..

Any Comments:

Completion of Questionnaire

Thank you very much for completing this questionnaire. As we stated, all data will be anonymised in any reporting. If you have any further questions and queries, do please contact me.

Yours sincerely

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University of Hertfordshire

Appendix B

Topic Guide for Key Informant Interviews

National Evaluation of POPP:
Key Informant Interview Topic Guide

Interviewees

Four key informants from each selected pilot site

- Project Manager
- Project Lead
- Older People's Lead (Officer)
- Older Person Representative

Topic Areas

1. Partnership
2. Implementation of interventions
3. Older People's Involvement
4. BME elder involvement
5. Third Sector Involvement
6. Impact
7. Culture change (Joint-working, driven by older people's needs, integration, shared agenda)
8. Sustainability
9. Impact of National Policies

Opening Question

Can you give me a brief description of your role? (POPP)

Can you tell me why your council area bid for POPP?

PROMPT>

What were the objectives that your council hoped to achieve with the POPP funding?

- What were you aiming to achieve? (i.e. easier access to services/ greater equity in access/ geographical coverage/ addressing historical gaps in services)

1. Partnership

Overarching Question

Could you tell me what partnership working means to you?

(i.e. a shared vision/ aims and service outcomes/ a shared consensus on strategic direction of the POPP programme/ clear spheres of responsibility and accountability)

Existing Partnerships/ strengthened by POPP

1. Do you feel that partnership working has strengthened in your area in the last 2 years? (If so how, what do you feel has contributed to this?)
2. Do you feel that POPP has helped to strengthen that partnership? (If not, what has?)

Financial partnership

3. Within Bradford are there shared budgets? If so what, where etc.
4. To what degree do partnerships within Bradford involve the sharing of financial risk with other agencies (i.e. joint commissioning)? Can you give any examples?
5. Do you know anything about the financial organisation within POPP? (Is that financial organisation differently structured than other joint budgets?)

Nature of the Partnership

6. To what extent do you think partnership should involve all partners being treated as equals in the decision-making process? (i.e. PCT/ Secondary Sector/ and Third Sector organisations like CVOs)
7. Do all partner organisations have the same level of influence, or is the influence of some organisations greater than others?
8. What is the level of commitment like from the various partners within your area? (Are some individuals/ agencies more committed than others?)
9. To what extent does the partnership rely upon a few key collaborative individuals? If so, from which agency are they?
10. Have there been benefits provided by the POPP partnership? (for partner agencies/ for the wider health and social care economy?)
11. Can you give examples of how the POPP partnership has been effective?
12. Could anything be done to improve the POPP partnership? If so, what would that be?

General barriers/ facilitators to partnership

13. Has there been a key barrier that has hindered the development of the partnership in your area? If so, what was it? (lack of commitment from one or more agencies/ lack of money in the system/ PCT reconfiguration)
14. Has there been a key driver (facilitating factor) that has helped the development of the partnership in your area? If so, what was it? (i.e. key individuals/ robust needs analysis/ central govt pressure/ more money in the system to pump-prime)

2. Implementation of interventions

Overarching Question

Do you know anything about the implementation of the interventions?

Can you tell me about how the POPP interventions were designed/ how the bid was put together?

1. What were the key factors considered in the development & design of the POPP interventions?
2. What were the barriers to the development & design of the POPP interventions?
3. What would you do differently if you were setting up a similar project again?

3. Older people's involvement

Overarching Question

Could you tell me how you are involving older people within your work? For example:

- Commissioning, volunteering, feeding into strategy

Do you know anything about the involvement of OP in the POPP projects? For example:

- The design stage (i.e. were older people/ CVOs consulted)

- Recruitment
- Delivery of services
- Governance (are older people on the steering group/ Partnership Board?)
- Evaluation

1. How were older people **recruited** to become involved with POPP? Was some form of appointment method or criteria adopted?
2. To what extent has the your POPP programme ensured older people have a 'real voice'? (i.e. leading the development of POPP rather than being led?)
3. What **support** has been given to older people involved within the governance, implementation and service delivery of POPP projects?
4. What training/preparation in working with older people did the Staff/ Board members have to make user involvement work? (time of meetings/ slow the pace/take longer to explain/ communication)
5. In what ways, if any, has the involvement of older people had an impact on the POPP services? (i.e. made them more user friendly)
6. In what ways might the involvement of older people had an impact upon the **sustainability** of the programme / projects (i.e. Do their views have political force?)?
7. Are there any drawbacks to having older people involved in the POPP programme?

4. Involvement of older people from black and minority ethnic (BME) groups

Overarching Question

Could you tell me in what ways older people from BME communities have been involved within the POPP programme in your area?

1. Have you encountered many problems involving older people from BME communities?

PROMPT> What sort of impact has your POPP programme had for older people from BME groups?

2.

5. Third sector and voluntary organisations' involvement in POPP

Overarching Question:

To what extent is the involvement of the third sector within Bradford valued by those that work within the statutory sector?

1. Is that involvement valued by all partner agencies?
2. Are services provided by voluntary organisations as likely to be sustained as those being developed 'in-house' by statutory organisations?

6. Impact

Overarching Question:

Do you know of the impact of POPP in your area?

(What do you think has been the primary impact of POPP in your area?)

1. How successful has your POPP programme been in achieving its objectives?
2. Are the POPP projects influencing any broad change in the strategic direction of health and social care in your area? Is so, how?

7. Culture change

Overarching Question:

Across POPP, many of the sites are arguing that POPP is providing a vehicle for 'culture change'. Is that something you are trying to achieve? (I.e. in partnerships/ individuals feeling greater trust/ working across boundaries/ OP Involvement/ how individuals perceive and work with older people)

1. If so, what are the factors that influence culture change?

(i.e. sustained commitment from all partners/ strategic realignment of priorities/ time/ low turnover of staff/ key personnel)?

2. In what ways are the POPP projects in your area driving a culture change?

(i.e. what is different in the way decision-making is made/ risk sharing/ OP involvement)

8. Sustainability

Overarching Question:

Have you been/or will you be involved in the sustainability discussions within your POPP site?

Who will be/has been involved in the process of deciding which POPP services would be sustained beyond the funding process? (i.e. is this decision made only at the strategic level?)

1. To what degree will/has sustainability depend(ed) upon proving 'effectiveness' and 'cost-effectiveness'? (i.e. Will the sustaining of POPP services involve ensuring that cashable savings can be removed from the secondary/acute sector?)
2. Are there other competing demands/priorities that may also affect the decision to sustain the POPP projects? (i.e. lack of money)

9. National Policies

Overarching Question:

What do you feel has been the main policy driver on OP services in Bradford? (i.e. NSF-Older People, PBC, LAA, PbR, Health Act flexibilities (pooled budgets), specific health/ social care targets)

1. How has this been helpful?
2. Is there a government policy which you would say has been a **key barrier** to the POPP programme? If so, how has this been unhelpful?

Thank you for answering my questions. Is there anything that I have not asked you about that you would like to add?

Appendix C

Older Persons Interviews Topic Guides

National Evaluation of POPP:
Older Persons Interviews Topic Guides

Interviewees

- 5 OP within POPP i.e. receiving a service
- 5 OP not involved in POPP – Originally proposed four groups of people:
    - Previously refused POPP
    - Individuals aware of POPP through advertising
    - Individuals never heard of POPP
    - Not eligible for POPP

Introduction to the Interview

All interviewees will have received a letter and information leaflet prior to the interview summarising the project and detailing the key areas of the interview and our role as the National Evaluation Team. Prior to the start of the interview, each individual will be taken through these key areas once again. Issues surrounding confidentiality and why the interview is being tape recorded will also be discussed. The researcher will stress that there are no right or wrong answers and what we are trying to do is find out a little bit more about their service provisions and their experiences surrounding these services. Participants will then be asked to sign the consent form.

A sheet detailing key demographics will also be completed (see attached). These questions will be asked at the end of the interview following, it is hoped, the building of trust.

Service Use

Firstly I'd like to discuss some of the services that you currently receive and also those that you have received in the past. So, first let's start with some of the services you have at the moment>

1. What services do you currently receive?

Prompts

- Where do you go for that service?
    - NB, there are likely to be multiple services – so these all need to be teased out)
- Do you know which organisation is responsible for that service?
- How did you hear about that particular service?
    - E.g. through local advertising, a health professional, peer etc.
- Did you have to wait for that service to start?
    - If so how long?
    - Were there any problems in waiting?
    - Where you given information in that time as to alternative services?
- How do you actually get to that service?
    - What are the transport links like?
    - Does the service provide any travel arrangements?
- How long have you been using the service?
- Do you have to pay for that service?

- If, so how much have you had to pay?
- Do you mind paying for the service or do you think that it should be available for free?

Service choices

2. When you were offered the service that you were, were you given a choice about other different services that were available?

Prompts

- What choices were you offered?
- Was there one individual that talked you through your options? If so, who was that individual?

Service Information

3. What information did you receive about the service that you use?

Prompts

- Did you find the information you received about the services helpful?
- What did that information actually tell you about the services?
- Did you feel able to ask questions about the services?

Timeliness of the Service

4. Do you think that the service you received was offered to you at the right time?

Prompt

- Should that service have been perhaps offered to you earlier? Why do you think that?

Satisfaction with current services

5. What do you like about the service(s) you currently receive?

Prompts

- Is there anything you don't like about the service?
- Do you think it could be made better? If so, how?
- Do you feel that you are able to tell 'x' if there is something wrong with the service?
- What about how the service is being delivered? Do you feel that you are able to say how the service should be delivered – eg., the times of the service, how the staff work with you etc.

Outcomes from Service Provision

6. What difference does the service you receive make to your life?

Prompts

- What do you feel that service helps you to do?
- Do you feel safer, more supported?
- If you hadn't had this service, what do you think are some of the problems that you might have had? Do you think you could have got help anywhere else?

Knowledge of POPP

POPP Only

7. Have you heard of the Partnerships for Older People Projects or POPP?

Prompts:

- Do you know who the project is funded by?
- Do you know when the POPPs programme started in your area?
- Do you know if any of the services you mentioned are within the overall POPP programme?
- Do you know if you have been referred between different services within POPP, or used different services across the POPP programme?

8. How did you make initial contact with the POPPs programme?

Prompts:

- Did they contact you?
- Did you or a family member make contact?
- Were you referred? If so by whom?

Entry into specific services

9. You've obviously had some/ quite a few services. What about other services you have had before, can you remember when you first started receiving a particular service?

Prompts:

- What was that for?
- How long have you had that service for?
- Do you still receive that service?
- Why were you offered that?
- Do you think that was given at the right time or would it have been better to be earlier?,

POPP, 'Value Added'

10. [POPP ONLY] When you think about the service you receive at the moment from POPP, do you think that it is any different from other services that you may have received?

Prompts:

- How is it different? The staff? The actual service provided is better/worse?
- Did you find that service helpful? In what way did that service help you?
- Is there anything about that service that you would like to change or see introduced? E.g. Longer opening hours, shorter waiting lists etc.

Unmet Need

11. We've talked a little about the services you use and how you entered these services, but are there any difficulties or problems you are having that perhaps you need help with that these services are currently not addressing?

Prompts:

- Have you spoken to anyone about this? If so, what response did you receive? If not, why not? Did you feel unable to do so?

- If there was a response, do you feel that this was an appropriate response?
- Were you happy with the outcome?

Older People Involvement in Designing Services/ Strategies

12. [POPP ONLY] So we've spoken about the specific POPP services, could you tell me, are you involved with POPP in any other way than as a service user?
Prompts:
- Are you on a steering group or committee to do with POPP?
- Have you been involved in providing any feedback or advice on service provision in your area? If so, how?
- Have you been involved in the evalution?

13. What has been your experience of involvement?
Prompts
- Have you felt that your views have been taken into account?
- Do you feel that you and your peer group are leading the development of the POPP programme?
- Has there been any support and/ or training to help you feed in your views and/ or to get a handle on working with committees etc.

14. [**All Participants]To what extent do you feel that you have been able to have an influence on the services provided in your area?**
- How have you been able to feed in your views?
- Have you ever been asked to sit on a committee, older person's group etc.
- Do you feel as though you have adequate opportunities to express your opinions on services within your area?

Quality of Life

One of the areas that we are looking at within the evaluation is how POPP and/ or other services impact on people's quality of life

15. What do you think is important to ensure that you have a good quality of life?
Prompt
- For example, having enough money, having transport, having a network of family and friends etc.

16. How would you say your quality of life is at the moment?
Prompt:
- So, good it could not be better or, so bad it could not be worse?

Social Isolation

17. Do you think that you have a good network of friends and/ or family?
Prompt:
- How often do you meet socially with friends or relatives or work colleagues?
- Do you think that the services you get help you to [either maintain] or [build] your contacts with friends and family?
- What factors do you feel are important in order to ensure that individuals are included in the community? E.g. transport links, services 'coming to you', opportunities to socialise .

Round Up

Thank you very much for your time, that's all the questions I wanted to ask and the end of the questionnaire. Are there any further comments you would like to make that you don't think we picked up through the questions?

Will send you a copy of the report if you would like.

Appendix D

Focus Group Topic Guide: Operational Staff / Volunteers

National Evaluation of POPP:
Focus Group Topic Guide: Operational Staff/ Volunteers

Interviewees

- Between 8 – 15 participants including operational staff, health and social care professionals, project workers and volunteers working within POPP projects.

Topics

1. Joint-working/ partnership
2. Involvement of older people
3. POPP projects
4. Impact
5. Culture change
6. Sustainability

All interviewees will have received a letter and information leaflet prior to the focus group event summarising the project and detailing the key areas of the interview and our role as the National Evaluation Team. Prior to the start of the event, the group will be taken through these key areas once again. Issues surrounding confidentiality and why the researcher will be taking field notes will also be discussed. The researcher will stress that there are no right or wrong answers and what we are trying to do is find out a little bit more about the service provisions and the experiences of operational staff surrounding the POPP services/ interventions. Participants will then be asked to sign the consent form.

Opening Question
How well do you think the overall POPP programme is progressing in your area?

PROMPTS>
- Are some services/interventions working better than others?
- If so, why might this be the case?

1. Joint-Working

Overarching Question:
Could you tell me what partnership working means for you?

PROMPTS>
- What is good about joint working between different agencies? Can you give any examples?

- To what extent is there effective joint working between PCT/ LA and third sector organisations in your area?

- To what extent are all partner agencies equally committed to joint working practices?

- Were there effective joint working practices prior to POPP? Could you give an/some example(s)?

- To what extent has POPP helped to strengthen/improve the existing joint working practices? If so, could you give an/some example(s)? If not, why do you think it hasn't strengthened

- To what extent are low level generic services provided by voluntary and community sector organisations valued as equally as services provided by statutory organisations?

- To what extent are third sector organisations more or less involved with delivering services to older people in the area since the POPP programme commenced? Can you think of any examples?

- As far as you know, is there some sharing of financial resources between different sector agencies (i.e. PCT, LA)? Can you think of any examples?

- In your opinion, what have been the key challenges to greater joint working? (i.e. PCT reconfiguration, financial constraints within one or more organisation, culture/agendas of partner agencies, particular personnel)

- What would improve joint working within your area?

2. Involvement of older people

Overarching Question:
To what extent have older people been involved within the POPP projects/ interventions?

PROMPTS>

- In what ways are older people involved within the POPP programme in your area?

- To what extent is it a good thing to have older people and/or their representatives involved with the delivery of services? (i.e. does the involvement of older people improve the services being delivered?

- Would the running and delivery of POPP services be improved with more or less involvement of older people?

- What support do you think that older people require if they are to be effectively involved with the design, delivery and governance of POPP projects?

- To what extent do older people and operational staff focus upon the same things within the POPP programme/ projects (i.e. outcomes rather than outputs)?

- Has it been easy or difficult to recruit and/or maintain older people as volunteers within POPP projects? If it has been difficult, how do you think the situation could be improved?

- To what extent, if any, will/ would the involvement of older people in the POPP projects help the projects be sustained in the long-term? If so, how?

- Since the commencement of POPP, have services become more or less accountable to older people? Or are they about the same as before POPP? Is that a good thing?

3. POPP Projects

Overarching Question:
Would you say that the POPP projects in your area are fully integrated within the overall services delivered across the health and social care economy, or would you say that it is a 'bolt-on' extra?

PROMPTS>

- If you think it is a bolt-on extra, how could the services become more integrated?

- In your experience, what has been the greatest challenge in the development of the POPP project that you are involved with? What changes might improve the situation and better facilitate the development of this service?

- The DH funding for the POPP projects is two years. In what ways has this duration of funding helped or hindered the development of the POPP project on which you work?

- To what extent has the recruitment of staff to posts within POPP services been difficult?

- As someone working within a POPP project, to what extent do you feel involved in the overall POPP programme in your area? [Is there POPP 'branding'] Do you know what other projects make up the POPP programme in your area? Do you see these projects as being separate or part of the overall POPP programme?

- To what extent are the POPP services now in place better or worse than the services that previously existed for older people? If so, in what ways are they better?

- Do you believe that the POPP services will save money for either the PCT and/or the LA? If so, how will they do this?

4. Impact

Overarching Question:
What do you think has been the main or primary impact of POPP in your area?

PROMPTS>

- In what ways has the POPP programme impacted upon the quality of life of older people? Can you think of any examples? (i.e. have services become more geographically equitable? Do services respond quicker to older people? Services themselves are easier to access for older people? A wider range of choice of services is available? Are OP more aware of the services available to them? Are older people more readily referred to specialists?

- In what ways has the POPP programme affected the experience of carers?

- In what ways has POPP had a beneficial impact on various groups of older people (i.e. BME/ MH/ Socially deprived/ Learning Disabilities)?

- To what extent do you think the POPP programme is driving changes in the overall services provided within the health and social care economy? (has it in any way been a catalyst for wider changes?)

5. Culture change

Overarching Question:
Across POPP, many of the sites are arguing that POPP is providing a vehicle for culture change. Within your site, how would you define 'culture change'?

PROMPTS>

- What does culture change mean in practice?
- What variables effect 'culture change'?
- How is culture change achieved?
- How long does it take for new working practices to become embedded?

6. Sustainability

Overarching Question:
What services are going to be sustained in your area?

PROMPTS>

- What do you think will influence whether services will be sustained? (i.e. they can be proven to be cost-effective, they save money, older people are involved and represent a political force)
- Have you had any input as to which POPP services will be sustained and/or how they are to be sustained?

Round Up
Thank you very much for your time, that's all the questions I wanted to ask. Are there any further comments you would like to make that you don't think we picked up through the discussion?

We will send you a copy of the report if you like.

Appendix E

Topic Guide for ‘Exit’ Interviews with Project Managers

National Evaluation of POPP:
Topic Guide for 'Exit' Interviews with Project Managers

Telephone Interviews

Interviews (n=29) will be conducted with the Project Leads/ Managers from POPP pilot sites as they leave their posts at the end of the two year funding period.

Topic Areas

1. Designing, implementing and developing the POPP pilot
2. Extracting savings from secondary care
3. Key outcomes of the local POPP programme
4. Sustainability
5. Key learning points to be disseminated

All interviewees will have received a letter and information sheet prior to the interview summarizing the evaluation project and an invitation letter detailing the key areas of the interview. Participants will have been asked to return a signed consent form. Prior to the start of the interview the participant will again be taken through key issues concerning confidentiality, and it will be emphasised that although the interview will be recorded and transcribed, the participant is assured complete anonymity. It will also be emphasised that the interview can be terminated by the participant at any time.

Opening Question

- **Overall, do you believe the POPP initiative has been a worthwhile and successful exercise within you pilot site?**

<u>Context</u>

1. **What were the main issues relating to the implementing and developing of the POPP pilot?**

   Prompts>

   - What was your relationship like with the Department of Health?
   - What sort of relationship existed between the various POPP partners (ASC, PCT, VCOs, secondary trusts) at a strategic level?
   - What difficulties did you experience with getting POPP onto the local strategic agenda?
   - What sort of input did the partners (ASC, PCT, VCOs, secondary trusts) have in the design and writing of the bid?
   - How did you go about agreeing with your partners (ASC, PCT, VCOs, secondary trusts) their respective levels of responsibility and (match-) funding for the POPP projects?

- What were the main issues relating to the setting up the local evaluation?

- If you were to be involved with setting up a similar project again in the future, would you do anything differently? If so, what?

Mechanisms

2. What sort of financial impact did the POPP programme/ services have in your health and social care economy?

- Were monies extracted across the local health and social care system (i.e. shifted from secondary to primary care, or from health to social services)?

- If savings were generated from POPP, were they successfully extracted from other agencies/ repatriated to social care?

- Did you use/develop a model for the extraction of any savings?

- Did you have an agreement with Chief Executives that if you demonstrated savings that money would be extracted from or transferred to other agencies [Go through each of the projects]?

Outcomes

3. What, in your view, were the key Outcomes from the POPP programme?

- Better trained workforce
- Financial savings
- Increased older people's involvement
- Increased quality of life for older people
- More appropriate services for older people
- Improvements in the shift from institutional to community care
- Improvements in the efficiency of existing services

Prompts>

- Were the outcomes those that had been expected at the beginning of the POPP programme?

- Were any of these outcomes given priority over others?

- Have there been beneficial changes in partnership working in your area that can be ascribed to the POPP programme? If so, what were they?

4. Will the projects in your area be successfully sustained

Prompts>

- How many of the projects were sustained (go through projects)?

- [If a distinction is made between projects and their outcomes being sustained] In what ways might the outcomes of the POPP programme be sustained if the projects themselves are not?

- Are the projects to be sustained into the long-term? Or, is future funding assured in the short-term only, with the aim of ensuring sufficient time for further evaluation?

- What rationale determined the decision to sustain some projects rather than others (if some not sustained)?

- How were those that were sustained to be funded into the long-term?
  - What levers were utilised?
  - Which agency/agencies is/are to provide funding?
  - What were the difficulties involved with establishing funding?
  - To what extent was the Social Reform Grant (SRG) necessary to ensure sustainability? Could the services have been sustained without the SRG?

- How was evidence used to support the business case for projects to be sustained?
  - Cost-effectiveness
  - Increase in quality of life (QoL)
  -

5. What are the key learning points from the sustainability exercise?

Prompts>

- What would you do differently if you were involved with a similar project again?

Appendix F

Topic Guide for ‘Exit’ Interviews with Chief Executives / Directors of Social Services Departments

National Evaluation of POPP: Topic Guide for Chief Executives / Directors of Social Service Departments

Telephone Interviews

A sample (n=12) of Chief Executives/ Directors of social service departments will be recruited to undertake telephone interviews with the National Evaluation Team (NET).

Topic Areas

- Rationale for bidding for POPP funding
- Respective involvement of other agencies in the development of the POPP programme
- The transfer of monies around the local health and social care system
- Sustainability
- Outcomes and wider impact of POPP programme

All interviewees will have received a letter and information sheet prior to the interview summarizing the evaluation project and an invitation letter detailing the key areas of the interview. Participants will have been asked to return a signed consent form. Prior to the start of the interview the participant will again be taken through key issues concerning confidentiality, and it will be emphasised that although the interview will be recorded and transcribed, the participant is assured complete anonymity. It will also be emphasised that the interview can be terminated by the participant at any time.

Opening Question

- **How involved have you been with the POPP programme in your area?**

<u>Outcomes</u>

1. **What were the principal outcomes of the POPP programme in your area?**
   - Improvements in efficiency and cost efficiency across the health and social care system?
   - Improvements in the shift from institutional to community care
   - Improvements in focussing upon preventive services
   - Improvements in the quality of life and/or the well-being of older people
   - Improvements in partnership working between agencies

2. **How will the services [developed with POPP funding] be sustained in the longer-term?**

   Prompts>
   - Are the projects to be sustained into the long-term?

- Which organisations agreed to commission those projects?

- Are the projects to be sustained likely to be continued in the same format? For example, the same number of staff, management structure etc. If not, how might these have changed?

- How are the outcomes to be sustained if the projects themselves are not?

3. Has the partnership working integral to the POPP programme had a wider influence upon the local health and social care economy? If so, what?

Prompts>

- Have other areas of the local authority (or PCT) utilised any learning from the POPP experience?

- Have any of the innovations seen in the POPP programme been adopted across the authority (e.g. involvement of older people on recruitment panels)?

4. Overall, what would you say has been the value of the POPP programme within your area?

Thank you very much for agreeing to be interviewed and for participating in this study.

Appendix G

Topic Guide for Interviews with Members of the Department of Health (DH) Project Management Team

National Evaluation of POPP: Topic Guide for Interviews with Members of Department of Health (DH) Project Management Team

Telephone Interviews

Face-to-face semi-structured interviews with members of the Department of Health (DH) POPP Programme Team and the Care Services Improvement Partnership (CSIP) team will be undertaken.

Topic Areas

1. The rationale of the POPP programme and selection process
2. Management of pilot sites
3. Support provided to pilot sites
4. Recognition of POPP on the national agenda
5. Outcomes achieved/ sustainability
6. Influence of POPP on wider strategic agenda
7. Learning to be disseminated

All interviewees will have received a letter and information sheet prior to the interview summarizing the evaluation project and an invitation letter detailing the key areas of the interview. Participants will have been asked to return a signed consent form. Prior to the start of the interview the participant will again be taken through key issues concerning confidentiality and it will be emphasised that although the interview will be recorded and transcribed, the participant is assured complete anonymity. It will also be emphasised that the interview can be terminated by the participant at any time.

Opening Question

- **Overall, would you argue that the POPP programme had been successful?**

Prompt>

- If yes, how are you defining 'successful'?
- What have been the major barriers/ facilitators

Context

1. What were the overall objectives and rationale behind the setting up of POPP?

Prompts>

- Why was it set up as a competitive bid?
- What rationale/ criteria were used to select sites to be funded? (i.e. innovation; partnership design; older people's involvement; financial savings)?
- Why were these criteria the ones that were used? Were there specific priorities?

Mechanisms

2. What would you argue were the main areas concerning your interaction with/management of the POPP pilot sites?

Prompts>

- What was the process of management of the projects (i.e. collegial; hierarchical)?
- How do you think the sites perceived their relationship with you?
- Did your approach to project management change over the course of the initiative? If so, how? (i.e. did it become more hierarchical and less collegial?)
- If your approach changed, what was the rationale for this change?
- What information/ feedback/ data did you expect to get from the sites? What didn't you get and why?
- Do you feel that there were specific actions that you had to take in order to ensure that the POPP programme continued to progress? If so, what were those actions?

3. What type of support did you either give or make available to the pilot sites?

Prompts>

- Did the pilot sites seek out specific support from your team?
- Were other 'experts' brought into the process of support?
- Should there have been further support given? If so, what should that have been?

4. Do you feel that the POPP programme has affected the overarching national policy. If so, how?

Prompts>

- Were there specific actions you undertook to feed into the policy process?
- Were there specific requests for feedback from other policy groups and/ or stakeholders (e.g., MPs, SSH etc)?
- Have any policies been built on the POPP outcomes? If so, which policies?
- What further influence (if any) do you think POPP will have on health and social care policy?

Outcomes

5. What were the key outcomes that you expected from the POPP programme?

- Community development
- Systemic changes
- Growth of partnership
- Greater involvement of older people
- Financial savings
- Increased quality of life for older people
- The provision of more appropriate services for older people

- Which of these outcomes would have been given priority/ were most important?

6. To what extent were these outcomes achieved?

Prompts>

- Where there outcomes you expected that were not achieved? What would these have been?

7. What would you argue you were looking at when envisaging sustainability within each of the pilot sites?

Prompts>

- Sustainability of a particular 'model' of financial transfer?
- Sustainability of the particular projects?
- Sustainability of any culture change?

8. How easy or difficult do you think the pilot sites found it to 'sustain' their POPP model?

Prompts>

- Were there particular areas that were not sustained that you felt could have been continued? If so, why?

9. Are there any specific learning points that can be taken from your experience of the management/ support of the POPP project?

10. If you were to do a programme similar to POPP in the future what would you do differently? What would you do the same?

Thank you very much for agreeing to be interviewed and for participating in this study.

Appendix H

Quality of Life Questionnaire

PSSRU
University of Kent

University of Hertfordshire




National Evaluation of Partnerships for Older People Projects

Monitoring Quality of Life for Older Citizens

Locality Code ☐☐☐☐

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 local service team ☐

Administration Only:

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

The questionnaire is being completed as part of an interview ☐

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**

Sometimes you will find an instruction telling you which questions to answer next, like this

	Yes	No
	☐	☑

If 'No' go to question 4

4. Please say why not (write in the space provided)

If you have any queries about this Questionnaire, please phone:
Richard Wagland on (01707) 281215
or
Email: POPP@herts.ac.uk

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:

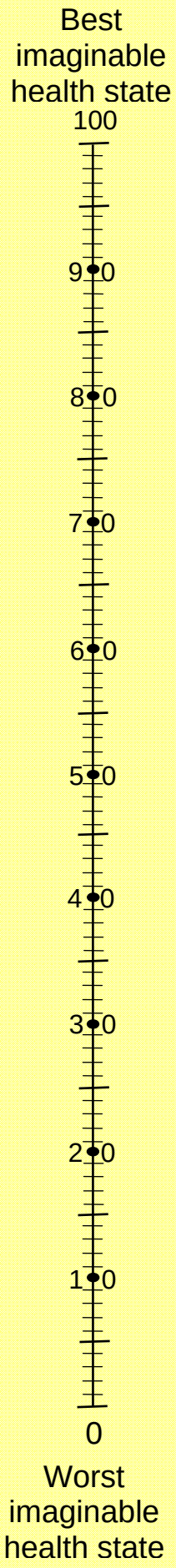
Better ❑
Much the same ❑
Worse ❑

PLEASE TICK ONE 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

14 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 ……..

15 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**
……	☐	☐	……
……	☐	☐	……

16 **<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)*			
……	☐	☐	……
……	☐	☐	……

17 **<u>In the last 3 (three) months</u>, 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? ……..

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.

18 **Have you experienced serious illness?**

(Please tick the box next to the answer that best describes your experience)

	Yes	No
in you yourself	☐	☐
in your family	☐	☐
in caring for others	☐	☐

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

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

20 **Are you**:

Male	Female
☐	☐

21 **Are you:**

- A current smoker ☐
- An ex-smoker ☐
- Never smoked ☐

22 **Did your education continue after the minimum school leaving age?**

Yes	No
☐	☐

23 **Do you have a Degree or equivalent professional qualification?**

Yes	No
☐	☐

24 **If you know your postcode, would you please write it in the box below.**

My post code is: ☐

25 What is your marital status?

(Please tick the box that applies to you)

- Single ☐
- Married ☐
- Cohabiting ☐
- Widowed ☐
- Divorced or separated ☐

If 'Yes' go to question 25a

25a **If widowed, can you please indicate how long you have been widowed?**

(please tick the box that applies to you)

- Less than six months ago ☐
- Six months, less than a year ☐
- 1 year, less than 3 years ☐
- 3 years, less than 5 years ☐
- Five years or more ☐

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

Please tick one

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

27 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 ……

28 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
- ☐ Caring for a relative or friend
- ☐ Temporarily sick or disabled
- ☐ Long term sick or disabled
- ☐ Looking after family member(s)
- ☐ Other *(Please specify)* ……

29 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
- ☐ Invalidity allowance
- ☐ Disability working allowance
- ☐ Disability living allowance
- ☐ Incapacity benefit
- ☐ Attendance allowance
- ☐ Others *(please describe)* ……

How much do you receive altogether in benefits each week?

£ ……

30 **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 - £99 (£0 - £5,199 per year)
- ☐ £100 - £149 (£5,200 - £7,799 per year)
- ☐ £150 - £249 (£7,800 - £12,999 per year)
- ☐ £250 - £349 (£13,000 - £18,199 per year)
- ☐ £350 - £449 (£18,200 - £23,399 per year)
- ☐ £450 - £599 (£23,400 - £31,199 per year)
- ☐ £600 - £749 (£31,200 - £38,999 per year)
- ☐ £750 or more (£39,000 or more per year)

31 **What ethnic group do you consider yourself to belong to?**

(Please tick one)

- ☐ White
- ☐ Chinese
- ☐ Black African
- ☐ Black Caribbean
- ☐ Black Other
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ None of these

32 **Are there any other comments you would like to make?**

THANK YOU

FOR COMPLETING OUR QUESTIONNAIRE

Please return to the local project team

Dr Richard Wagland
Research Fellow – POPP
CRIPACC
University of Hertfordshire
College Lane
Hatfield
HERTS AL10 9AB

No stamp will be needed

Appendix I

Financial Evaluation Data Requirements (FEDR) Form

POPP FINANCIAL EVALUATION DATA REQUIREMENTS

PLEASE RETURN FORM TO j.conlon@herts.ac.uk BY [DATE]

POPP Site	
Contact Name	
Contact Telephone Number	
Contact Email	

Expenditure (£s)		**Financial Years…** 2008/9 Quarters 1 and 2 (Forecast expenditure)	2008/9 Quarters 1 and 2 (Actual expenditure)	2008/9 Quarters 3 and 4 (Forecast expenditure)	2008/9 Quarters 3 and 4 (Actual expenditure)	2008/9 Whole year (Forecast expenditure)	2008/9 Whole year (Actual expenditure)
A. Overall project Governance and management [See Note 1]							
Project lead	Time spent on POPP (% over year)						
	Salary plus on-costs (per annum)						
Project manager 1	Time spent on POPP (% over year)						
	Salary plus on-costs (per annum)						
Project manager 2	Time spent on POPP (% over year)						
	Salary plus on-costs (per annum)						
Project manager 3	Time spent on POPP (% over year)						
	Salary plus on-costs (per annum)						
Project manager 4	Time spent on POPP (% over year)						
	Salary plus on-costs (per annum)						
Project manager 5	Time spent on POPP (% over year)						
	Salary plus on-costs (per annum)						
B. Specfic projects [See Note 2]							
Project 1						-	-
Project 2						-	-
Project 3						-	-
Project 4						-	-
Project 5						-	-
Project 6						-	-
Project 7						-	-
Project 8						-	-
Project 9						-	-
Project 10						-	-
Project 11						-	-
Project 12						-	-
C. Evaluation [See Note 3]……						-	-
D. Dissemination [See Note 4]……						-	-
E. Other costs [See Note 5]							
Other 1						-	-
Other 2						-	-
Other 3						-	-
Other 4						-	-
Other 5						-	-
Other 6						-	-
F. Total expenditure……							

Funding/budget (£s)

G. POPP Grant……							
H. Other Grants (e.g. Assistive Technology Grant)							
Other 1						-	-
Other 2						-	-
Other 3						-	-
Other 4						-	-
Other 5						-	-
Other 6						-	-
I. Other funding (e.g. not specific grant funding, contributions by partners) [See note 6]							
Non-grant 1						-	-
Non-grant 2						-	-
Non-grant 3						-	-
Non-grant 4						-	-
Non-grant 5						-	-
Non-grant 6						-	-
J. Total (planned) funding……							
K. Unplanned funding (to cover overspends)……..							

Notes

1 We want to account for the management input to POPP. Please list all management staff not counted in 'specific project costs' category (item B), giving an estimate of the proportion of their time through the period (year or quarter) they spent on POPP. Please also provide their salary cost, including on-costs.

2 Please provide all costs associated with the specific project elements of your POPP.

3 Please indicate the cost of your evaluation team.

4 This cost category covers, for example, project launch costs, publicity materials (user info leaflets...), attendance at conferences, etc…

5 Please enter any other cost associated with the POPP but not counted elsewhere.

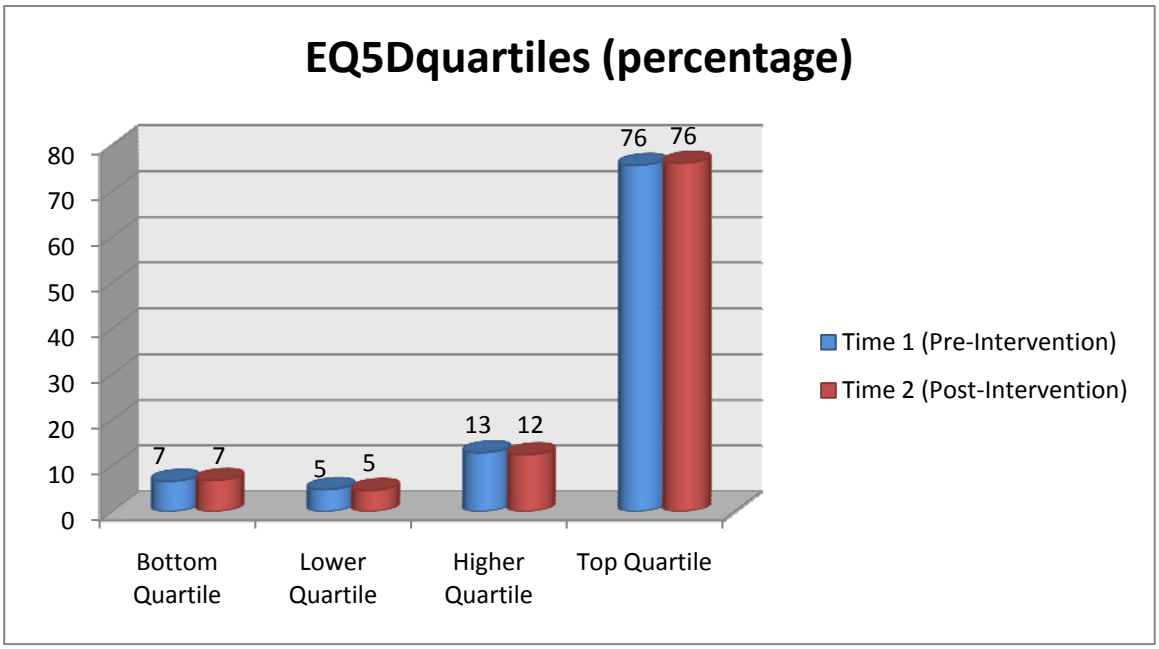
6 This category covers all other sources of funding including any use of mainstream funding to cover project management, administration and other overhead costs.

Appendix J

Health Related Quality of Life Quartiles

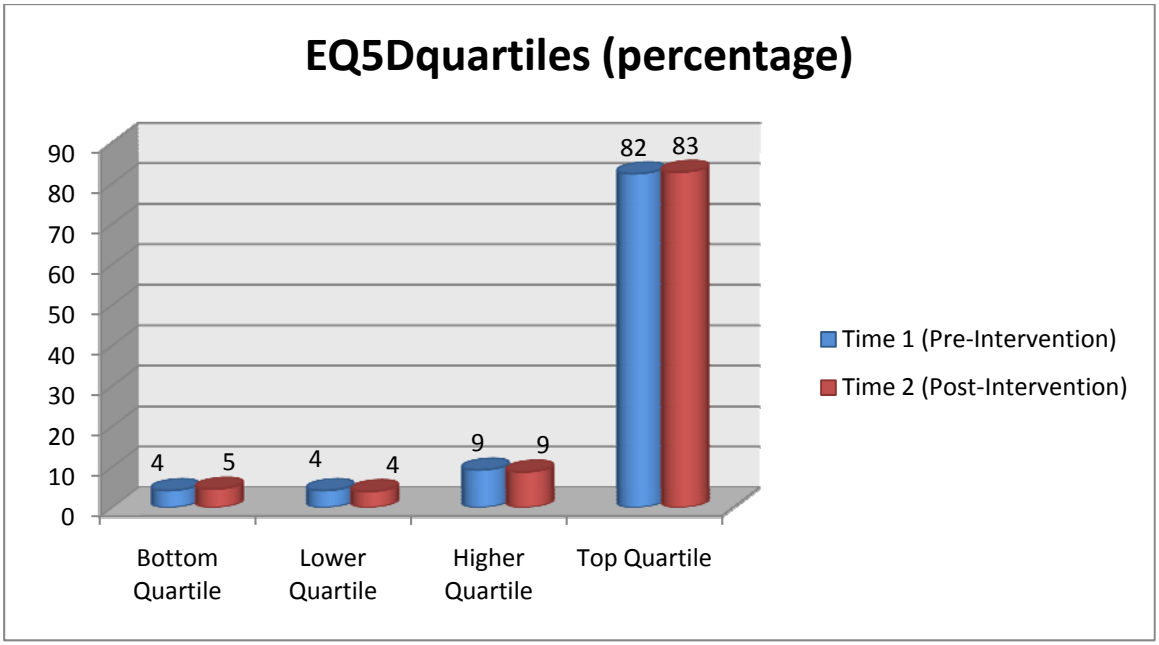
EQ5D quartile change for whole sample:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	98 (7%)	90 (7%)
Lower quartile	71 (5%)	61 (5%)
Higher quartile	190 (13%)	164 (12%)
Top quartile	1118 (76%)	1006 (76%)



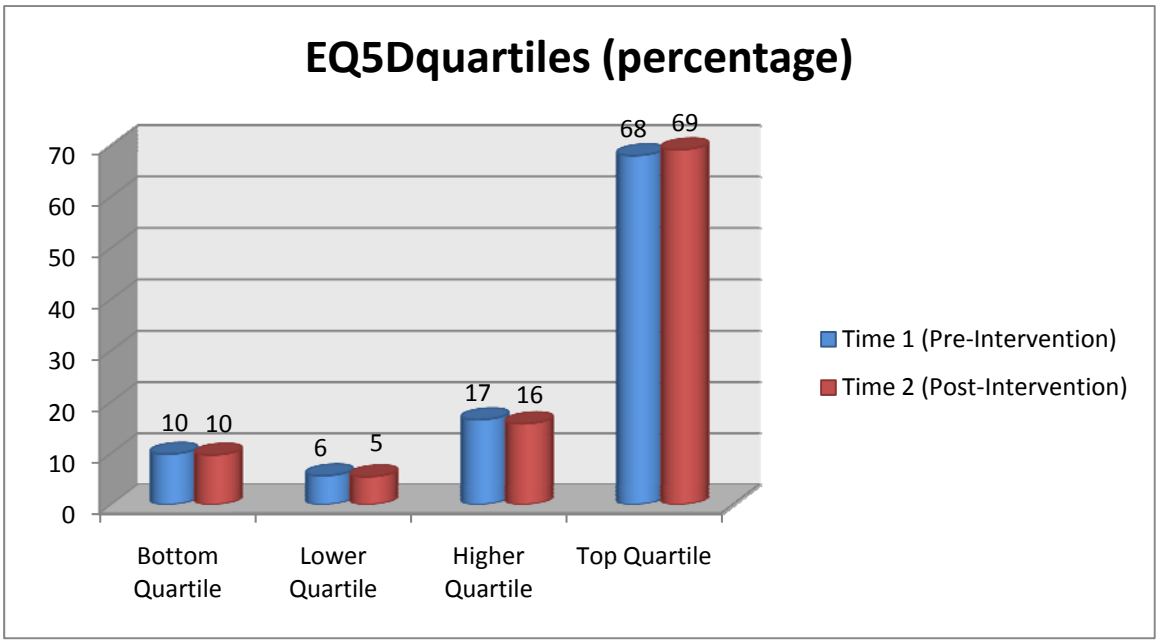
EQ5D quartile change for Needs Level 1:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	33 (4%)	31 (5%)
Lower quartile	33 (4%)	27 (4%)
Higher quartile	73 (9%)	60 (9%)
Top quartile	650 (82%)	567 (83%)



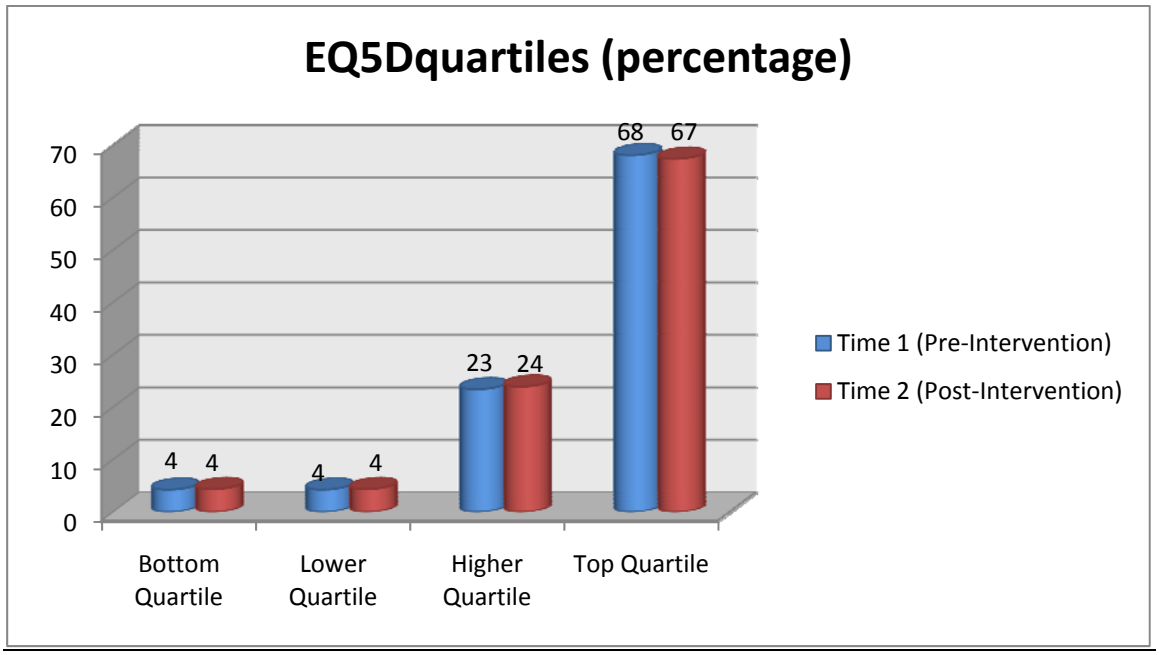
EQ5D quartile change for Needs Level 2:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	63 (10%)	57 (10%)
Lower quartile	36 (6%)	32 (5%)
Higher quartile	106 (17%)	93 (16%)
Top quartile	436 (68%)	408 (69%)



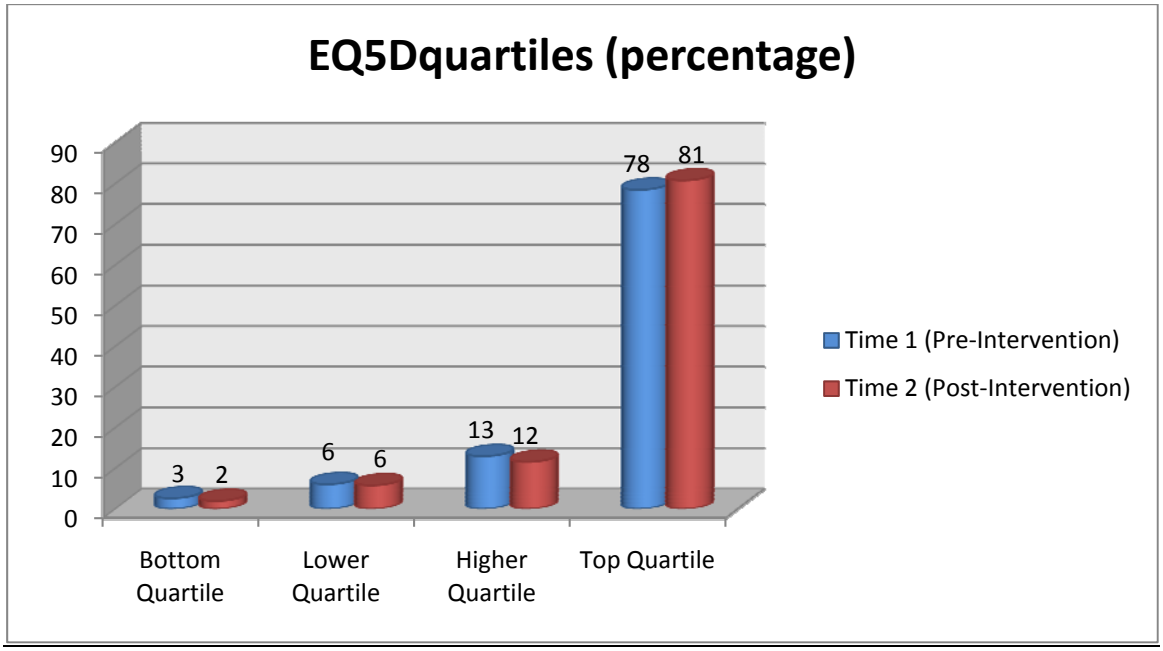
EQ5D quartile change for Needs Level 3:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	2 (4%)	2 (4%)
Lower quartile	2 (4%)	2 (4%)
Higher quartile	11 (23%)	11 (24%)
Top quartile	32 (68%)	31 (67%)



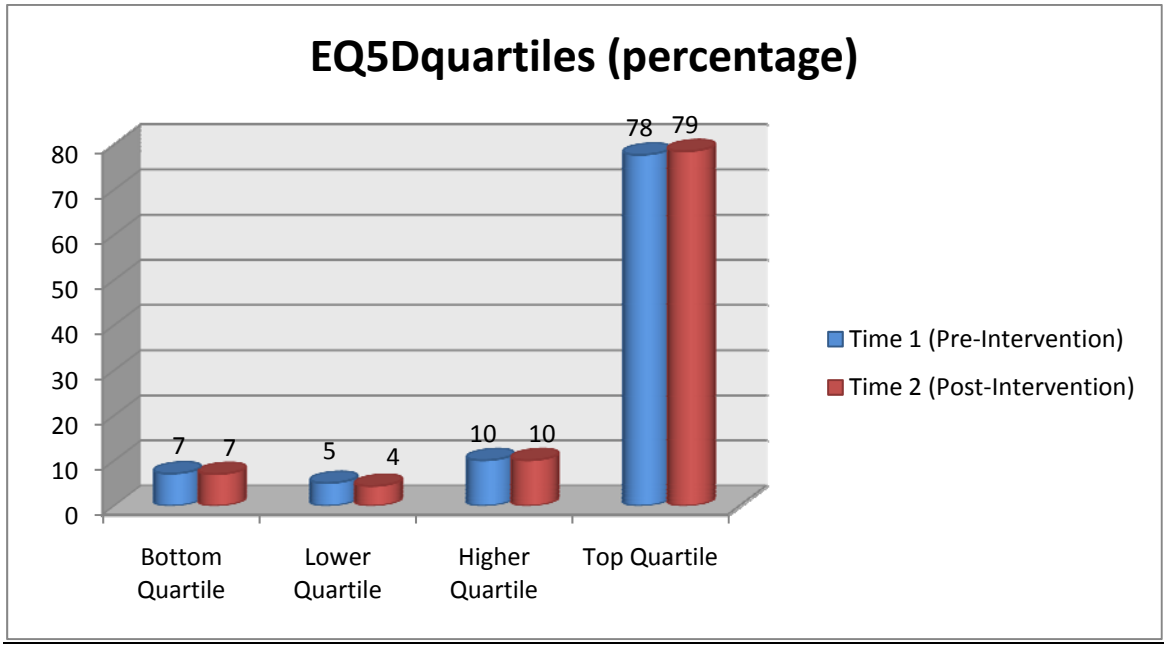
EQ5D quartile change for Category 1 - Well Being: Practical:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	3 (3%)	2 (2%)
Lower quartile	7 (6%)	6 (6%)
Higher quartile	15 (13%)	12 (12%)
Top quartile	91 (78%)	84 (81%)



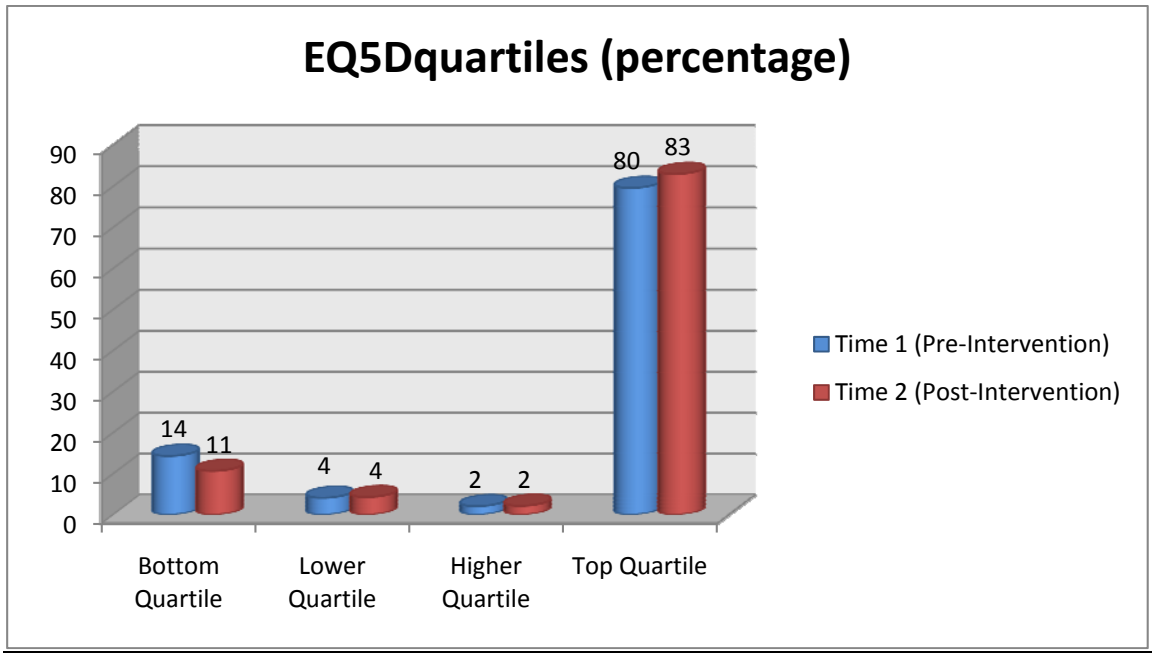
EQ5D quartile change for Category 2 - Well Being: Emotional/Social Isolation:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	17 (7%)	16 (7%)
Lower quartile	12 (5%)	10 (4%)
Higher quartile	24 (10%)	23 (10%)
Top quartile	185 (78%)	179 (79%)



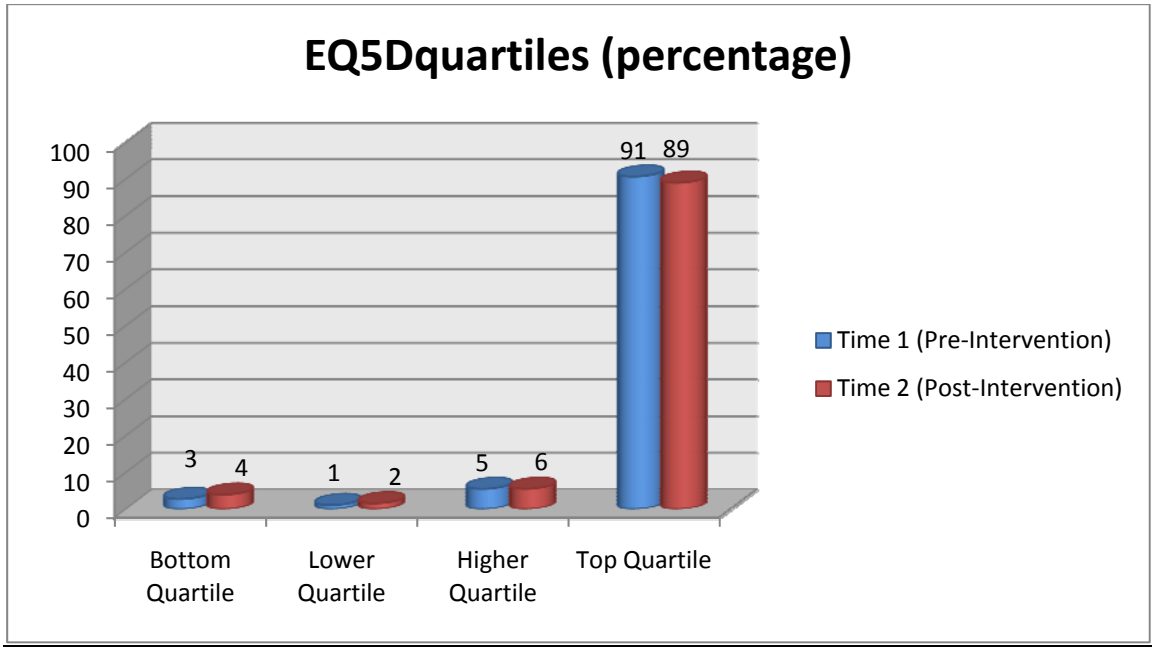
EQ5D quartile change for Category 3 - Well Being: Physical Health:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	7 (14%)	5 (11%)
Lower quartile	2 (4%)	2 (4%)
Higher quartile	1 (2%)	1 (2%)
Top quartile	39 (80%)	39 (83%)



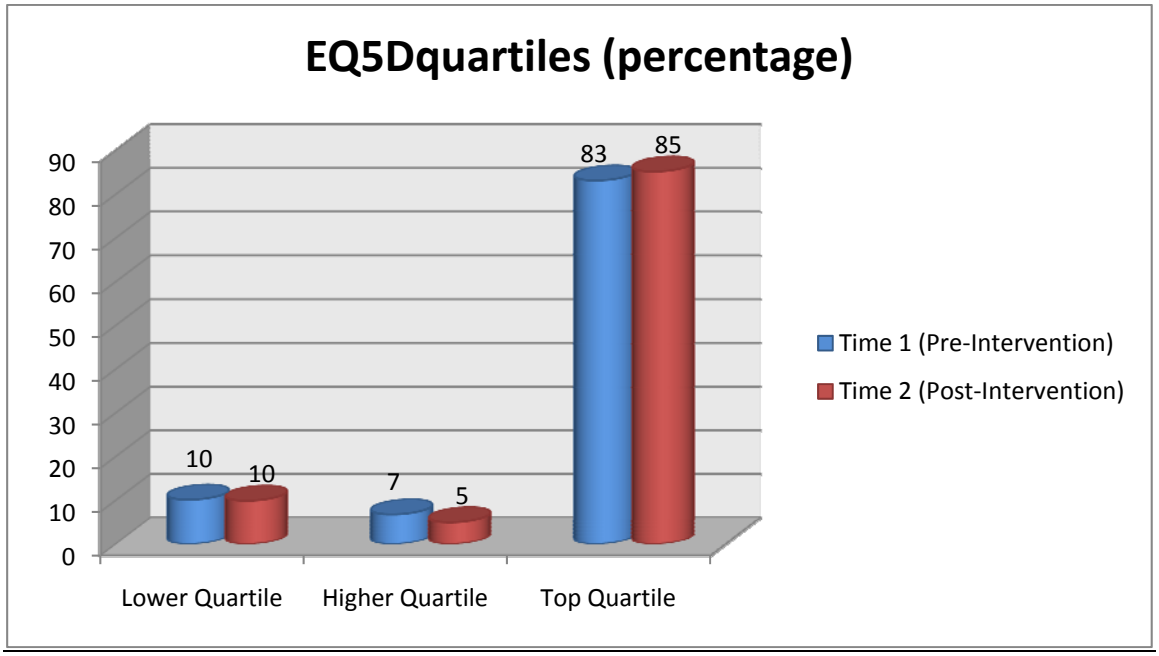
EQ5D quartile change for Category 4 - Well Being: Geographical:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	5 (3%)	5 (4%)
Lower quartile	2 (1%)	2 (2%)
Higher quartile	10 (5%)	7 (6%)
Top quartile	165 (91%)	113 (89%)



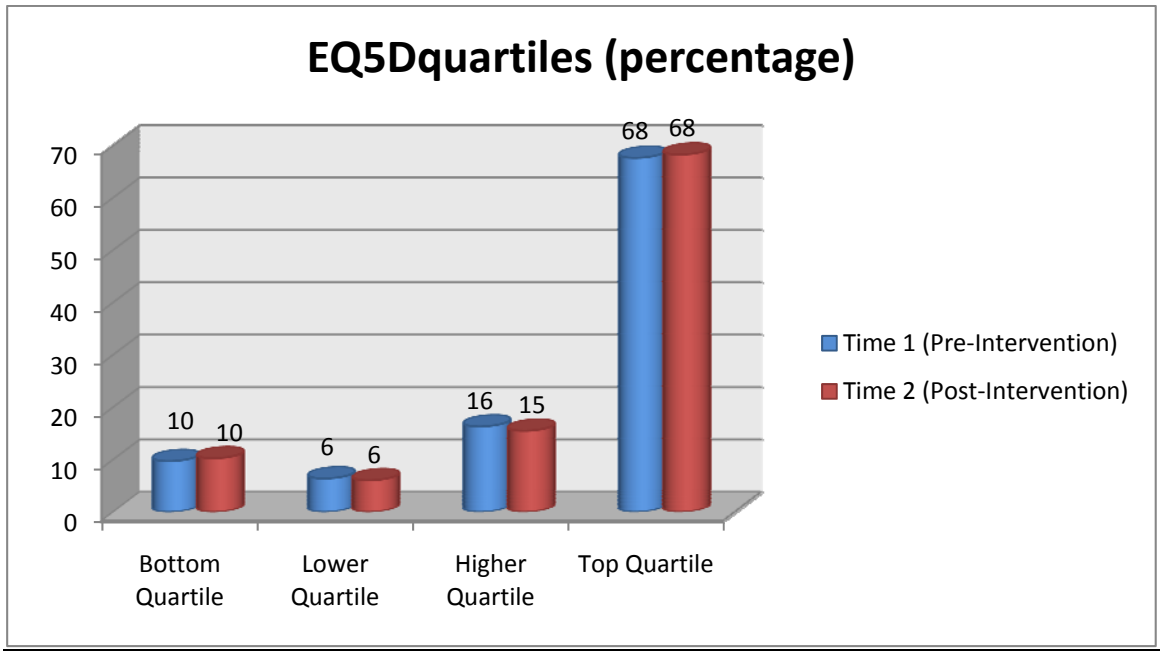
EQ5D quartile change for Category 5 - Information, Sign-posting and Access:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	0 (0%)	0 (0%)
Lower quartile	9 (10%)	8 (10%)
Higher quartile	6 (7%)	4 (5%)
Top quartile	74 (83%)	69 (85%)



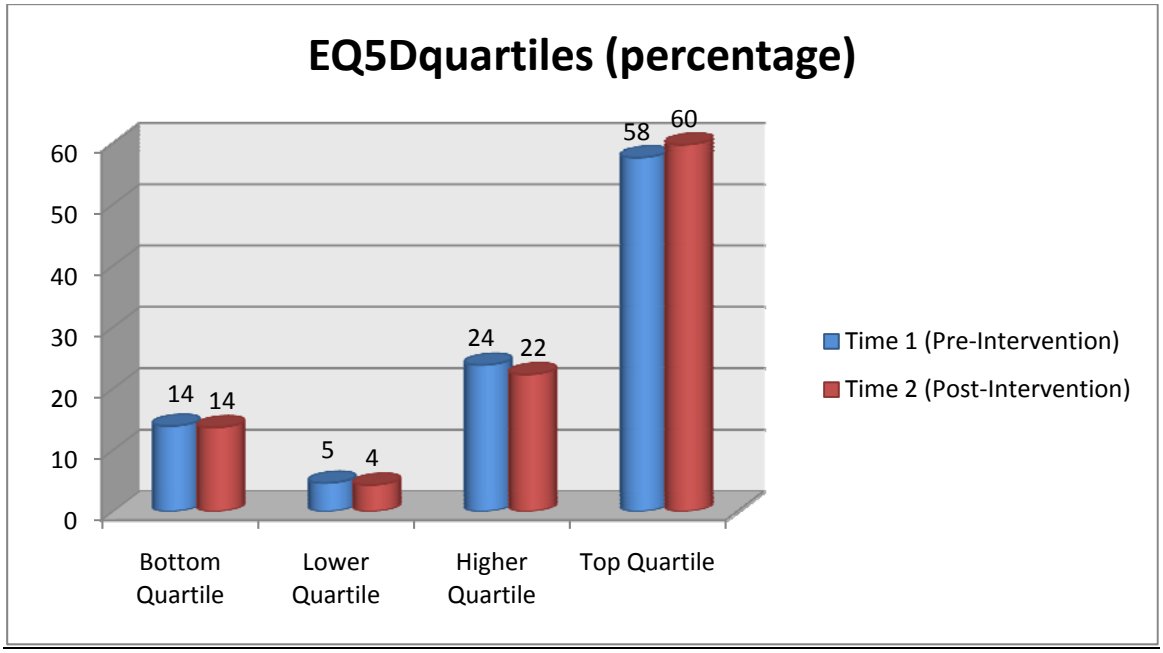
EQ5D quartile change for Category 7 - Proactive Case Co-ordination:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	41 (10%)	39 (10%)
Lower quartile	27 (6%)	23 (6%)
Higher quartile	69 (16%)	59 (15%)
Top quartile	286 (68%)	260 (68%)



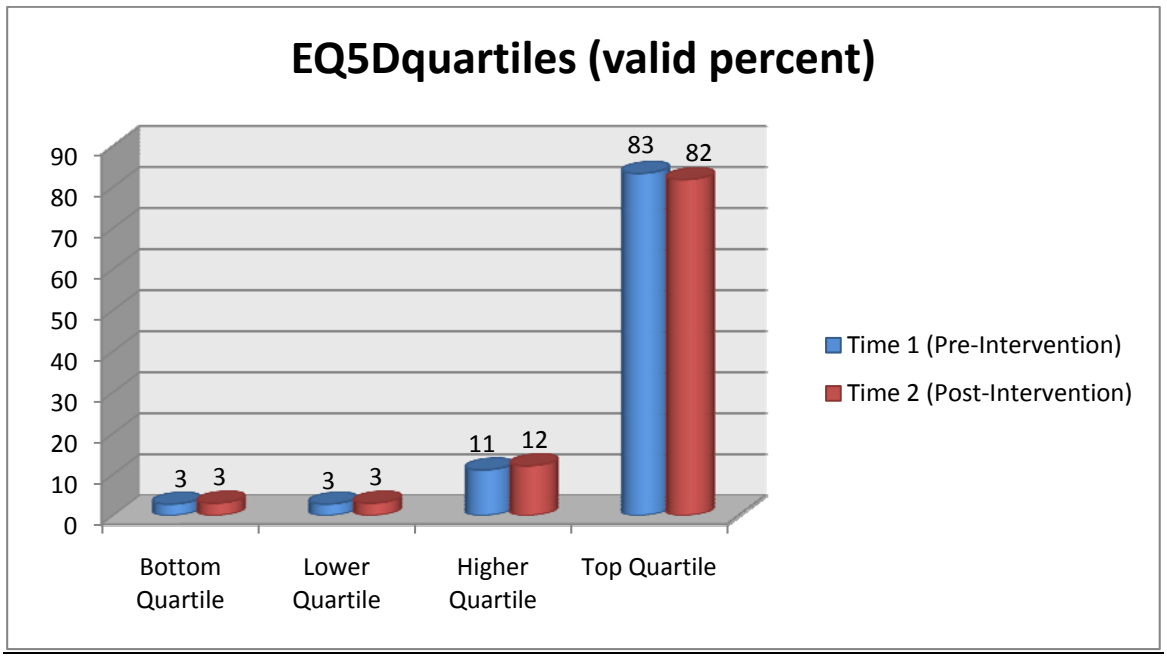
EQ5D quartile change for Category 8 - Long-term Conditions/Complex Care:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	21 (14%)	19 (14%)
Lower quartile	7 (5%)	6 (4%)
Higher quartile	36 (24%)	31 (22%)
Top quartile	87 (58%)	83 (60%)



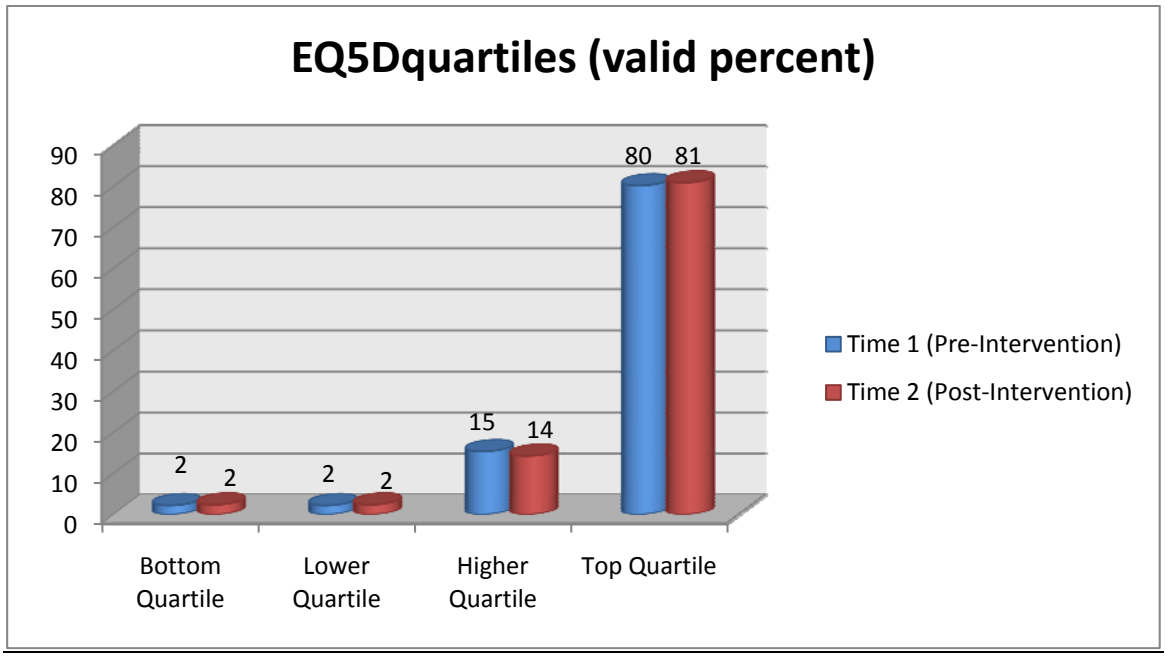
EQ5D quartile change for Category 9 - Hospital Discharge:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	1 (3%)	1 (3%)
Lower quartile	1 (3%)	1 (3%)
Higher quartile	4 (11%)	4 (12%)
Top quartile	30 (83%)	27 (82%)



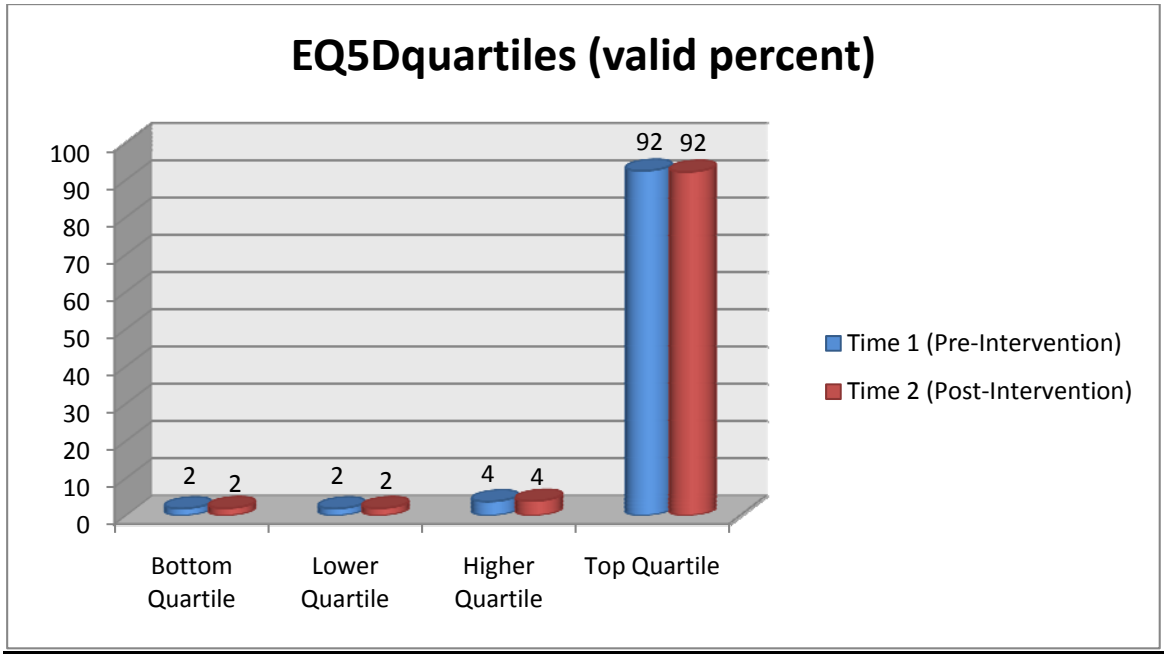
EQ5D quartile change for Category 10 - Specialist Falls:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	2 (2%)	2 (2%)
Lower quartile	2 (2%)	2 (2%)
Higher quartile	14 (15%)	12 (14%)
Top quartile	73 (80%)	68 (81%)



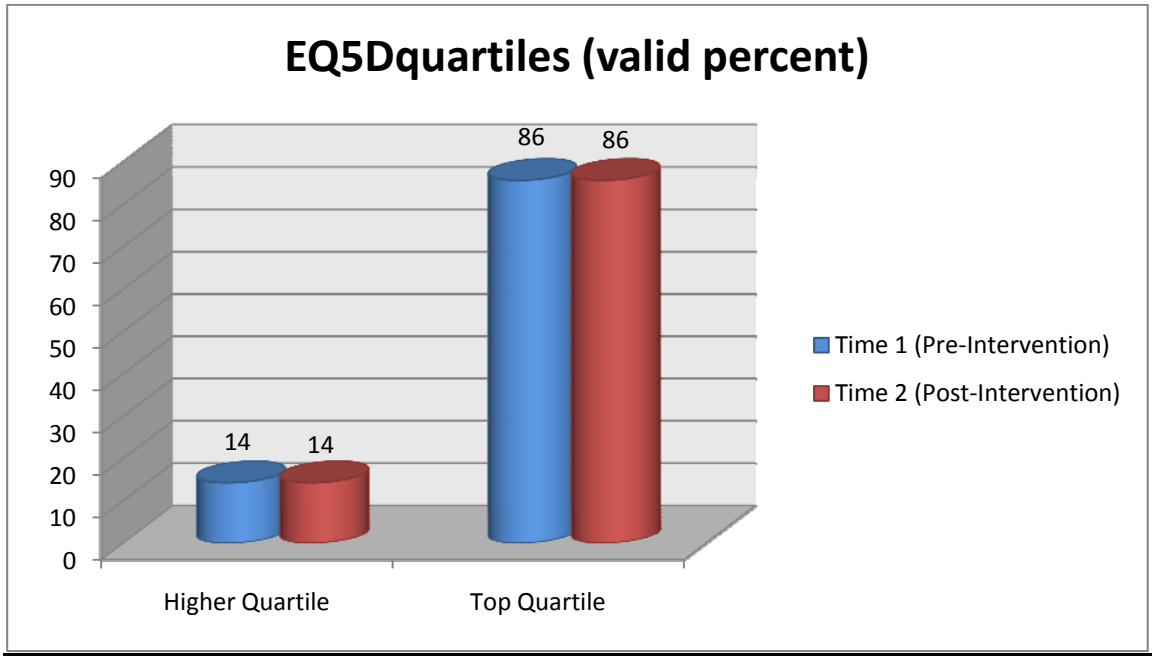
EQ5D quartile change for Category 11 - Involving Older People:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	1 (2%)	1 (2%)
Lower quartile	1 (2%)	1 (2%)
Higher quartile	2 (4%)	2 (4%)
Top quartile	49 (92%)	47 (92%)



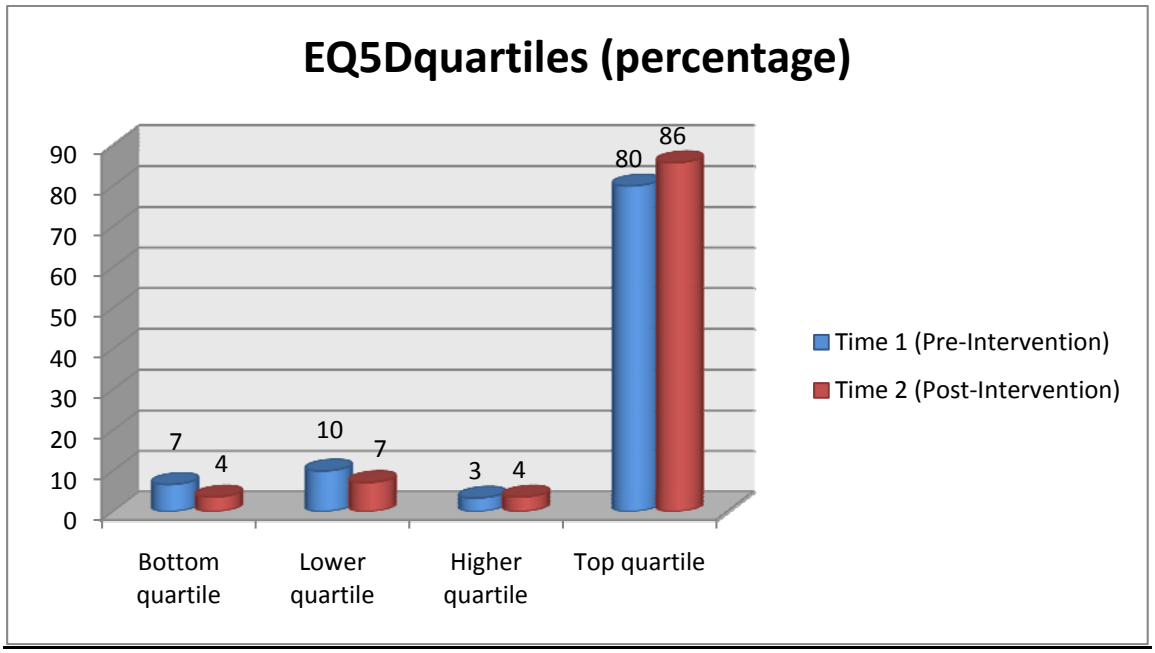
EQ5D quartile change for Category 12 - Carers Services:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	0 (0%)	0 (0%)
Lower quartile	0 (0%)	0 (0%)
Higher quartile	3 (14%)	3 (14%)
Top quartile	18 (86%)	18 (86%)



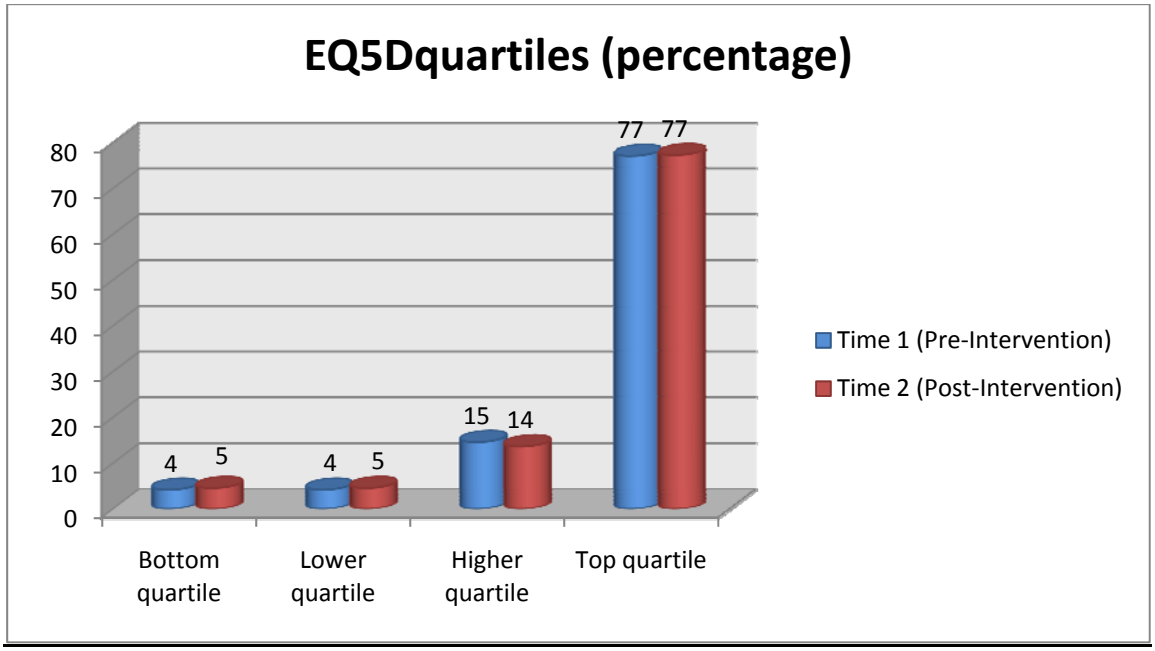
EQ5D quartile change for SPoW code 1 - Improving productivity-material/physical aids:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	2 (7%)	1 (4%)
Lower quartile	3 (10%)	2 (7%)
Higher quartile	1 (3%)	1 (4%)
Top quartile	24 (80%)	24 (86%)



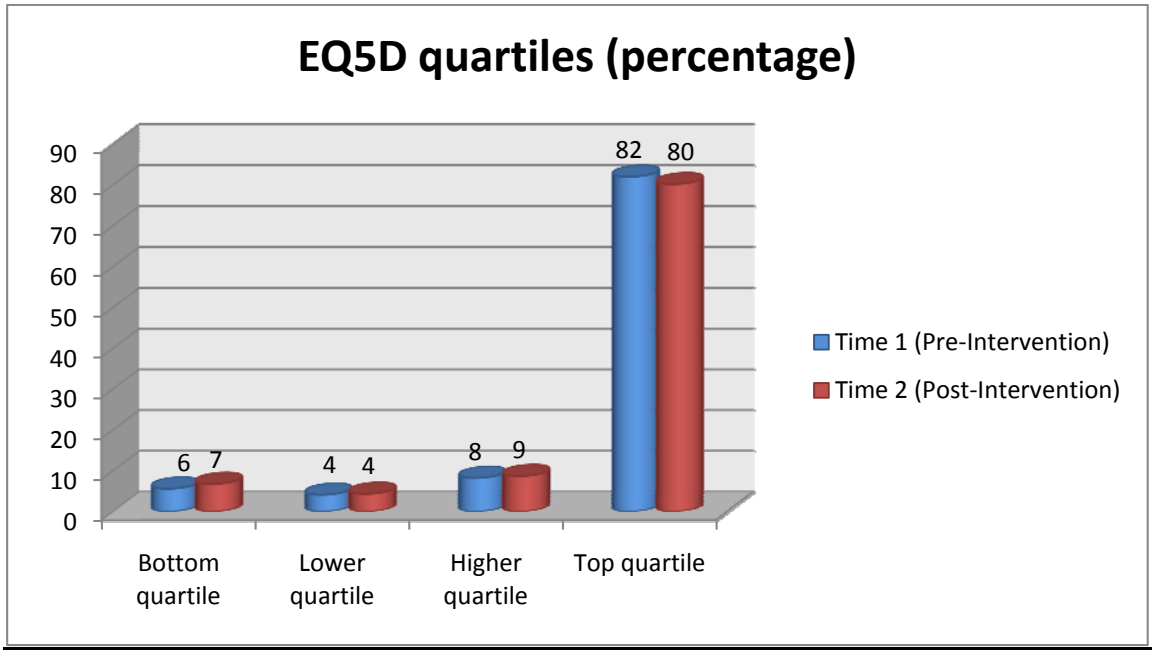
EQ5D quartile change for SPoW code 2: Substituting for production process in households:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	8 (4%)	8 (5%)
Lower quartile	8 (4%)	8 (5%)
Higher quartile	28 (15%)	24 (14%)
Top quartile	148 (77%)	136 (77%)



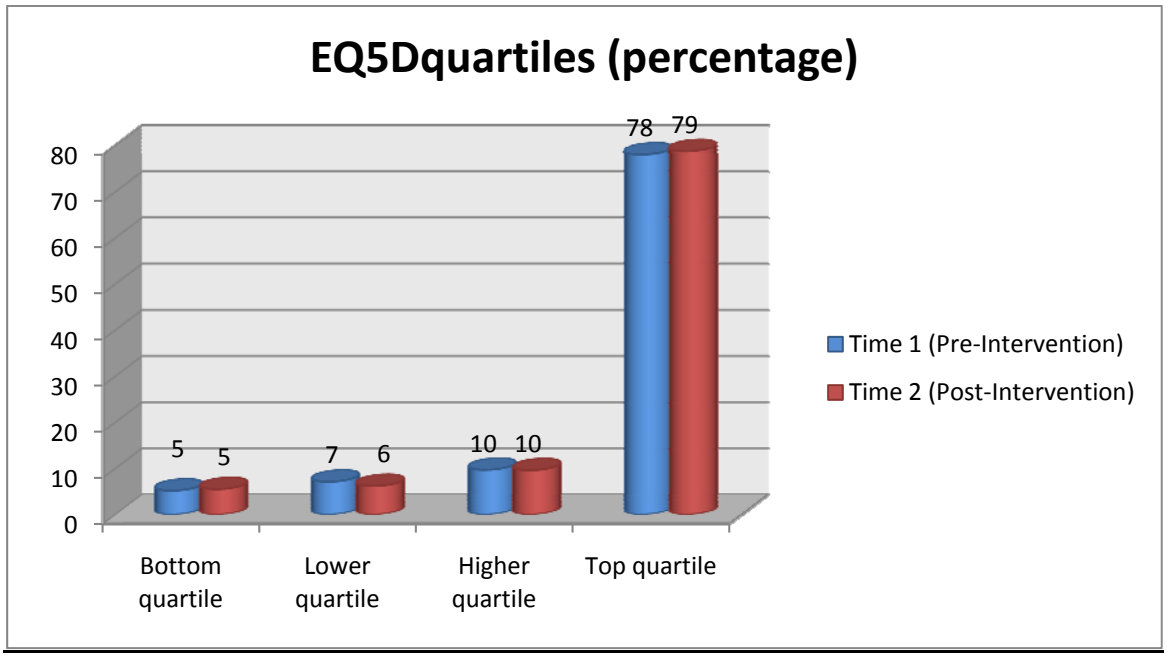
EQ5D quartile change for SPoW code 3: Supply intermediate outcomes to household:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	15 (6%)	14 (7%)
Lower quartile	11 (4%)	9 (4%)
Higher quartile	22 (8%)	18 (9%)
Top quartile	219 (82%)	166 (80%)



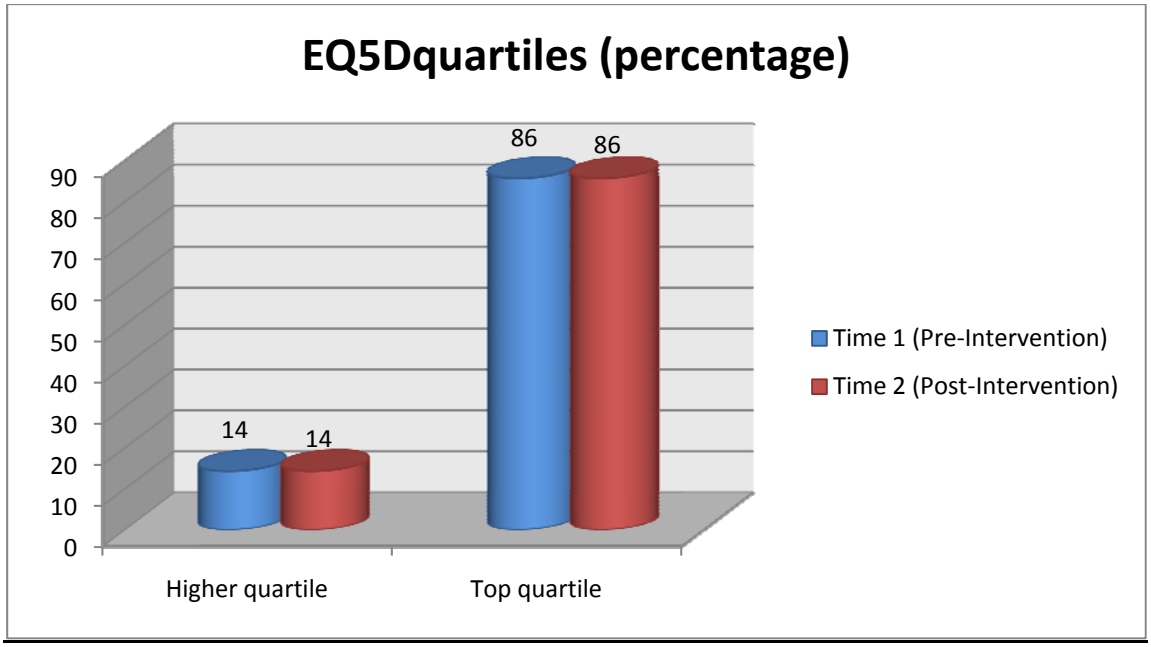
EQ5D quartile change for SPoW code 4: Technical efficiency of informal care network:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	8 (5%)	8 (5%)
Lower quartile	11 (7%)	9 (6%)
Higher quartile	15 (10%)	14 (10%)
Top quartile	121 (78%)	115 (79%)



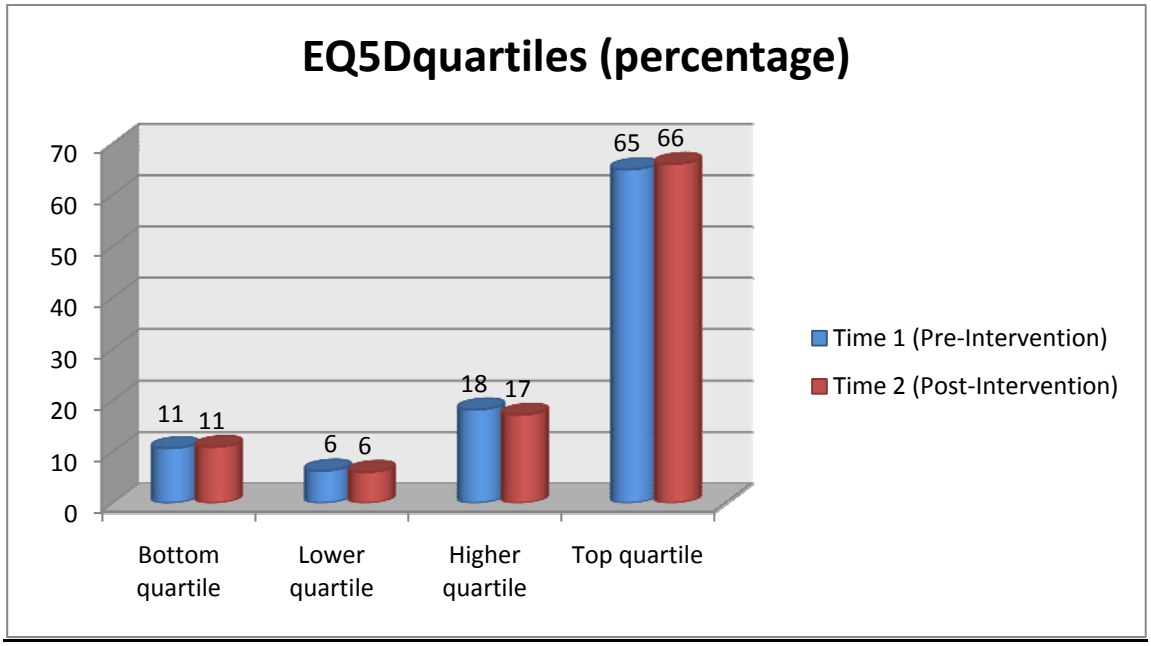
EQ5D quartile change for SPoW code 5: Reduce demand for help within the informal care network:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	0 (0%)	0 (0%)
Lower quartile	0 (0%)	0 (0%)
Higher quartile	3 (14%)	3 (14%)
Top quartile	18 (86%)	18 (86%)



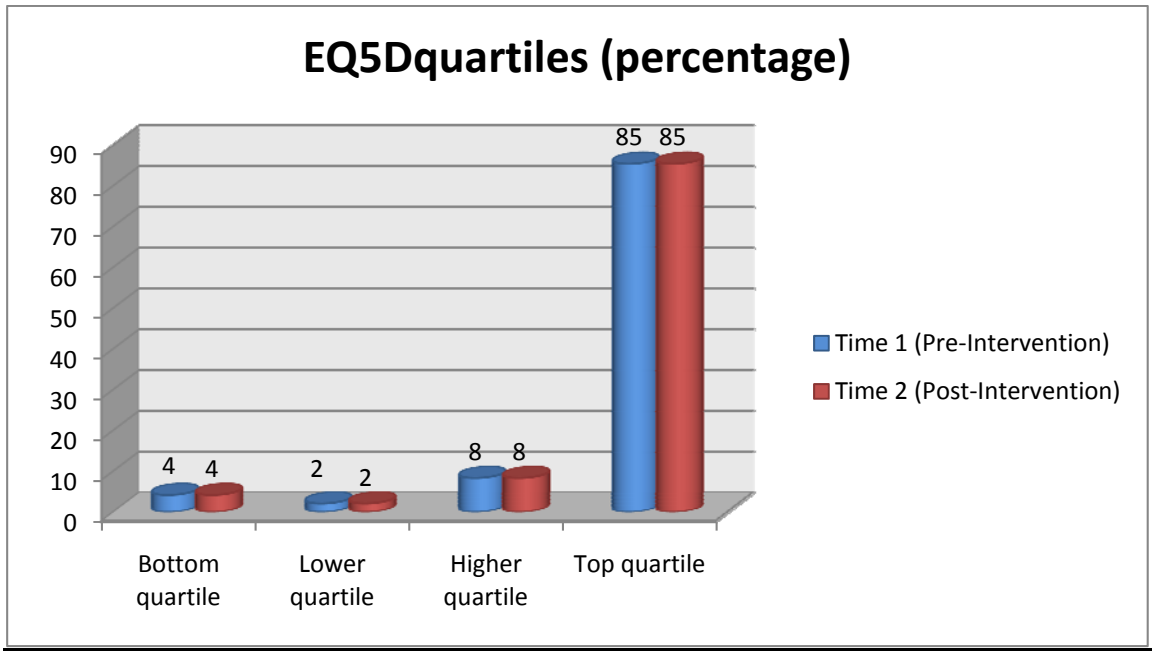
EQ5D quartile change for SPoW code 6: Increase efficiency of service inputs:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	51 (11%)	47 (11%)
Lower quartile	30 (6%)	26 (6%)
Higher quartile	87 (18%)	74 (17%)
Top quartile	311 (65%)	285 (66%)



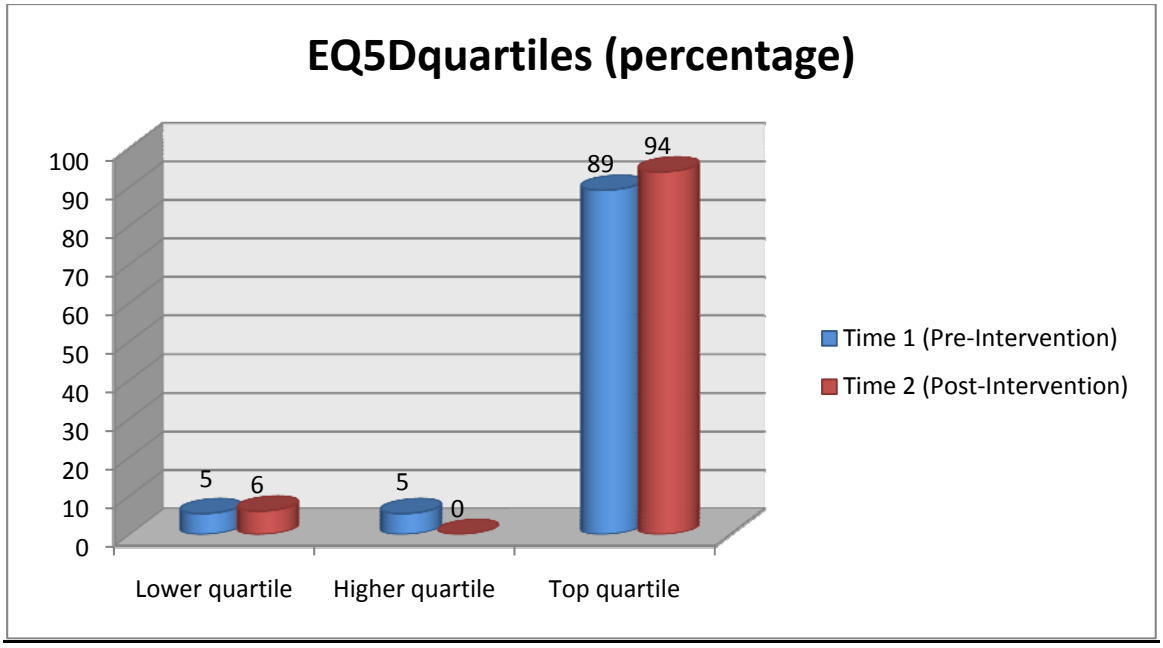
EQ5D quartile change for SPoW code 7: Contribute to the human capital or skills of household:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	2 (4%)	2 (4%)
Lower quartile	1 (2%)	1 (2%)
Higher quartile	4 (8%)	4 (8%)
Top quartile	41 (85%)	41 (85%)



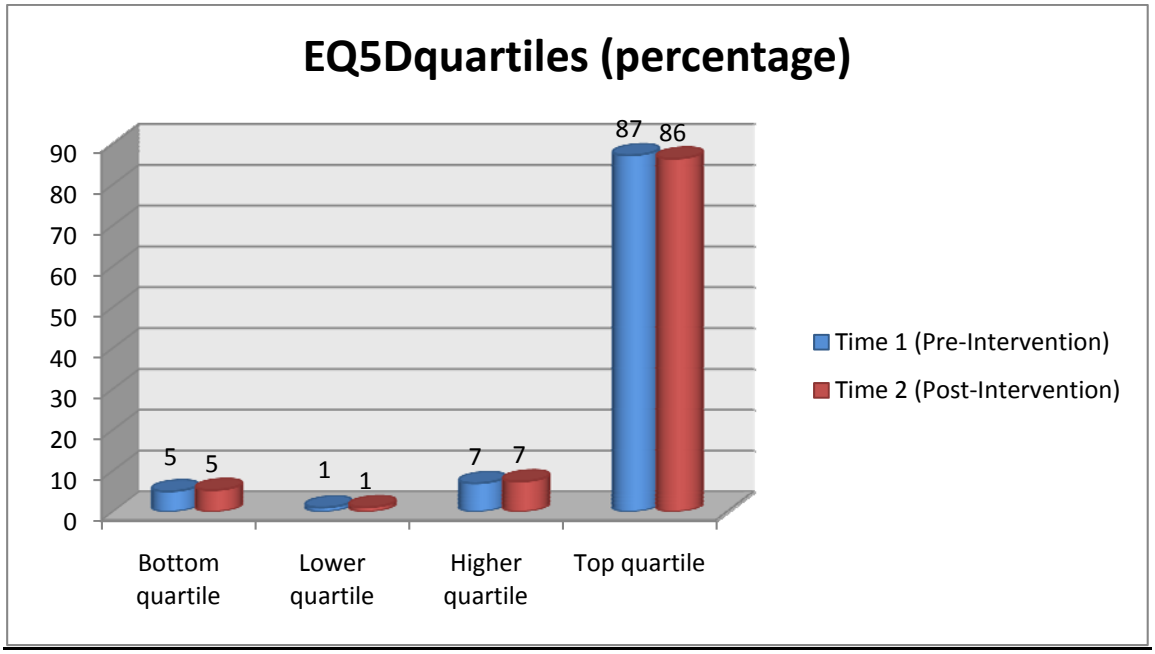
EQ5D quartile change for SPoW code 10: Improving accessibility of environment for individuals to produce their own welfare:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	0 (0%)	0 (0%)
Lower quartile	2 (5%)	2 (6%)
Higher quartile	2 (5%)	0 (0%)
Top quartile	33 (89%)	31 (94%)



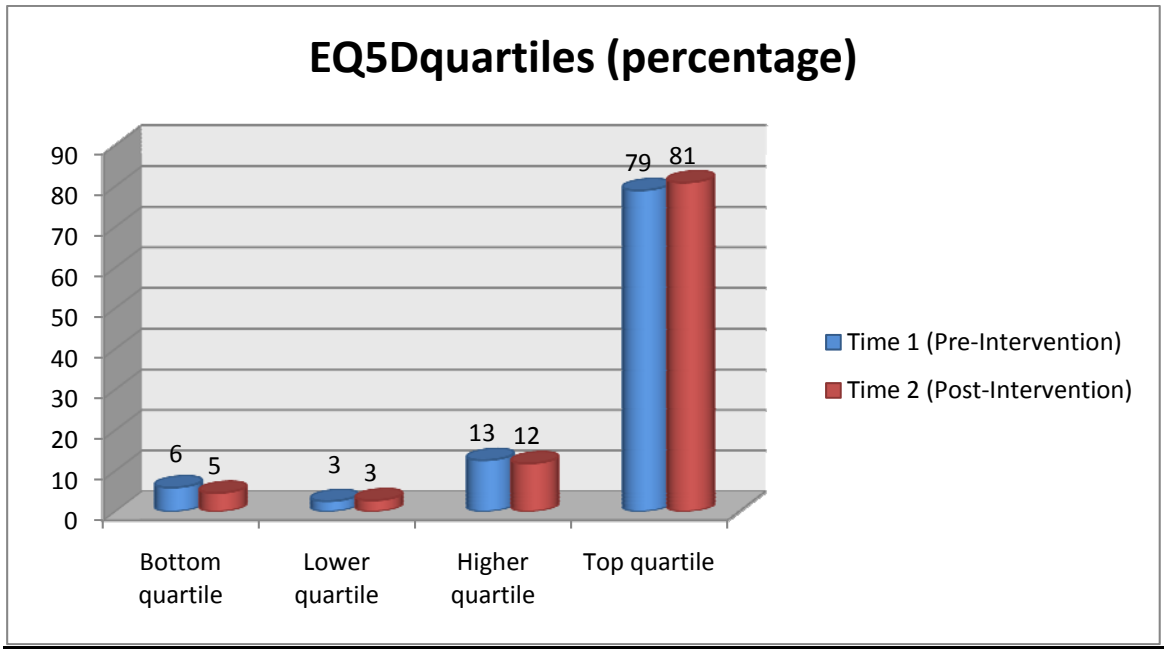
EQ5D quartile change for SPoW code 11: Building sustainable communities:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	5 (5%)	5 (5%)
Lower quartile	1 (1%)	1 (1%)
Higher quartile	7 (7%)	7 (7%)
Top quartile	88 (87%)	82 (87%)



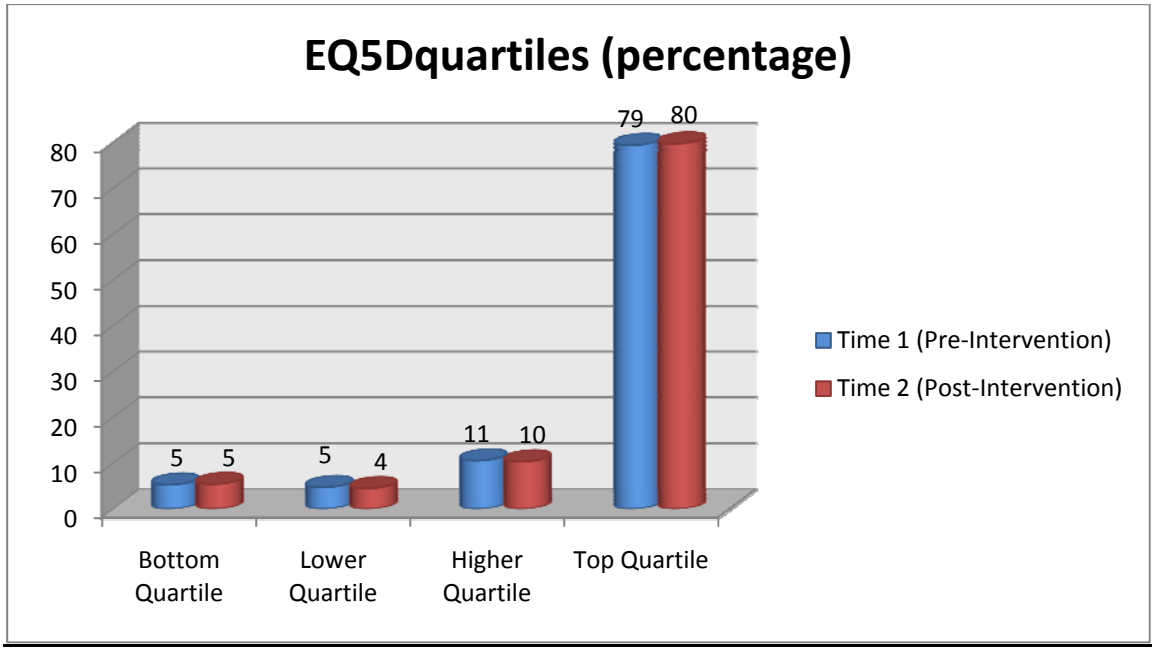
EQ5D quartile change for SPoW code 12: Improving productivity - personal capacity development:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	7 (6%)	5 (5%)
Lower quartile	3 (3%)	3 (3%)
Higher quartile	15 (13%)	13 (12%)
Top quartile	94 (79%)	89 (81%)



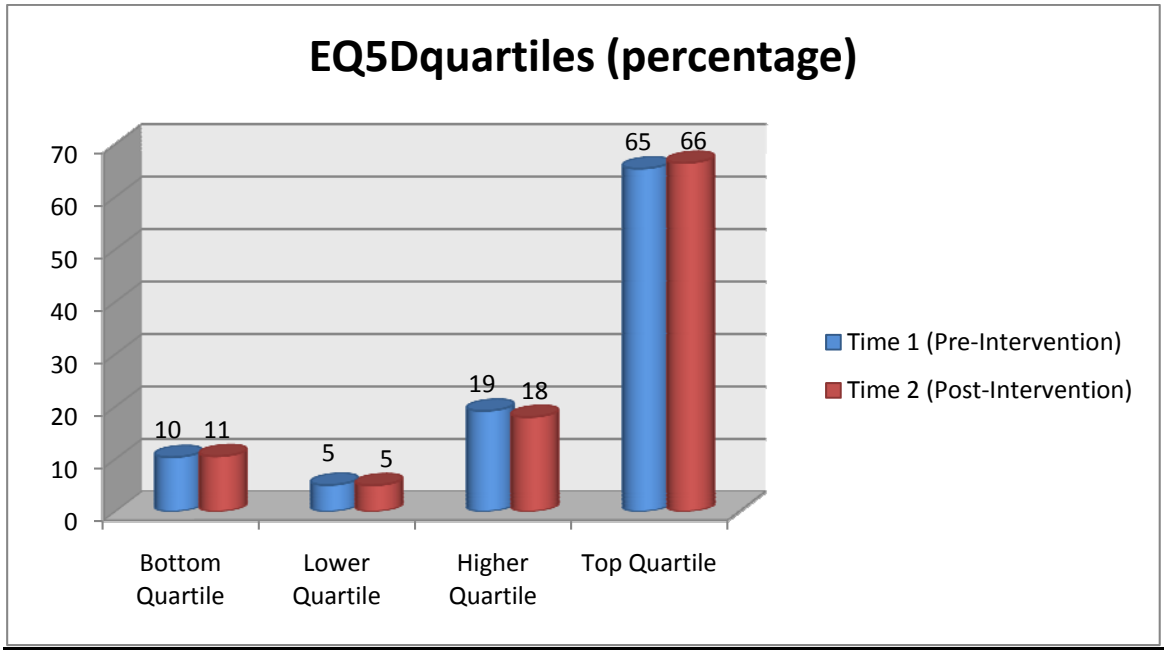
EQ5D quartile change for Community Facing:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	57 (5%)	52 (5%)
Lower quartile	51 (5%)	43 (4%)
Higher quartile	114 (11%)	99 (10%)
Top quartile	859 (79%)	766 (80%)



EQ5D quartile change for Hospital Facing:

	Time 1 (Pre-Intervention)	Time 2 (Post-Intervention)
Bottom quartile	41 (10%)	38 (11%)
Lower quartile	20 (5%)	18 (5%)
Higher quartile	76 (19%)	65 (18%)
Top quartile	259 (65%)	240 (66%)



Appendix K

POPP Standardised Activity Data

ANNEX A

Partnerships for Older People Projects
Standardised Activity Data

*Please complete a separate return for **each** project/ intervention within your POPP pilot using this form. You are asked to provide data for each project/intervention from **[specific quarter specified].***

1 Contact Details for the POPP Project

POPP PROJECT TITLE	
POPP Project Contact Name	
Contact Telephone Number	
Contact Email	

2 Staff Details for the Project

This information is being requested to provide an indication of the size and capacity of each project within the overall pilot.

Total Number of Social Services Staff (WTE) (Within Project)	#
Total Number of Health Staff (WTE) (Within Project)	#
Total Number of Voluntary Organisation Staff (WTE) (Within Project)	#
Total Number of Volunteers (WTE) (Within Project)	#

3 User Contact/ Referral Details

This information is being requested to provide an indication of:

- *how many individuals are in contact with the POPP service*
- *how many individuals are in contact with the service as a result of a formal referral and*
- *source of referral.*

The information on numbers of contacts and referrals combined with the age and sex of users will provide useful data regarding how services are being accessed and by whom.

We have asked for data on the total number of forecast contacts. This is the number of contacts you planned for when developing your POPP implementation plan for [Year] as recorded in your end of year reports submitted [Year]. We understand that for some

projects it may take longer to receive the target number of referrals and where this is the case, pilots are invited to provide contextual information.

It is recognised that services which target those most at risk, are not open to self referral or 'contact' by potential service users / clients. For example, a specialist falls service, which is only referred to by other professionals once they have undertaken an initial assessment using a specially designed falls screening tool. For any such projects please explain why the data field is non-applicable.

Total Number of Users Contacting the POPP Project (This includes telephone calls, face to face contacts, drop-in etc. Please **do not** include the more 'formalised' referrals from self and other services)			#	
Total Number of Users Referred to the POPP Project (This includes more formalised referral routes from self and different services)			#	
Source of Referral (Please put the numbers of users against each particular service referred)				
	Self Referred		#	
	GP Referred		#	
	Social Services Referred		#	
	Housing Organisation (Includes statutory & Voluntary)		#	
	Voluntary Organisation Referred		#	
	Mental Health Trust Referred		#	
	Hospital Referred		#	
	Other POPP Project		#	
	Other(s) (Please Specify)		#	
Sex of User Referred (Please give numbers within each category)				
	Female	#	Male	#
Age Ranges of Referred Service Users (Please give numbers within each category)				
		Under 50	#	
		Aged 50 – 59	#	
		Aged 60 – 64	#	
		Aged 65 - 69	#	
		Aged 70 – 74	#	
		Aged 75 – 80	#	
		Aged 80 - 84	#	
		Aged 85+	#	

Total Number of Forecast Contacts for <u>2007/08</u> (Please provide the numbers you had envisaged for this quarter based on your revised POPP implementation plan for 2007/08)	#

4 Details on Users Receiving Service

This information is being requested to provide an indication of how many individuals are receiving the service or have been through the service in comparison to overall activity i.e initial contact, referrals. It is recognised that in some cases an individual will have 'received' the service i.e they will have accessed the service and still not be in 'receipt' of the service as a further intervention is needed.

Total Number of Service Users Receiving a Service within the POPP Project (This incorporates both those service users who have been offered a service but have yet to receive it and those individuals who have actually received the service)			#	
Sex of User Receiving a Service within the POPP Project (Please give numbers within each category)				
	Female	#	Male	#
Age Ranges of Users Receiving a Service within the POPP Project (Please give numbers within each category)				
		Under 50	#	
		Aged 50 – 59	#	
		Aged 60 – 64	#	
		Aged 65 - 69	#	
		Aged 70 – 74	#	
		Aged 75 – 80	#	
		Aged 80 - 84	#	
		Aged 85+	#	
Total Number of Forecast Service Receipt for 2007/08 (Within your revised implementation plan for 2007/08 you will have forecast the total number of expected users in receipt of services for your POPP Project. Please give this number)			#	

5 Referral-On' Data'

This information is being requested to provide an indication of how many individuals who have had initial contact with the POPP service, (or have actually received and been through the service), are then referred to another service. This should provide useful information regarding outcomes for individuals and how POPP services are facilitating access to other services/agencies.

Total Number of Service Users Referred to Other Services. (Please record the 'referral on' data for those users that have received a POPP service and/or initial contact)		#
Type of Service 'Referred-Onto' (Please give number of service users within each category)		
	GP	#
	Other Health Professional	#
	Social Services	#
	Housing Organisation (Includes Statutory & Voluntary)	#
	Voluntary Organisation	#
	Mental Health Trust	#
	Hospital	#
	Other POPP Project	#
	Other(s) (Please Specify)	#

6 Compliance with equality legislation

The Local Authority with administering responsibility for the POPP pilot has a duty to promote all current and forthcoming equality legislation and to ensure that the services and approaches delivered under Partnerships for Older People Projects comply with all such legislation. The Local Authority should ensure that its delivery partners are aware of, and are complying with, their responsibilities in this area.

Please provide any relevant update to the information provided within your POPP end of year report for [year] regarding work undertaken to ensure compliance with equality legislation.

7. Ethnicity

This information is being requested to provide an indication of the equality of access to the project or services that you are providing. We are aware that some of you are also collecting faith based information. Please do attach this information with this report.

Ethnic Community	**Number of Users**
White British	#
Chinese	#
Black African	#
Black Caribbean	#
Black (Other)	#
Indian	#
Pakistani	#
Bangladeshi	#
Other (Please Specify)	
	#
	#
	#
	#
	#

8. Further Activity Data

If there is any further activity data that you have been monitoring, which has not been covered by this report, but you feel would be helpful in demonstrating the progress of your pilot please do attach this information with this report. If this information is used, names of author(s) will be cited.

Appendix L

Service Use Costings

Service use costings

The Client Services Receipt Inventory (Beecham & Knapp 1992) was included within the standardised questionnaire to measure any changes in service use following the POPP interventions. Respondents to the questionnaire were asked to detail the type of services used and the number of times they received such services three months prior to the POPP intervention and three months post the POPP. To assess whether costs reduced or increased, each specific service was assigned an overall cost. The tables below give the necessary costs for within the areas of secondary care, local surgery or health centre, services received at home and day care. A weighted average using the number of bed-days for those aged 60+ was taken within secondary care provision as the type of admission ward or procedure was not known. A weighted average was similarly used where costs differed substantially between London and other areas.

Table 1: Costs for Hospital Service Use

Hospital Service Use					
Service	**Unit Cost Summary**	**Cost (£)**	**Cost with Inflator (3.4%)**	**Data Drawn from:**	**Notes**
Accident & Emergency	Per attendance	91	94	Curtis & Netten	Taken mean of high cost investigation (105) and Lower cost investigation (77)
Emergency Ambulance	Per patient journey	246	254	Curtis & Netten	
Paramedic Unit	Per patient journey	323	334	Curtis & Netten	
Inpatient Attendance	Per Bed Day	153	158	Curtis & Netten	See Table 1 for breakdown
Outpatient Attendance	per follow-up attendance	113	117	Curtis & Netten	See Table 2 for breakdown
Hospital Physiotherapy	Per appointment	30	31	Curtis & Netten	See Table 3 for breakdown
Hospital Occupational Therapist	Per appointment	30	31	Curtis & Netten	See Table 4 for breakdown
Wheelchairs	Per year	197	204	Curtis & Netten	See Table 5 for breakdown

Table 1a: Breakdown of Inpatient Attendance: Per Bed Day

TABLE ONE					
Hospital Costs for Hospital Stay					
	Service	**Unit Cost Summary**	**Cost (National Average)**	**Cost with Inflator (3.4%)**	Number of bed days 60+
	MENTAL HEALTH SERVICES				
	Elderly	Per bed day	217	224	2,397,360
	PATIENT REHABILITATION				
	Elderly	Per bed day	187	193	6,735,143
	General Surgery	Per bed day	93	96	1,756,671
	General Medicine	Per bed day	119	123	6,878,110
	Cardiology	Per bed day	101	104	920,024
	Rehabilitation	Per bed day	149	154	510965
					19,198,273
	TOTAL AVERAGE		144.3333333	149.2406667	
	WEIGHTED AVERAGE		152.6502182	157.8403256	

Table 1b: Breakdown of Outpatient Attendance services

TABLE TWO			
Outpatient Attendance - Per Attendance			
	Service	**Cost (National Average)**	**Cost with Inflator (3.4%)**
	Drug & Alcohol Services	107	111
	Other Services - Adult	126	130
	Elderly	106	110
	General Outpatient Cost - Adult	113	117
	TOTAL AVERAGE	**113**	117

Table 1c: Breakdown of Hospital Physiotherapy services

TABLE THREE					
Hospital Phsyiotherapy					
	Unit Costs	**London**	**Non-London**	**London with Inflator**	**Non-London with Inflat**
	Per Hour	24	21	25	22
	Per Hour of Client Contact	37	32	38	33
	Per Hour in Clinic	35	31	36	32
	Total Average	32	28	33	29
		Average	**30**	**Average**	**31**

Table 1d: Breakdown of Hospital Occupational Therapist

TABLE FOUR					
Hospital Occupational Therapist					
	Unit Costs	**London**	**Non-London**	**London with Inflator**	**Non-London with Inflat**
	Per Hour	24	21	25	22
	Per Hour of Client Contact	40	35	41	36
		32	28	33	29
		Average	**30**	**Average**	**31**

Table 1e: Breakdown of NHS Wheelchairs (by type)

TABLE FIVE			
NHS Wheelchairs			
	Unit costs	**Unit Costs**	**Cost with Inflator (3.4%)**
	Per self or attendant propelled chair	78	81
	Per active user per chair	156	161
	Per powered chair	359	371
		197.6666667	204.3873333

Table 2: Costs for Local Surgery or Health Centre

Local Surgery or Health Centre					
Service	**Unit Cost Summary**	**Cost (£)**	**Cost with Inflator (3.4%)**	**Data Drawn from:**	**Notes**
GP Appointment	Per Appointment	25	26	Curtis & Netten	Including direct care & with qualification costs.
GP Telephone Consultation	Per consultation	27	28	Curtis & Netten	Including direct care & with qualification costs.
Practice Nurse	Per consultation	10	10	Curtis & Netten	
Community Physiotherapist	Per visit	16	17	Curtis & Netten	Including with qualification costs
NHS Community Occupational Therapist	Per visit	16	17	Curtis & Netten	Including with qualification costs
Community Chiropodist	Per visit	9	9	Curtis & Netten	
Community Pharmacist	Per patient related activity	47	49	Curtis & Netten	Including with qualification costs
Clinical Pyschologist	Per prof. chargeable hour	38	39	Curtis & Netten	
Cognitive Behavioural Therapist	Per session	52	54	Curtis & Netten	
Non-Directive 'Counsellor'	Per Session	34	35	King et Al 2000	Average cost per session of NDC inlcuding 44.8% Pay & Prices Index from 2000/1 (Curtis & Netten: 197)
Generic Direct Care Counselling	Per Session	41	42		Taking average from Clinical Psychologist, CBT, NDC.

Table 3: Costs for services received 'at home'.

Services at Home					
Service	**Unit Cost Summary**	**Cost (£)**	**Cost with Inflator (3.4%)**	**Data Drawn from:**	**Notes**
GP Home Visit	Per Appointment	69	71	Curtis & Netten	Including direct care & with qualification costs.
Nurse Home Visit	Per visit	17	18	Curtis & Netten	Including with qualification costs
Community Physiotherapist	Per visit	44	45	Curtis & Netten	Including with qualification costs
NHS Community Occupational Therapist	Per visit	44	45	Curtis & Netten	Including with qualification costs
Community Chiropodist	Per visit	16	17	Curtis & Netten	
Social Worker	Per Hour of client-related work	43.5	45	Curtis & Netten	See Table 6 for breakdown
Home Care/ Home Help	Per Hour Face to Face	20	21	Curtis & Netten	See Table 7 for breakdown
Meals on Wheels	Per Meal	4.3	4.4	PSS EX1 Return 2004/5	Cost per meal at 2004/5 plus 9.3% Pay & Prices Index from 2004/5 to 2005/6

Table 3a: Breakdown of social worker cost by specialty

TABLE SIX			
Social Worker			
	Social Worker - Level - Per hour of client related work	**Unit Costs**	**Cost with Inflator (3.4%)**
	Social Work Team Leader	42	43
	Social Worker - Adult	33	34
	Social Work - Assistant	22	23
	Approved Social Worker - Mental Health	77	80
	Total Average	43.5	45

Table 3b: Breakdown of cost of home care hours over seven days.

TABLE SEVEN				
	Home Care per hour face to face	**Cost per hour**	**Hours per week**	**Total cost per week**
	Weekday Contact	16	60	960
	Weekday Evenings	19	60	1140
	Saturdays	24	24	576
	Sundays	32	24	768
	Total Average	**22.75**	168	3444
	Weighted average	**20.5**		

References

Curtis L, Netten A: Unit Costs of Health & Social Care 2006: PSSRU: University of Kent

King M, Sibbald B, Ward E, Bower P, Lloyd M, Gabbay M, Byford S: 2000: Radomised controlled trial of non-directive counselling, cognitive behaviour therapy and usual general practitioner care in the management of deptression as well as mixed anxiety and depression in Primary Care: HTA: Vol 4: No.19

NHS Health & Social Care Information Centre: Social Care Statistics: Personal Social Services Expenditure & Unit Costs: England: 2004/5

Appendix M

Quality of Life Indicators Discussion Document 1

National Evaluation of the Partnerships for Older People Projects
Discussion Document 1
Quality of Life Indicators

1 Introduction

The Quality of Life Indicators (QoL) form part of the National Evaluation (NE) Core Dataset. Within the NE Proposal (http://www.smartgroups.com/vault/POPP) it was argued that a single measure would be used across all likely 31 Partnerships for Older People (POPP) pilot sites. The underpinning rationale was to enable an assessment and comparison of the impact of the innovative interventions on the quality of life for older people. The key research question is: 'Do the interventions ensure improved quality of life for older people?'

This discussion paper summarises the initially proposed structure and details the feedback received to date from the POPP Leads (PLs) and Local Evaluators (LEs). Integrating and building on these ideas and concerns, a revised proposal for the inclusion and implementation of the QoL is put forward. It must be stressed that this is a discussion document. The detail within this paper will be refined and developed following further 'virtual' conversations and/ or workshops with the key stakeholders.

2 Core Dataset: Quality of Life

Within the NE Proposal (see 4.1.5) (http://www.smartgroups.com/vault/POPP) it was suggested that the 'Growing Older Quality of Life Questionnaire' (Bowling et al 2006) would be developed to incorporate a range of easily completed outcome scales (eg, Hospital Anxiety and Depression Scale: Zigmond & Snaith 1983). The resulting easy to complete tool would then be piloted and validated prior to administration across the whole population to whom the interventions were directed. At the time of submission of the proposal, it was not known what the projects would be, or which pilot sites would be selected. However, it was recognised if the QoL was to provide an indicator of change, it would be necessary to administer this at a minimum of two points. This would be at entry to the intervention and at discharge or, at an appropriate agreed time. The lack of knowledge of the type of interventions similarly impacted upon the suggested method of administration and analysis. It was stated that only following further negotiations with the LEs would this be finally decided. Nevertheless, it was recognised that the variety of interventions and needs any QoL to be designed in such a way to facilitate flexibility of administration. For example, dependent on the interventions and user/ client group, the tool needed to be suitable for self-completion, telephone interviews or face-to-face interviews. It was suggested that the analysis could either be carried out locally allowing for immediate feedback and integration into the development of the local interventions or, centrally with planned feedback structures and timescales.

The level of health and well-being of older people within the interventions may not allow for measuring the changes in QoL across the whole population. As such, those individuals with severe and enduring mental health problems or severe dementia would be excluded (MREC Application: Ref 06/Q0411/61). However, it was also important that the measurement of QoL did not unnecessarily exclude those with disabilities (eg, chronic disease, visual impairment, literacy difficulties) (see 4.4 below).

3 Comments from the PLN Meeting – April 2006

3.1 Introduction

A short, initial presentation of the QoL indicator, the proposed sample, method of administration and analysis was given by the NE team at the Project Leads Network (PLN) meeting of April 10 2006. This meeting was also attended by those LEs who had been appointed. The QoL indicators to be developed were given to each participant ('National Evaluation of Partnerships for Older People Projects (POPP): Quality of Life Indicators/ Well-Being Indicators to be Developed'). Those included within this handout were:

- Well-Being Questionnaire (Bowling et al 2006)
- Quality of Life Postal Follow-Up Questionnaire (Bowling 2002/3)
- Quality of Life Baseline ONS Questionnaire
- Hospital Anxiety and Depression SCALE
- Ryff Scales: 14 Item
- Ryff Psychological Well-Being Scales
- Rosenberg Self-Esteem Scale and Pearlin Personal Mastery Scale

The meeting then divided into 'break-out' sessions to discuss the development and implementation of a single QoL indicator that would be used across the likely 31 sites. The following gives a distillation of the comments and concerns that were put forward.

3.2 Development of QoL

- Some individuals felt that they would wish to be involved in the development of such a tool.
- A 'virtual' working group was suggested.
- The tool should be developed with the involvement of older people.
- Concerns were expressed as to how any resulting tool would be validated.
- It was questioned if one specific QoL indicator would be valid or rigorous given the diversity of interventions and users.

3.3 Length/ Included Indicators/ Administration/ Analysis of QoL

- The final QoL should be no more than two pages and take 20 minutes to complete.
- The QoL should ensure the measurement of key domains and not be limited by length.
- There was support for a compulsory core questionnaire with additional modular options.
- The QoL indicator should be designed as a self-administration tool. Face to face administration would be limited by the capacity of the local evaluators
- Detailed work should be carried out with a cohort of individuals rather than the whole population.
- The analysis should be carried out centrally given the capacity of the LEs and the perceived need for specialist systems.

4 Revised Proposal

4.1 Introduction

Following these comments and, further discussions within the NE team, the DH, Change Agent Team and QoL experts, the following revision to the QoL facet of the Core Dataset it put forward. It is recognised that this may necessarily be a

compromise. For example, there is a dichotomy between the wishes of some individuals for a short, self-administered questionnaire and others who envisage the necessity of detailed work with a small cohort of individuals. It is therefore suggested that the NE Team and LEs discuss the development and administration of the following suggested two/ three QoL/ Wellbeing indicators:

- A short questionnaire that would be self-administered and directed toward a wide population.
- A longer questionnaire that would measure specific key domains (HM Government: 2005) and be directed toward a sample of sites and users.
- A QoL indicator specifically directed toward individuals with mental health difficulties.

These questionnaires are presented below.

4.2 Short Questionnaire

4.2.1 Type

It was stated above that one of the key concerns of the LEs was that of the length and ease of completion of the QoL indicator. There are few short QoL measures that could incorporate the depth and rigor that some individuals would find necessary. It is therefore suggested that the EQ-5D is used (see:

- http://www.smargroups.com/vault/POPP, and
- http://gs1.q4matics.com/Eurogol/PublishWeb/)

and an addition is made to this indicator of two key questions, (**rephrased**), drawn from the Growing Older Quality of Life Questionnaire (Bowling 2006):

4 Thinking about the good and bad things you have mentioned that make up your quality of life, which of the answers on this card best describes the quality of your life as a whole?

(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	☐

5. And what single thing would improve the quality of your life?

The EQ-5D can be self-administered and, takes no more than five minutes to complete. However, the EQ-5D is a utility score allowing a Quality Adjusted Life Year (QALY) that could feed into the cost-evaluation. It will not allow for the 'tracking' of any change in self-reported QoL across the sites. The above two questions would allow a limited assessment of impact. These could also be extended to incorporate the following:

1. First of all, thinking about your life as a whole, what is it that makes your life good - that is, the things that give your life quality? You may mention as many things as you like.

2. And what is it that makes your life bad - that is the things that reduce the quality in your life? You may mention as many things as you like.

3. Thinking about all these good and bad things you have just mentioned which one is the most important to you?

This would result in a short questionnaire that would take limited time to complete, enable the generation of QALYs and the tracking of the changes in QoL. It could also be flexible enough to be telephone or LE administered to the frailer clients.

Points for Discussion

- Should the short questionnaire include the utility score and questions 4 & 5 (above)?
- Should the short questionnaire include the utility score and questions 1 – 5 (above)?

4.2.2 Validation of tool

It is suggested that the tool is validated through two focus groups with older people. Within these the older people will be asked to complete the questionnaire and then a discussion would be held around the key areas of, for example, presentation, relevance, ease of completion etc. Further validation would be carried out through correlation.

4.2.3 Population/ Sample

This combination of utility score and QoL would be quick and simple to complete. It does not incorporate questions irrelevant to large groups of the population. It is recognised that some interventions will only have a single contact with their users/ patients. The use of a utility score (EQ-5D) ensures that such single contacts can be captured. Similarly, the incorporation of QoL does give an indication of 'base-line' or 'state of mind' data within a single administration. However, benefit will also be obtained if it is completed across a time interval eg, at start of intervention and at 'discharge'. The suggestion is therefore that a wide an administration as possible of the short questionnaire is carried out.

Points for Discussion

- Can the short questionnaire be used across the whole population?
- Should sampling be undertaking?
- What sampling frame could be used? (For example, rural/ urban, typology of intervention, service user or client demographics)
- Should there be a single administration of the instrument?
- Can administration be carried out at a minimum of two time points?

4.2.4 Administration

It is recognised that there may be capacity issues for the Local Evaluators. It is also important to note that administration of such a tool could not be done by operational

staff on behalf of their clients. The design of the tool, that of self-administration ensures minimum research bias. Nevertheless, there will be some individuals for whom chronic conditions, eg, arthritis, visual impairments or literacy difficulties would result in their exclusion from completing a self-administered tool. A 'staged' administration route is put forward for discussion. In the first stage, information packs would be sent from the NE Team to the LEs who would then pass these onto the operational staff running the intervention. The information pack would include a letter to the user/ carer, a synopsis of the project, a user information sheet, the QoL tool and a self-addressed envelope to be returned centrally to the NE Team. The operational staff would give this information pack to users along with the 'normal' information, eg, listings of services, eligibility criteria etc. Where an individual is unable to carry out a self-completion of the tool, their name will be taken by the operational staff member and sent to the Local Evaluator. The Local Evaluator could then use telephone contact to consent the user and administer the tool. The outcome of this would then be sent back to the NE Team.

Points for Discussion

- Do LEs feel able to pass the 'information packs' onto key operational staff within the interventions?
- Will the capacity of the LEs allow for a small number of telephone interviews?
- How can we ensure that those individuals with disabilities and chronic conditions are not excluded from the evaluation?

4.2.5 Analysis & Feedback

The analysis of the short questionnaire would be carried out by the NE Team. The results could be broken down into localities as well as providing overarching findings across the likely 31 sites.

Points for Discussion

- How would the LEs want the results presented?
- What should be the timeframe for feedback?

4.3 Developing the QoL/ Well Being Indicator

The short-questionnaire would be adequate for administration across the wider population. However, if the impact of the interventions are to be rigorously 'tracked' a longer QoL/ Well-Being questionnaire is proposed. This will be administered to sample of individuals across the sites and from a sample of sites.

It is argued that owing to the innovative focus of the POPP interventions and the user group, a QoL/ Well-Being Indicator will need to be developed. The priorities for action within 'Opportunity Age' (HM Government 2005) include: the achievement of higher employment rates, the management of independence, the inclusion of older people within the wider society in a full and active role, and supporting and facilitating necessary independence and control (HM Government 2005: xiii). To track the progress toward such priorities, five domains were presented *'as the most relevant to assessing progress in older people's quality of life'* (HM Government 2005 :80). We are suggesting that we use these domains as a basis of measurement. That is, the existing questions within a variety of QoL/ Well-Being indicators would be juxtaposed to measure these domains. The table below indicates how this might be developed.

MEASURE/ TOOL	GOQOL	FU QoL	QoL ONS	OPUS	CAMDEN	ROSENBURG/ PEARLIN	RYFF	OTHER TOOLS?
DOMAIN:INDEPENDENCE WITHIN INCLUSIVE COMMUNITIES								
Housing and the Home								
Neighbourhood & Security			pp43 - 50					
Social Networks & Involvement			pp53 - 58					
Getting Out & About								
Information & Choice								
Perceptions of Independence								
DOMAIN: HEALTHY, ACTIVE AGEING								
Living Longer & Healthier Lives			pp25 - 32					
Freedom from Disease/ Injury								
Access to Treatment								
Keeping Healthy & Active				Food Sn1				
Mental Health/ Well-being			pp14 - 16				Short Ryff	
Health			pp19 - 24					
DOMAIN: FAIRNESS IN AND OUT OF WORK								
Employment					H4			
Goods & Services			pp33 - 42					
Consultation								
DOMAIN: MATERIAL WELL-BEING								
Incomes								
Expenditure								
Poverty					A3/H1,2,3			
Wealth								
Planning ahead/ informed dec.						Pearlin		
DOMAIN: SUPPORT & CARE								
Need for Care		Self-Ass.		Persnl S2				
Intensive Care at Home/ Res/ Nursing/ SA				S2	B2,D1,F2,G5			
Provision of Lower Level Care and HA								
Informal Care from Carers (Friends/ Rel)			pp59 - 62					
Effective Care Standards						Pearlin Q2		
Lonliness			pp17 - 18					

M - 111

The measures/ tools given in the above table relate to those QoL/ Well-Being Indicators that were circulated at the PLN meeting in April with the addition of OPUS (Netten et al 2002). The following provides the 'key'.

- GOQoL: Growing Older Quality of Life Questionnaire (Bowling) Blue Paper
- FUQoL: Follow up Quality of Life Survey (Bowling): Yellow Paper
- QoL ONS: Quality of Life ONS Questionnaire (Bowling): Green Paper
- OPUS Older People's Utility Scale for Social Care:(Netten et al 2002)
- CAMDEN Improving QoL for Camden's Older Citizens 2005: http://www.smartgroups.com/vault/POPP
- ROSENBURG/ PEARLIN: Rosenburg Self-Esteem Scale/ Pearlin Mastery Scale: Peach Paper
- RYFF: Ryff Psychological Well-Being Scales: Purple Paper

It can be seen from the table that not all domains are measured by the collected tools. Similarly, where there are measures in some areas, these do not necessarily measure what may be required. For example, within the domain of 'Healthy, Active Ageing', the 'variable' of 'Living Longer and Healthier Lives', the collected QoL instruments only measure day-to-day activity.

Points for Discussion

- Should a full QoL indicator be developed that could be administered in a sample of sites with a sample of users/ patients?
- Do we wish to measure all the domains listed?
- Are all the domains relevant to the POPP pilot sites?
- Can we select items for a number of tools to create a hybrid tool that can be used across the POPP pilot sites?
- Are there other tools that might address the gaps in measurement?
- Are there other aspects of QoL/ Well-Being that we should be trying to measure?
- What demographic details do we feel may be necessary to collect?
- Are there specific questions that need to be included? For example, use of GP services, use of A&E, use of voluntary organisation interventions?

4.3.1 Sampling

Owing to the capacity issues raised by some of the LE, it is suggested that the QoL indicator is administered in a sample of authorities and with a sample of users. Further work will be necessary to identify the typology of interventions, the number of users and demographics of the users (Documentary Analysis see NE Proposal) in order to develop a sampling framework.

Points for Discussion

- Should the longer questionnaire be used only within certain sites?
- Should the longer questionnaire be directed toward certain groups of individuals or should a sampling framework be used?

4.3.2 Validation/ Administration

It is envisaged that the developed tool will be validated through a series of focus groups with older people. It will be presented as a self-administration tool, individuals will complete this and then it may be reduced further through a 'ranking' exercise.

That is, the older people will say what 'variables' are important in assessing their general health and well-being. A correlation testing will then be carried out.

In order to assess the changes in QoL across the sites, the tool will need to be administered at a minimum of two points. It is suggested that the staged strategy discussed above (4.2.4) is used. That is, an information pack is sent to the LEs to pass onto operational staff with guidance on when they should be given for self-completion. For example, these could be given to participants at entry to the intervention and at a further time (eg 3 or 6 months) and/ or at discharge. However, again, to ensure individuals are not excluded owing to disabilities or literacy problems, a number of telephone interviews could be carried out.

Points for Discussion

- Do LEs feel able to pass the 'information packs' onto key operational staff within the interventions?
- Will the capacity of the LEs allow for a small number of telephone interviews?
- How can we ensure that those individuals with disabilities and chronic conditions are not excluded from the evaluation?
- What should be the 'ideal' length of the longer questionnaire? For example, should it be set at a maximum of 20 minutes?

4.3.3 Analysis

Any developed tool will be measuring the changes in quality of life of the participants as they move through or, have contact with, the pilot interventions. Such data may be invaluable to the local sites in monitoring and/ or developing their projects. It may be that the LEs would wish to have control of the analyses and feed back to the NE team. The NE team would then carry out 'secondary analysis' to ensure an overview of the development across the sample sites can be provided. Alternatively, the questionnaires could be returned in the same way as the shorter questionnaire (through SAEs to the NE team) and analysed centrally.

Points for Discussion

- Would the LEs wish to carry out the analysis and feed this into the NE Team?
- Do the LEs have the capacity/ systems to carry out the analysis?

4.3.4 Developing the QoL Indicator through a Work Group

If it is agreed that a 'longer' QoL/ Well-being Indicator should be developed, it is suggested that this is done in three ways. An initial draft will be posted on the POPP website for comment. The tool will then be developed by the NE Team. At the stage of having a further draft, a day meeting will be held. All LEs will be invited to attend along with key members of the NE Team (Ann Bowling, Angela Dickinson, Brenda Roe). Experts in the wider field will also be invited including Professor Ann Nettis (PSSRU: Kent, POPP Local Evaluator and member of the National Evaluation team exploring 'Individual Budgets') and Anna Leach (Opportunity Age). It will also be an opportunity to include individuals carrying out parallel evaluations, eg, Maureen Moroney (LinkAge Plus). The day will involve key presentations of QoL instruments and a final draft of the QoL will be produced. This will then be piloted in the focus groups. Proposed dates for this meeting are 19th/21 or 22 June.

Points for Discussion

- Would LEs wish to have this level of input in designing a longer questionnaire?
- Should all LEs be included or, should a sub-group be formed?
- Could development of the questionnaire be carried out in a different way?

4.4 Inclusion and Quality of Life

Older individuals may have health problems that will impact on their ability to complete a self-administered questionnaire. Strategies have been suggested that could ensure adequate inclusion. There was concern that a single instrument would not be suitable for individuals with mental health problems. It has been stated that individuals who are unable to consent, or have severe and enduring mental health problems or severe dementia will be excluded from the research (MREC Application: Ref 06/Q0411/61). However, it is also argued that for individuals will transient difficulties (eg, bi-polar disorder or depression) exclusion would not be appropriate. The challenge therefore is to ensure inclusion but to recognise that any QoL measure selected should be targeted toward their needs and ensure valid measurement. Within the PLN meeting, Dr Jon Barrett, from Liverpool John Moores University and local evaluator for Knowsley, briefly presented a tool that had been used and validated for users with mental health problems. It may be that the NE team and LE develop this further for use across the sites specifically concentrating on mental health services and systems

Points for Discussion

- How can we ensure equality of access in the QoL measure and administration?
- Should a separate tool be developed for those pilot sites that are concentration on mental health interventions?
- How should this be developed?
- How should such a tool be administered?
- Should users/ clients only receive that tool or should they also be included in the short questionnaire?
- How would pilot sites working with users with mental health difficulties wish to analyse the information?

5 Responding to the 'Points for Discussion'

This discussion document puts forward a number of questions. Given the time we have to discuss the QoL instruments within the Local Evaluator/ National Evaluator meeting on Monday 8 May, it is recognised that all the questions will not be able to be addressed. Similarly, some LEs are unable to attend the meeting and Project Leads may well have comments. If anyone has any further comments or concerns following the meeting, they can send their responses to the NE Team (POPP@herts.ac.uk) or can telephone Karen Windle: (01707 286595) or Richard Wagland (01707 281215). We would be grateful to receive any comments, but given the timeframe, we will need to have all responses by **31st May 2006**.

6 Key References

Many of you will have used Quality of Life indicators before and, understand the theory and processes behind such measurement. Nevertheless, for those who feel they would like to read further around this area, the following provides a very limited starting point, for what is a huge area of literature.

Bond J, Corner: 2004: Quality of Life and Older People: Open University Press: Berkshire

Bowling A: 2005: Ageing Well: Quality of Life in Older Age: Open University Press: Berkshire.

Bowling A: 2004: Measuring Health: A Review of Quality of Life Measurement Scales: Open University Press: Berkshire

Walker A, Hennessy C: 2005: Understanding Quality of Life in Old Age: Open University Press: Berkshire

Appendix N

Quality of Life Indicators Discussion Document 2

National Evaluation of the Partnerships for Older People Projects
Discussion Document 2
Quality of Life Indicators

1 Introduction

The type, extent and focus of the Quality of Life Indicator (QoL), forming part of the National Evalution (NE) Minimum Dataset (MDS), has been discussed within several fora. Following the initial presentation at the PLN meeting of 10 April 2006, breakout groups were formed to discuss the proposals. The feedback from these groups was incorporated into an initial 'Discussion Document' (NE POPP: Discussion Document 1: May 2006: http://www.smartgroups.com/vault/POPP). The points for discussion from that document were explored at the Local Evaluators (LE) and NE Meeting of 8 May 2006. Notes were taken by group facilitators and written feedback to the discussion document was provided by four pilot sites.

This further discussion paper summarises the initial discussion document, the feedback given/ received, details the suggested QoL type and format and puts forward decision and action points for further discussion at the meeting 21 June 2006.

2 Comments from/ following NE/ LEs Meeting – 8 May 2006

2.1 Introduction

The discussion paper (NE POPP: Discussion Document 1: May 2006: http://www.smartgroups.com/vault/POPP) included a synthesis of the background and rationale behind a standardised QoL measure, incorporated comments from the PLN Meeting of April 2006 and gave a revised proposal. The later, mindful of capacity and variation of focus of the local evaluations, suggested two/ three QoL/ Well-Being Indicators (WBI):

- A short questionnaire that would be postal questionnaire, self-administered and directed toward a wide population. The 'Short-Form' QoL presented was that of the EQ-5D (utility score) with a suggested 1 – 5 additional questions drawn from ONS QoL (Bowling 2006).
- A longer questionnaire that would measure specific key domains (HM Government) and be directed toward a sample of sites and users and;
- A QoL indicator specifically directed toward individuals with mental health difficulties.

Within each of these sections specific discussion points were incorporated around:

- The type of questionnaire.
- Validation of any resulting tool.
- Population/ Sample.
- Type of administration.
- Analysis and Feedback.

The following gives a synopsis of the comments and feedback received.

2.2 Short-Form QoL Indicator

- Overall support for such a tool was given.
- Those sites involving users with severe dementia felt that such a tool would not be appropriate, although it was recognised that these individuals had been excluded from the National Evaluation (MREC Application: Ref 06/Q0411/61).
- There was a similar question as to whether such a tool would be suitable for those individuals with functional mental health problems (e.g., anxiety, depression).
- The tool should be administered at two points to ensure that any changes in self-reported QoL could be demonstrated.
- Support was given for additional questions. However, these were requested to be in 'closed' format to ensure ease of data collation/ analysis.
- The QoL should incorporate a question on ethnicity within any 'demographics' section.
- Differences of views were apparent around the population/ sample question. Some LEs argued that the QoL could be administered to all those older people moving through their interventions; the whole population. For others, the focus of the pilot projects, the capacity of the LE teams and the perceived user needs necessitated a sample of individuals rather than the overarching population.
- Such differences in views were similarly expressed around the administration of the tool. Some LEs stated that a self-completion tool would be adequate, whilst for others the focus of the pilot sites and the needs-level of the population would require either face to face or telephone administration.
- The question of data analysis had disparate responses. For some LEs the data collation and analysis could be done within the locality ensuring direct feedback to the pilot intervention, whilst for others it would be necessary for the NE team to carry out that analysis and feedback to the sites.

2.3 Quality of Life/ Well-Being Indicator

- The development of a QoL/ WBI was generally supported. However, there were questions as to whether the time and effort needed to administer and analyse a long instrument would be commensurate to anticipated returns.
- That the tool should not be a 'compulsory component'. Rather, sites could 'opt-in' should they wish.
- There was support for the 'hybrid tool', using key domains and developing questions to ensure these could be measured.
- There should be as many 'closed' questions as possible to ensure ease of collection/ data collation/ analysis.

3 Revised Proposal

Integrating these comments, the following revisions to the QoL section of the MDS is put forward. Again, as with the prior revision it is recognised that this may necessarily be a compromise. Similarly, it is again argued that the focus, format and client/ user group of the interventions are diverse both within and across the sites. As such, in making the revisions, the NE team have tried to be as pragmatic and flexible in the suggestions as possible whilst still ensuring methodological validity and rigour. Within this revised proposal, concentration has necessarily been focused on the Short-Form QoL given that this will be used across all sites and is within the 'Progress Reporting' needed by the Department of Health (see POPP Pilots: Proposals for Progress Reporting: A Discussion Paper http://www.smartgroups.com/vault/POPP). As such, there are tight timescales around this process. Nevertheless, the longer QoL/ WBI still needs to be developed ready for use by August 2006.

3.1 Short-Form QoL

It is argued that the following Short-Form QoL instrument be used across the 31 proposed sites.

3.1.1 Type

The EQ-5D is to be used as a core of the questionnaire. However, there are some suggested changes. The format of the questionnaire will be changed to give the following layout:

- **Front Page**: Giving title of the overarching evaluation.
- **Instructions/ Letter**: Project and questionnaire.
- **Header section**: To include type of administration (Face-to-Face, Telephone, Self-Completion), title of intervention, date of administration, first administration or second and site code.
- **Section 1: Your Health Today**: To incorporate the EQ-5D questionnaire with sections Mobility, Self-Care, Usual Activities, Pain/Discomfort, Anxiety/ Depression, 12 months and thermometer.
- **Section 2: Quality of Life**: To incorporate the following questions:

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 ☐

How much are the statements on the left like you or your life at the moment
Please tick the box next to the answer that best describes the quality of your life

	Very like me/ my life	Quite like me/ my life	Not much like me/ my life	Not at all like me/ my life
I enjoy my life overall	☐	☐	☐	☐
My quality of my life could be better	☐	☐	☐	☐
In all, I've got a good life	☐	☐	☐	☐
I don't like the way some things are in my life	☐	☐	☐	☐
I'm pretty happy with the way things are in my life	☐	☐	☐	☐
I haven't got a lot of quality of life at the moment	☐	☐	☐	☐

- **Section 3: A Little Bit About Yourself**: To include ethnicity data (GHS), questions 1, 2, 3, 4, 7, 8 & 9 (EQ-5D) and questions MQL_2/3/4/5a/5b (ONS Omnibus Survey (Green Paper) in 'National Evaluation of Partnerships for Older People Projects (POPP): Quality of Life Indicators/ Well-Being Indicators to be Developed). Question MQL_8 will also be incorporated. However, this question will be changed to a multi-response to ensure that if individuals are carers or students and still retired, some activity can be included.
- **Section 4: Local QoL**: This section can ensure that each locality can add those questions they wish allowing an adequate and robust focus on the specific interventions. This may include specific service or process outcomes.

Points for Discussion/ Decision/ Action
- Are there any difficulties in using the Short-Form QoL as the standardised measure across all sites?
- Should further sections be included within the Short-Form QoL?
- Are there additional questions that should be incorporated?
- Are there specific 'layout' issues that need to be addressed, e.g., type of font, size of font, bound, stapled etc?

3.1.2 Population/ Sample

Across and within each of the pilot sites there is a high level of diversity as to the focus and inclusion of the client group. Reliable population statistics around particular areas (e.g. older people suffering anxiety/ depression) are not available. There is no single outcome measure (e.g., reduction in mortality) that can be used for all 31 proposed sites. As such, we cannot carry out a 'power calculation' that would give us a 'statistically significant' sample. We do not know, for many sites, the numbers of individuals going through the intervention and within the sites some of the pilot interventions are not suitable. For example, within Bradford, one of the interventions involves training mental health workers.

Given this variety and the flexibility demanded by the LEs, we are going to have to necessarily take a pragmatic or 'haphazard sample' (Sapsford R: 1999: 86). We do not wish to dictate that you administer this questionnaire to all of your population if you feel that would not be suitable. We are therefore suggesting that LEs develop, with their PLs and Project Managers (PM), the extent and focus of the sample.

Points for Discussion/ Decision/ Action
- Will you as a pilot site be administering to your whole population?
- What sampling framework will you be using?
- What numbers of individuals do you envisage administering the questionnaire?
- Are there specific pilot interventions that will be excluded?
- How does this information need to be fed back to the NE team?
- Does this information need to be included within the 'Header Section' of the QoL (see 3.1.1 above)?
- What methodological support (if any) do you need from the NE team in developing your sampling frame?

3.1.3 Administration of the Short-Form QoL

Time-line of administration

Within the administration of the short-form QoL, there are two particular areas for consideration. The first is the times of administration. It has been noted above, that there is agreement that the tool should be administered at two points, at base-line

(i.e., entry to the scheme) and at a point of either exit or at a three month or six-month time period. The time-line of administration of the second questionnaire will be dependent on the specific intervention. For example, Camden is carrying out a 12 session exercise programme for clients with mental health needs. As such, the tool would be administered at entry to the scheme and following delivery of the last session. The LEs will need to work closely with the PL and PM to assess when it would be appropriate to administer the tool.

Points for Discussion/ Decision/ Action

- At what points do you feel it would be appropriate to administer the tool?
- What variations of administration might you have across the interventions?
- What support (if any) do you need from the NE team?

Type of administration: Self-completion/ Face to Face/ Telephone Interview

The tool will be designed to be self-administered. Information packs will be sent from the NE Team to the LEs who could then either adapt the package for local services or, pass on to the operational staff to be sent out as a self-administered questionnaire. Nevertheless it is recognised that for some sites and, for some users it will be necessary to carry out either a face-to-face administration or telephone interview. The LEs again, with the PLs and PMs, need to make decisions around key areas of the method of administration. It is recognised that some sites may use only self-administered questionnaires, some sites will only use face-to-face interviews, some only telephone interviews whilst for some a combination of methods will be necessary. To ensure that there is methodological rigour around choices, the type of administration is to be requested as a variable within the questionnaire. This will ensure that central analysis can be undertaken to assess and evaluate any differences in outcomes or reportage.

Points for Discussion/ Decision/ Action

- What type of administration will you be using?
- Does that administration differ across the pilot interventions?
- Is recording the mode of administration adequate?
- What training needs (if any) are there?
- What support on training and/ or selection of type of administration do you need from the NE team?

3.1.4 Data Analysis

It was noted above (see 2.2) above that there was no overall agreement as to the arrangements for data collection, data entry or data analysis. Some sites wished to carry this out at locality level whilst others felt that as they were carrying out postal, self-administration questionnaires these could simply incorporate self-addressed envelopes for return to the NE team. Again, the sites need to make decisions around how they would wish to carry out the collation and analysis. The outcomes would need to be fed back to the NE team, but this could simply be sent as a dataset either within Excel or SPSS.

Points for Discussion/ Decision/ Action

- Are you going to carry out data-entry locally or is this a central NE responsibility?
- What support, (if any), do you want from the NE team to facilitate data-entry (if local), e.g., Excel or SPSS variable listing and coding?
- Are you going to carry out data analysis locally or send the dataset to the NE team for central analysis?

- What support, (if any), do you want from the NE team to facilitate local analysis?
- Should the data be fed back to the NE team as a raw data file or in report form?

3.1.5 Feedback/ Outputs

The initial outcomes from the QoL indicators will need to be included within the Interim Report (November 2006) and any further progress/ interim reports.

Points for Discussion/ Decision/ Action

- Should the outputs be reported on a site-by-site basis?
- Should the outputs be reported on a health activity basis, e.g., Falls Programmes, Exercise Programmes, Mental Health Café's, etc?

3.2 Quality of Life/ Well-Being Indicator

It was argued in the previous discussion paper (NE POPP: Discussion Document 1: QoL Indicators: May 2006: http://www.smartgroups.com/vault/POPP) that the short-form questionnaire would be adequate for administration across the wider population. However, if the impact of activities was to be rigorously 'tracked' it would be necessary to include a longer questionnaire that explored specific domains around social isolation, control and autonomy, community involvement. It is recognised that not all of the sites would wish to use the QoL/ WBI (see 2.2.3). Some have already developed their own or, have identified those existing tools that would be suitable for their population. Nevertheless, for those that do wish to opt-in, the following is put up for further discussion and development.

3.2.1 Type

Within the discussion paper (1), the domains from Opportunity Aging were juxtaposed against the identified QoL instruments. However, following discussions with the DH team, QoL experts and CSCI it has been decided that the domains of the 'Adult Services: Outcome Framework' (see accompanying attachment) should be used. These incorporate:

- Improved Health & Emotional Well-Being
- Improved Quality of Life
- Making a Positive Contribution
- Increased Choice & Control
- Freedom from Discrimination
- Economic Well-Being &
- Maintaining Personal Dignity

Within each of these domains specific individual outcomes are given. Each of these outcomes will necessitate breaking down and developing specific questions.

Points for Discussion

- Should all the domains (listed above) be included?
- Which statements from the specific individual outcomes are important to incorporate?
- In the instruments available (National Evaluation of Partnerships for Older People Projects (POPP): Quality of Life Indicators/ Well-Being Indicators to be Developed), are there specific questions that can be used?

3.2.2 Administration

The administration of the questionnaire consists of three areas. The first is that of site use of the questionnaire. It was noted above (2.2.3), that the general consensus from the written and verbal feedback was that the longer QoL/ WBI should be a choice, rather than a requirement.

Points for Discussion

- Are you, as a pilot site going to use the longer-form questionnaire?
- What involvement do you want in the development?

The second area of administration concerns that of timeliness. As discussed above (see 3.1.3) sites will need to decide at what points the longer questionnaire is to be administered. Finally, the sites will need to decide how the questionnaire is to be delivered to the selected client group. For example, should the QoL/ WBI be designed as a self-completion tool or that or a structured (administered) design?

Points for Discussion

- At what point(s) should the longer QoL/WBI be delivered?
- What should be the design of the tool?
- What support, (if any) do you need from the NE team?

3.2.3 Sample

It is recognised that it is unlikely to be appropriate to administer the QoL/WBI to the full population. As with the short-form it will be necessary for those sites opting into the longer questionnaire to make decisions around a number of issues.

Points for Discussion/ Decision

- Within which interventions will the longer QoL/ WBI be used?
- Is there a particular sampling frame that you would wish to use?
- What support, (if any), do you need from the NE team?

3.2.4 Analysis

It was discussed above (3.1.4) that there was no consensus as to analysis. Some sites argued strongly for analysis at the locality level, whilst others perceived this to be a central responsibility. Again, where sites are to use the longer QoL/WBI, similar issues will need to be decided.

Points for Discussion/ Decision

- Are you going to carry out the analysis locally or is this a central responsibility?
- What support, (if any), do you need from the NE team? For example, provision of Excel or SPSS variable file?

4 Validation

The developed tools will be validated through a series of focus groups with older people. Both will be presented as a self-administered tool. Following any necessary changes in questions, structure, layout a further ‘check’ will be carried out with a ‘reference group’ of older individuals. A final correlation will be carried out to ensure that the variables included are rigorous and valid.

5 Ethics

LEs will be aware that if the interventions and thus their population involve NHS staff, premises or patients, it will be necessary to submit an ethics form to the Local Research Ethics Committee (LREC). Similarly, submission to local PCT and NHST Research & Development (R&D) governance committees will be necessary. Where the sample or population is that of Social Care clients and staff, or organisations contracted by Social Care it will be necessary to move through the social care governance system. A presentation on the Ethics Process was given at the LE/NE meeting of 8 May 2006 (http://www.smartgroups.com/vault/POPP/Evaluation/) that detailed the process and on-line information.

Within your application (whether LREC or SC Governance) **it will be necessary to specify the QoL instruments you will be using, the type of administration, the population/ sample and the mode of analysis.** It is recognised that the short-form QoL may not be available at the time of your ethics application. However, within the form you can specify that the tool is in development, that it is being formed around the EQ-5D, a validated and widely used instrument and, that you will provide a copy to the LREC on receipt of the questionnaire. Similarly, for the longer QoL/ WBI you can identify the domains and the question areas and indicate how this is to be developed and validated. Many LRECs will provide conditional agreement around the evaluation, subject to receipt of the QoL forms. This ensures that you are not penalised for any iterative research tool development. As such, the necessary development of the QoL will not hold you back from making an overarching ethical submission.

The NE team have posted their MREC application (Corec_Application_Form: http://www.smartgroups.com/vault/POPP/Evaluation/) and have given information on the QoL that they will be using. It may be helpful for the sites to look at this document prior to submission of their own LREC, R&D or Social Care governance. Support can be provided from the NE team if that would be wished.

6 Further Activity

It is recognised that we are working under tight timescales for ratification of the short-form QoL and the development and ratification of the longer form. The following activities are therefore suggested.

- The draft of the short-form questionnaire will be posted onto SmartGroups 19 June 2006.
- The form, layout, question inclusion, etc., of the short-form QoL will be discussed at the QoL meeting 21 June 2006.
- Changes will be made and a final QoL will be developed for validation within a series of focus groups within July 2006.
- The short-form QoL will be available by End July/ Early August 2006 for use within the sites.
- An excel sheet will be sent round to each local evaluator asking them to confirm their sample, their timeline of administration, their type of administration and their selected collation and analysis strategy. The form will be sent with the final version of the short-from QoL.
- The longer QoL/WBI will similarly be discussed on 21 June 2006.
- A draft will be developed over July 2006 and posted onto the website.
- Validation of this draft will then be carried out ensuring it is available early September 2006.

7 Responding to the 'Points for Discussion/ Decision/ Action'

This second discussion document provides points, not just for discussion, but for decision. Many of you are able to attend the meeting on 21 June. However, for those of you that cannot attend please do provide your feedback to this document by **Wednesday 28 June 2006** to either k.l.windle@herts.ac.uk or POPP@herts.ac.uk. Alternatively you can telephone Karen Windle (01707 286595) or Richard Wagland (01707 281215). Within your feedback, we would be grateful if you could make an initial indication of your type of sampling, administration and analysis (if known) and, if you, as a site, would wish to opt-in for the longer QoL/ WBI.

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Appendix O

Quality of Life Indicators Final Discussion Document

National Evaluation of the Partnerships for Older People Projects Quality of Life Indicators Final Discussion Document

1 Introduction

Following two iterations of the suggested standardised quality of life tool (Discussion Documents 1 & 2, see http://www.smartgroups.com/vault/POPP) final feedback has been received. A meeting was held on 21 June 2006 to further explore the short-form questionnaire and agree the domains of the second longer form questionnaire. This meeting included representatives from the pilot sites of Brent, Camden, Manchester, Somerset, Southwark, Worcester and Luton, the later site feeding in views from Bradford and Leeds. Five users from the Public Involvement in Research Group (PIRG, based at the University of Hertfordshire) also attended, along with representatives of the National team and evaluators from LinkAge Plus. Notes were taken by facilitators at this meeting and written feedback was provided by five further sites unable to attend. Following the feedback, further discussions were held with the Treasury, DH and the NE team.

This final document concerns the short-form questionnaire only. It summarises the feedback received, details the rationale to the necessary changes, presents an update on the question of ethical approval and specifies the new timeframe. The final draft questionnaire has been posted on the smartgroups website. A further document will be posted in September with the longer-form quality of life that will incorporate the adult services outcomes framework.

2 Feedback from Discussion Document 2 and Meeting 21 June 2006

In discussing the structure and contents of the questionnaire the key points put forward included the following:

- The 'Introduction to the Questionnaire' was felt to be too long. It was recognised that much of this information would be necessary. However, many sites would wish to add their own letter and it was felt this should accompany rather than be incorporated into the questionnaire
- The use of the analogue scale, the 'thermometer', was questioned as regards the ease of completion and the outcomes.
- It was recognised that there was a tension between providing a short questionnaire and including adequate quality of life indicators. It was argued that the inclusion of only two questions on QoL would not be robust.
- It was argued by some researchers that the final section of 'About Yourself', included questions where the rationale was not clear. In particular, it was argued by some that such questions may be felt intrusive, given the relative paucity of the quality of life indicators.
- The length of the questionnaire was again discussed. It was argued by some evaluators that the form should take no more than 5 minutes to complete. In contrast, others argued that it was the content, rather than length that should be concentrated on ensuring adequate measurable outcomes.
- The difficulties of a lack of proxy indicator and the use of the EQ-5D were raised for those evaluators working within the area of mental health (see 3.2 below)

- Any final questionnaire should be distributed in the most appropriate way for the sites as many wished to insert their own logos and questions.

3 Final Proposal

3.1 The Questionnaire

Following the feedback and further discussions with the Treasury, DH and the NE team, there have been substantial changes to the questionnaire. The following provides the detail of those changes along with the rationale behind their inclusion or omission. The full questionnaire (final draft form) has been posted onto the smartgroups website. It is likely that individuals will be somewhat concerned around the length of the questionnaire. However, if the NE team are to ensure that the correct data around cost-effectiveness, quality of life, service use and levels of deprivation are to be included, a limited two-page questionnaire will not be robust or indeed valid. The questionnaire has been designed to be in booklet form with eight (back-to-back) pages.

3.1.1 Additional Questions/ Sections

It will be noted from the questionnaire that the Quality of Life section has additional questions. As has been stated, (see 2 above), there were concerns as to the adequacy of the included 'measures'. Following consultation with Professor Ann Bowling, the short-form Ryff has been included. This ensures a measure of psychological well-being can be assessed. The rationale behind including the Ryff is two-fold. It has been proven to provide valid psychological measurement as a self-administered tool (Springer & Hauser 2002) and has been widely used in quality of life studies (see for example, Ryff 1991, 1995, 1996, Keyes 2005, Greenfield & Marks 2004 etc.). The second rationale was somewhat more pragmatic. That is, the NE team are mindful of the requirements that any questionnaire should be as 'tight' as possible. The Ryff is one of the shorter psychological well-being scales providing rigour and validity.

A new section has been added on 'Service Use'. This is essential if the user (micro) level changes are to be assessed. For example, it may be that as the consumer/ user/ patient moves through the POPP intervention, their service use changes. This will allow insight into the effectiveness of the specific intervention. For example, if the project is focusing on Falls Prevention, one of the outcomes of such a project may be reduction in contact with secondary or primary health care services. The inclusion of service use questions will allow this change in the health economy to be monitored and assessed. Such data is similarly important to feed into the cost-effectiveness analysis ensuring the service change at the micro-level can be evaluated. The questions allow the building of costs through itemising service use and detailing the time spent with the individual. At this stage, the NE team have not included the POPP initiatives within the interventions. As each pilot site would recognise, this information will also be necessary to assess level of use and cost. These questions will be included into the questionnaire. How and when this will be done is detailed more fully in section 3.3 below.

To support the mirco-level cost-effectiveness analysis, the questions around service use also incorporate questions on costs borne by users. Consumers/ users or patients are asked to indicate if they have paid for any services and, the level of assistance they have received from relatives. Such cost-analysis is supported by the level of benefit received (see question 13 in 'About Yourself' section) and the total income per household (see question 14 in 'About Yourself' section). It is recognised that these two questions may be considered sensitive. They have been included in a

recent self-administered questionnaire and a good response rate was achieved. It may be that the pilot sites would wish to discuss the inclusion of these questions with the NE team. The mechanism for this is explored in section 3.3 below.

3.1.2 Removal/ Changes of specific Questions

From the feedback on Discussion Document 2 and, the meeting of 21 June, several questions within the 'About Yourself' section have been removed or changed. The following details these changes:

- Question 10b has been removed 'Can you please indicate how long ago did you divorce/ separate from your husband/ wife
- Question 11 has been changed to ask the number of adults and children within the household
- Question 11a, 'Please indicate how long you have lived alone' has been omitted
- An additional question on the type of accommodation has been added
- Changes have been made to question 13, ethic group, to simplify the groupings.

3.1.3 The Utility Scale – EQ-5D

As Sculpher argues, it is a '*reality for all ..systems that they need to make decisions about which interventions and programmes should be made available to patients from within limited budgets'* (2006: 527). To support the cost-effectiveness analysis, the EQ-5D has been incorporated to ensure the generation of QALY (Quality adjusted life years), the cost per life-year gained by the different intervention. The QALY is generated by the utility score and the length of time the individual is within their indicated health state. As researchers, you have asked for some supporting papers around the definition of a QALY and how the utility score is generated. As you will recognise, we cannot circulate academic papers owing to copyright, although we have provided key references (see 5 below). However, it may be helpful to give some guidelines around the utility score.

The first thing to note is that each of the responses within the EQ-5D is given a code. Using the example of the Anxiety/ Depression Section, it can be seen that the levels move from one through three:

Anxiety/Depression	
I am not anxious or depressed	❑ Coded as Level 1
I am moderately anxious or depressed	❑ Coded as Level 2
I am extremely anxious or depressed	❑ Coded as Level 3

To each of these levels a coefficient has been calculated (Dolan et al 1995) and is attached to the responses. The scoring tariffs can be seen below (Table 1)

Table 1: Reproduced from Dolan, Gudex, Kind & William 1995

Coefficients for Time Trade Off tariffs	
Dimension	**Coefficient**
Constant	0.081
Mobility	
Level 1	0
Level 2	0.069
Level 3	0.314
Self-Care	
Level 1	0
Level 2	0.104
Level 3	0.214

Dimension	Coefficient
Usual Activity	
Level 1	0
Level 2	0.036
Level 3	0.094
Pain/ Discomfort	
Level 1	0
Level 2	0.123
Level 3	0.386
Anxiety/ Depression	
Level 1	0
Level 2	0.071
Level 3	0.236
N3	0.269

The utility score is generated within EQ-5D by subtracting the relevant coefficients from 1.000, where 1.000 is equal to perfect health. In looking at the overarching questionnaire, responses made by an individual would be scored as follows (see Table 2).

Table 2: Example of scoring the EQ-5D

Section	Response Question	Code	Tarriff
Mobility	I have no problems in walking about	Level 1	0
Self-Care	I have no problems with self care	Level 1	0
Usual Activities	I have some problems with performing my usual activities	Level 2	0.036
Pain/Discomfort	I have moderate pain or discomfort	Level 2	0.123
Anxiety/ Depression	I am extremely anxious or depressed	Level 3	0.236

To this score would have to be added the constant of 0.081 and that of 0.269, the N3, (as level 3 occurs in a least one dimension). All of these are then **subtracted** from 1.000 (perfect health) to give a total value of 0.255. When thinking about what this means, it may be helpful to consider this in terms of percentages. So in the above example, the user has 25% of their optimum quality of life.

3.1.4 Analysis

To ensure that the tariffs from the EQ-5D do not have to be calculated by each pilot site, the NE team has produced an Excel Spreadsheet that provides the algorithm for the EQ-5D (see, Final Draft – Short Form Questionnaire – Variables & Algorithm for EQ-5D, http://www.smartgroups.com/vault/POPP). You will see an example has been completed for the utility score, giving the final scores of 0.255, 1.00, 0.656 and 0.050. As the codes are altered, the scoring will similarly change.

It is recognised that for some sites, there will be a wish for the analysis to be carried out centrally by the NE team. As such, the questionnaires will be returned in a stamped-addressed-envelope to the University of Hertfordshire. However, where the analysis is to be undertaken locally, all variables have been included within the Excel spreadsheet allowing for an ease of completion.

3.2 Proxy indicator – Mental Health

It was stated above (see 2), that concern was expressed by those researchers evaluating mental health initiatives that the existing standardised questionnaire did

not include a proxy measure. That is, a questionnaire directed toward the formal or informal carer, rather than the respondent. There were also concerns that the questions would not be 'sensitive' to the maintenance of, or changes in, quality of life for those individuals with a diagnosis of dementia. Four sites (Bradford, Camden, Leeds and Luton) are evaluating mental health initiatives focused on those individuals with moderate and severe dementia. Following on-going consultation with those sites, the DH and Treasury, a separate tool has been identified, that of DEMQOL. At this stage, DEMQOL does not have a utility score. As such, the NE team will need to discuss with those four sites how any findings and changes can be reported to ensure that outcomes can be compared across the 19 sites.

3.3 'Personalising' the questionnaire

From the feedback, most pilot sites indicated that they would wish to include site logos, their own introduction and information around the questionnaire. Similarly, some identified the need to include specific questions. As was also stated, for the cost-effectiveness analysis, the NE team will need to include within the questionnaire, questions on the specific POPP initiatives. Alongside this, there may be local initiatives that are providing considerable support to older people that are not included in the section 'Service Use'. Finally, it may be that you would wish certain questions in the 'About Yourself' section to be removed (where the utility score and cost-effectiveness is not compromised)

The NE team are therefore suggesting that each questionnaire is 'personalised' for each of the pilot sites. To do this, the pilot sites will need to **complete the attached proforma (see Appendix 1)**. This asks for specific information around the sample, administration and analysis. However, it also requests you to provide the NE team with the listing of the relevant POPP projects (where the sample will be drawn) and any local services that are providing specific support. Logos and introduction material is also requested. From this, we will then insert the necessary information, reformatting the numbers as appropriate and send an electronic copy.

3.4 Ethical Approval

The prior 'Discussion Documents' (1&2) stated that within your ethics application (whether LREC or SSRGF) it will be necessary to specify the QoL instrument(s) that you will be using, the type of administration, the population/ sample and modes of analysis. The NE team put this forward as it was recognised that each local site would be 'personalising' their questionnaire, administering it differently (self-completion/ telephone/ face to face) with some carrying out the analysis. As such, the NE team did not feel confident that the MREC would grant approval for the questionnaire given differences in administration and analysis. This was questioned in the feedback, with two sites stating that following conversations with their LREC, the questionnaire should be approved within the NE team MREC. A query was sent to COREC to clarify where approval should be sought. The response redirected the team back to the MREC. A query has been sent off and the NE team are awaiting any ruling. Further information on this will be sent round through the smartgroups website as soon as this is received.

4 Task & Timeframe

When you have had time to assess and evaluate the final draft of the questionnaire, the NE team would be grateful **if you could complete and return the attached proforma (Appendix 1)**. This allows the NE team to know the sample, administration and analysis needs. Similarly, it will allow you to indicate and attach any further questions, introductory information and logos. The timeframe of completion is obviously dependent on the timescales of the projects you are

evaluating. As such, if the project (involving individuals who will be completing the questionnaire) is to go 'on-line' in September, you may wish to send this information by mid-August. However, we would be grateful if you could return the proforma by **31 August 2006**. This will ensure that each questionnaire can be prepared and sent in a time for your field work.

5 References

5.1 References within discussion document

Keyes C L M: 2005: Chronic physical conditions and aging: Is mental health a potential protective factor? Aging International: 30, 88 - 104

Greenfield E A & Marks N F: 2004: *Formal volunteering as a protective factor for older adults' psychological well-being*: Journal of Gerontology: Social Sciences: 59B, S258 – S264

Ryff C D: 1996: *Psychological well being*: In Birren J E (Ed): Encyclopedia of gerontology: age, aging and the aged (pp365-369) Academic Press: San Diego, CA

Ryff C D: 1995: *Psychological well-being in adult life*: Current Directions in Psychological Science: 4, 99 – 104

Ryff C D: 1991: *Possible selves in adulthood and old age: A tale of shifting horizons:* Psychology and Aging: 6, 286 – 295

Springer K W & Hauser R M: 2002: Survey Measurement of Psychological Well-Being: Centre for Demography & Ecology Working Paper: 2002 – 09: University of Wisconsin-Madison.

5.2 References around QALY and Utility Score

Dolan P, Gudex C, Kind P & William A: 1995: A social tariff for EuroQoL: Results from a UK general population survey: Discussion Paper No 138: Centre for Health Economics: University of York: York

Drummond MR, O'Brien B, Stoddard LG, Torrance GW: 1987: Methods for the Economic Evaluation of Health Care Programmes: Oxford Medical Press: Oxford

Sculper M: 2006: *The use of quality-adjusted life-years in cost-effectiveness studies*: Allergy **61**: 527 – 530

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Appendix One

'Personalisation of the Questionnaire: Proforma to be completed by pilot sites.

Pilot Site		
Contact Name		
Contact Details	**Telephone**	
	Mobile	
	Email	

Question	'Personalisation' Need
Please indicate if you would wish your logos to be placed on the questionnaire (Please attach if relevant)	
Please indicate if you wish to incorporate an introduction within the questionnaire. (Please attach if relevant)	
Please indicate the name and contact number you would wish individuals to contact with queries (see p3 of the questionnaire)	
Please can you indicate those POPP preventions that you would wish to be included within the 'Service Use' section of the questionnaire (see 3.1.1 above).	
Please can you indicate those local service interventions that may be supporting your users (see 3.1.1 above). You may wish to discuss this with the PL or Project Manager.	
Please can you indicate if you **wish to omit** question 13 in the 'About Yourself' section from your questionnaire	
Please can you indicate if you **wish to omit** question 14 in the 'About Yourself' section from the questionnaire	
Sample	
Please indicate those interventions within which the users will be receiving the questionnaire	
Please indicate the numbers of individuals likely to receive the questionnaire	
Administration	
Please indicate how you will be administering the questionnaire (self-completion, telephone interviews or face-to face)	
If the questionnaires are to be self-administered, are these to be returned direct to the NE team?	

Question	'Personalisation' Need
Administration cont/…	
Please indicate the number of times you will be administering the questionnaire	
Please indicate the time-frame of administration (eg, 1 administration base-line, 2nd administration 3 months, 3rd administration 12 months etc)	
Analysis	
Please indicate if you will be carrying out the analysis centrally or locally.	
Please detail the name, address etc', of whom you would wish the questionnaires to be returned (see p16 of the questionnaire)	

Appendix P

Details of Proposed Research

DETAILS OF PROPOSED RESEARCH

Detailed outline of proposed research (see notes attached for further details). Please limit your response to twelve pages maximum.

1 BACKGROUND

1.1 Introduction

> *'Older people want the same things from life as everyone else, and social care has to move away from the assumption that the need to take part in society and to live an active and fulfilling life ends at the age of 65'* (Gordon Lishman OBE: Director General, Age Concern: DoH 2004a: 7)

The Partnerships for Older People Projects (POPPs) are aiming to change such assumptions across communities. POPPs *'aim to encourage councils in England with their NHS, local government and voluntary and community partners to devise innovative approaches to establishing sustainable arrangements for supporting older people in active and healthy living'* (DH 2005a). Within this overall aim is the expectation that such innovative and sustainable approaches must be embedded within and demonstrate progress toward policy implementation, achievement of national targets and practice commitments of holistic partnerships/ financial arrangements and that of preventative care (DH 2005b).

1.2 Partnership & Financial Organisation

> *'The absence of integrated working is long-standing, culturally embedded, historically impervious, obvious to all concerned and deeply entrenched in central and local government'* (Murray 2000: Appendix C, p.105)

It can be persuasively argued that five years on from Murray's quote, partnership working or collaboration has begun to be recognised as an essential core in managing the complexity of 'wicked issues' (Clarke & Stewart 1997), particularly within the area of older people's care (see e.g., Davey et al 2005, Glendinning 2003, Hudson & Henwood 2002, , Rummery & Coleman 2002). Such issues incorporate those areas of care that are multi-faceted, cannot be resolved by any one level of government, demand the involvement of many agencies at the local level to address key facets of the problem, do not fit easily within existing departmental structures and require interventions that go beyond the time limits typically found in strategies and plans (Leach & Percy-Smith 2001). Recognition of such tenets is imperative if *'better health and well-being'* (DH 2005c) is to be adequately facilitated for older people. The recognition of the need for partnership and initial developments has been driven, in part, by national policies (Windle & Wagland 2005), with the Labour government arguing that the breaking down of organisational 'silo's' is the key to effective service planning and delivery (Hudson & Henwood 2002). As such there have been a myriad of policies and procedures that expect the integration of partnership working. For example, 'Saving Lives: Our Healthier Nation' (DoH 1998) advocated a 'joined-up' approach across central government and locally through partnerships (Baker 2000). Health Action Zones were launched through the recognition that '*effective action to tackle ill-health and health inequalities was not the remit of one organisation or sector'* (Leach & Percy-Smith 2001: 202) and organisations from within and outside health were required to build robust partnerships. Collaboration has been further reinforced through the Health Act (DoH 1999); the NHS Plan (DoH 2000); the multi-sectoral standards of the Older People's NSF; the Long Term Conditions NSF (DH 2005f) and the Green Paper 'Independence, Well-Being and Choice (DH 2005d) amongst others. Such emphasis on partnership may well provide the impetus for individuals to experience *'the experiences of 'otherness' to jolt us into seeing problems in our own frame of reference'* (Goss 2001: 170). Within this drive to partnership, the centrality of users is paramount. Users are placed at the centre of the care matrix, ensuring that services should be **led by** users, responding to '*their needs and* wishes' (DoH2005e: 5) and ensuring choice and control. As such, users should be involved in strategic development, service design and delivery (e.g., see DoH 1998, DoH 1999, DoH 1999a, DoH 2000, DoH 2001, DoH 2004, DoH 2005f, DoH 2005g).

In meeting the needs and wishes of users overarching organisational partnerships are expected to deliver services in radically new and different ways. For example, the Health & Social Care Act 2001 initiated 'Direct Payments', *'a financial payment gives the person flexibility to look beyond 'off the peg' service solutions for certain housing employment, education and leisure activities as well as for personal assistance to meet their assessed needs* (DoH 2001). To deliver such solutions requires not only partnerships across organisations, but adequate shared financial arrangements. The Health Act 1999 contains three particular sections that underpin partnership working; Section 29, that expanded funding transfers from NHS to local authorities, Section 30 that permits local authorities to transfer funds to health authorities and, Section 31 that introduced the new flexibilities of pooled budgets, lead commissioning and integrated provision. In short, the Health Act removed legal obstacles to joint working between health and social care (Glendinning 2003, Hudson & Henwood 2002)

However, despite such policy requirements, along with the demonstrable 'wish' of organisations to work in partnership (Goss 2001), there remain problems in integrating adequate partnership. Guidelines for effective partnership working are increasingly available (eg, see Bowers et al 2003, DoH 2001b, Audit Commission 1998, LGA 1999, 2001, 2002). Nevertheless, the implementation of such guidelines (theory) into practice would seem to be patchy with organisations arguing that they have little evidence as to *'strategies that can be used to establish, strengthen and sustain local partnerships'* (Asthana et al 2002). Similarly, there are recognised obstacles to partnership working throughout the managerial, strategic and operational levels. These include decisions around who has authority or accountability, concerns as to the level of risk involved in devolving decision making (Windle & Wagland 2005), capacity (6 et al 2002), perceived undermining of professional legitimacy (Miller 2004), provisioning strategic collaboration and the mundane but thorny problem of information sharing (Goss 2001). As Goss (2001) argues, the difficulties of partnership are such that *'in some cases partnerships set up to bid for funding don't survive long enough to spend it'* (95). It will be the challenge for the POPPs bids to take forward the policy requirements and guidance to develop their structure and interventions so as to not be *'bolted onto conventional bureaucracies'* (Goss 2001: 159) and avoid the well-documented pitfalls. Similarly, it will be a challenge for the national and local evaluators to explore and measure the strengths and

sustainability of partnership. As Glendinning (2003) argues, there will be *'some formidable methodological challenges involved in detecting changes'* (148).

1.3 Shift of services/ resources

In designing their interventions the POPPs sites have concentrated on exploring innovation (eg whole systems refocusing) and preventative services within the community (DoH 2005c: Annex 1). The shift of services from that of secondary to primary care is not new (eg, see Platt Committee 1959, Hospital Plan 1962, 'The Way Ahead' DHSS 1977, NHSME 1991 and, the Tomlinson Report 1992). However, the challenge to either building on or developing existing services is that of sustainability. Many interventions or initiatives set up with time-limited funding cease delivering services/ resources on the cessation of funding (Windle 2001). Sustainability is central to the POPPs bidding process. Nevertheless, the reliance of policy flexibilities (eg, Health Act 1999) and any re-structuring of finances through policies (eg, Payment by Results) and the partnerships, will need to be incorporated into the national and local evaluations if learning and service development are to be achieved through development of sustainable, integrative models.

1.4 Preventative Care

Miller (2004) argues that *'it is difficult to find a contemporary policy document or set of good practice guidelines that does not have collaboration as the central strategy for the delivery of welfare'* (145). This is mirrored in the inclusion of preventative care (e.g., see DoH 2001a, 2001,2005d, 2005f, HMG 2005) with a focus on the offering of services that *'maintain health, not..just treat sickness'* (DoH, 2005e: 7). Standard 8 of the Older Person's NSF (DoH 2001c) will be taken forward in the POPPs process. It is envisaged that this will be strengthened with the PAF for councils and public health targets for the NHS in order to become *'better aligned to promote well-being, independence and health in old age'* (DoH 2004a). Nevertheless, at this stage it is not known how POPPs sites are conceptualising 'prevention'. Wistow & Lewis (1997) put forward a two-fold definition of prevention. They argued that prevention should be conceptualised as *'a) preventing or delaying the need for care in high cost, more intensive settings and b) promoting the quality of life of older people and their engagement with the community'*. However, although Wistow et al (2003) state that the first of the definitions has *'underpinned community care policies since at least the Guillebaud Report almost half a century ago'* (1), they go onto argue that it is only through adoption and integration of the latter half of the definition that promotion of health and wellbeing will be effective. As such, the national and local evaluations will need to explore how the partnerships are conceptualising 'prevention'.

2 RESEARCH CO-ORDINATION (Led by KW)

2.1 Project Management

The POPPs initiative will involve, over the life-time of the project, 36 partnership sites, local evaluators (internal or external), a member of the Change Agent Team and the national evaluators. The interventions themselves incorporate a wide diversity. To ensure a robust evaluation can be carried out a case study approach has been put forward coordinating three phases (see 4 below). It is recognised that such a complex, multi-stage and multi-strand programme or work will require strong project management. The core team selected within this bid have worked together over the last 20 months on the evaluation of the 'Innovation Forum: Improving the Future for Older People' (IFOP) (Wistow 2003). The IFOP involves nine local authorise, their health and community partners. Within each site, specific interventions have been put in place to meet the overarching headline target of 20% reduction in unscheduled bed days. The evaluation of this project has been developed and refined by all members of the team ensuring a flexible, robust and appropriate evaluation is in place. Nevertheless it is recognised that specific project management will need to be in place to ensure that the POPPs evaluation can deliver the necessary outputs and outcomes. The following strategy will be undertaken.

The overall project management will be organised through CRIPACC, University of Hertfordshire led by Dr Windle. Professor Wistow will work closely with Dr Windle to monitor the progress and output of the POPPs evaluation and each strand of the project will be led by a named individual. Dr Windle will manage a full time Research Fellow who will be responsible for the day to day data collection and analysis. It is emphasised that Dr Windle will ensure adequate 'milestone management' of the project. For example, initial project set up, framework and research tool development will require additional input at specific times. Although costed at 13 days (see Table H), the University of Hertfordshire have agreed that this innovative and important project should be supported. Dr Windle's post is 'Quality Related Research' funded and using this, the University of Hertfordshire will provide a further 17 days time, ensuring one day a month is available for project management throughout the lifetime of the project.

A steering group will be set up to include the full project team, user and carer representatives and two key stakeholders from the POPPs sites. The selection of the stakeholders will be undertaken through the Framework Development (see 4.1 below). The steering group will ensure quality assurance and guide the project management and Research Fellow.

2.2 Roles of the National Evaluators

Given the complexity of this project, the challenge for the national evaluators will be two-fold. The first task is to facilitate and assist in any exchange of learning around differing preventative, partnership models and evaluative tools. The second is to ensure that core baseline data can be designed and collated to ensure comparative measurement of the POPPs sites against the PSA targets along with the more qualitative requirements of the differing partnership/ financial and preventative models (e.g., structure, process and outcomes of the interventions and levels of sustainability). Embedded within these tasks is the need to build adequate working relationships with the member of the Change Agent Team, the POPPs sites and their evaluators, managing the formative and summative elements of the process. That is, in the formative stage, the evaluation will be an interactive process, setting up a dialogue between the different participants within the POPPs process and the national evaluators (Ovretveit 1998). In contrast, as

the interventions progress, there will be a need for timely feedback around the progress against external (PSA) and internal (intervention) objectives. Within this summative phase, care will need to be taken to ensure that these findings are presented and received as being within an evaluative rather than pejorative model. The core team within this bid have experience of how to balance these different tasks through their evaluation of the IFOP.. The National evaluators (Professor Wistow (Chief Investigator), Professor Martin Knapp, Catherine Henderson) and local (Drs Beech, Windle, Dickinson, Wagland) have ensured that the evaluation is an interactive process. Base-line measures and subsidiary indicators have been built and agreed and a semi-structured interview developed and used across sites to ensure comparative analysis. This has allowed timely and robust feed-back between and within the overarching evaluation and sites.

2.3 Roles of the Local Evaluators

Within the IFOP, the roles of the local evaluators are two-fold. The first is to assist in setting the base-line information and generating the core datasets (quantitative and qualitative), whilst the second involves responding to the specific locality needs (e.g., see Widiatmoko et al 2005) agreed and funded by the separate sites. Through agreeing intellectual property and negotiating across the Project Leads Network (PLN), this model has worked well ensuring that neither the national nor locality needs for measurement or outcomes is negated. From this positive experience we propose to replicate the IFOP approach for the evaluation of the POPPs models. An important ingredient is 'trust-building' and reciprocal information sharing. However, it is argued that the following suggested framework development (see Phase 1 below) and support and communication infrastructure will build the necessary relationships.

2.4 User Involvement

It has been stated above (2.1) that user and carer representatives will be involved in the Steering Group. They will be involved at each stage of the process and will feed into the design and pilot of tools, analysis and dissemination. To ensure a wide input of older people's experiences and perspectives can be integrated within the research process, there will be regular feedback to and assistance sought from wider user groups. These include the Public Involvement Reference Group (PIRG, CRIPACC, University of Hertfordshire) and PSSRU Advisory Group at LSE. Training for users in research methods has been carried out within PIRG. The POPPs evaluation will form a regular part of the agenda at their meetings.

2.5 Support and Communication Infrastructure

There are three strands to the support and communication infrastructure. The first is support by the National evaluators to the local evaluation teams. It has been stated above (2.3) that the positive experience within the IFOP will be replicated within the POPPs evaluation. An initial two day residential Framework Development meeting (see 4 below) will take place ensuring that agreement on the core dataset, cost effectiveness data and responsibilities of National and Local Evaluators is gained. Full support will be provided in ensuring the necessary data collection methods are clarified (see 4 below) and training will be provided on administrating quality of life measures (see 4 below). Within this meeting, time will also be set aside for open discussion on specific locality needs. Such support as to methods and research design will continue within the suggested quarterly residential PLN meetings. The full-time Research Fellow will also act as a central point of communication for queries and problems. However, dependent on the need and given the number of sites, it may be that individual POPPs pilots will need to be referred to their local Primary Care Research Networks (PCRNs) or Research & Development Support Units (RDSU) in regard to their local evaluation... Finally, it is suggested that a web-based discussion site is also made available to the members of the POPPs sites. This could be set up through the Change Agent Team or by the national evaluation team. The aims and structure of the site will be agreed following the initial framework development (see Phase 1 below). Similarly, members of the National Evaluation will attend the envisaged PLN meetings (see Framework Development).

2.6 Conflict of Interest

Following selection of the projects, no members of the proposed team are acting as local evaluators of the POPPs partnerships..

3 OVERARCHING RESEARCH AIM & OBJECTIVES

The aim is to compare and critically analyse the innovative partnership and financial approaches of the POPPS pilots. The national evaluation has six objectives reflecting the origins, process and outcomes of the POPPs implementation:

1. Identify, measure and profile partnership and financial models.
2. Examine the contribution of the POPPs pilots to meeting the relevant PSA targets.
3. Assess the cost-effectiveness of the POPPs pilots.
4. Explore, analyse and profile the shift of services/ resources toward preventative care.
5. Explore and contrast user/ patient experience of the interventions.
6. Identify the characteristics and mechanisms of partnership and financial approaches that can be transferred and integrated to other care groups.

4 PLAN OF INVESTIGATION

To ensure the process and linkages between the overarching objectives, questions, methods and outputs of each stage are made overt; a summary of the research process is given in Figures 1 & 2 (pp 6 & 7).

Overarching structure

All phases of the study will follow standard operating procedures and will not commence until ethics and research governance approval have been obtained. The project will incorporate three phases. The first phase (Exploratory) will involve 36 sites.

Figure 1: Summary of the Research Process: Phase 1

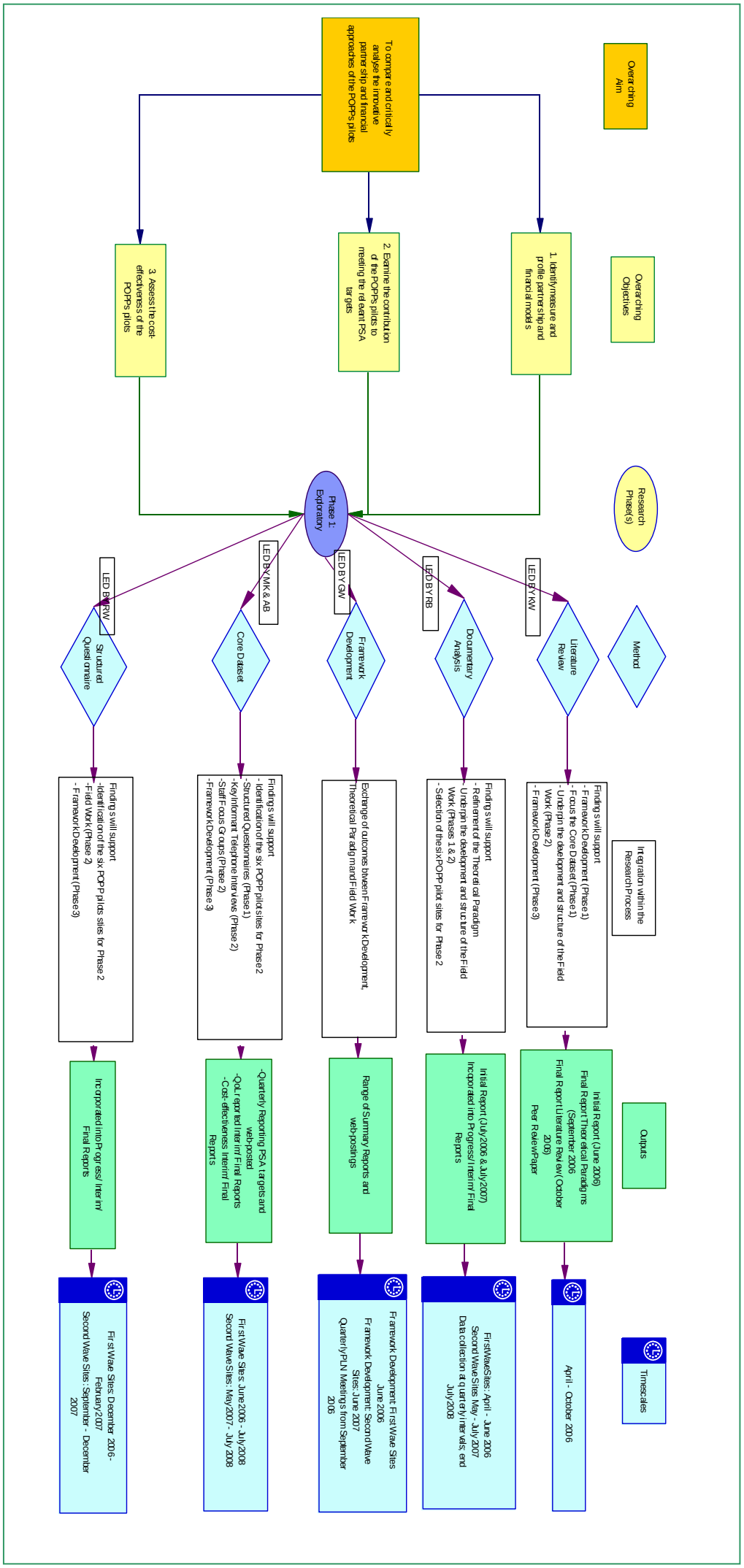
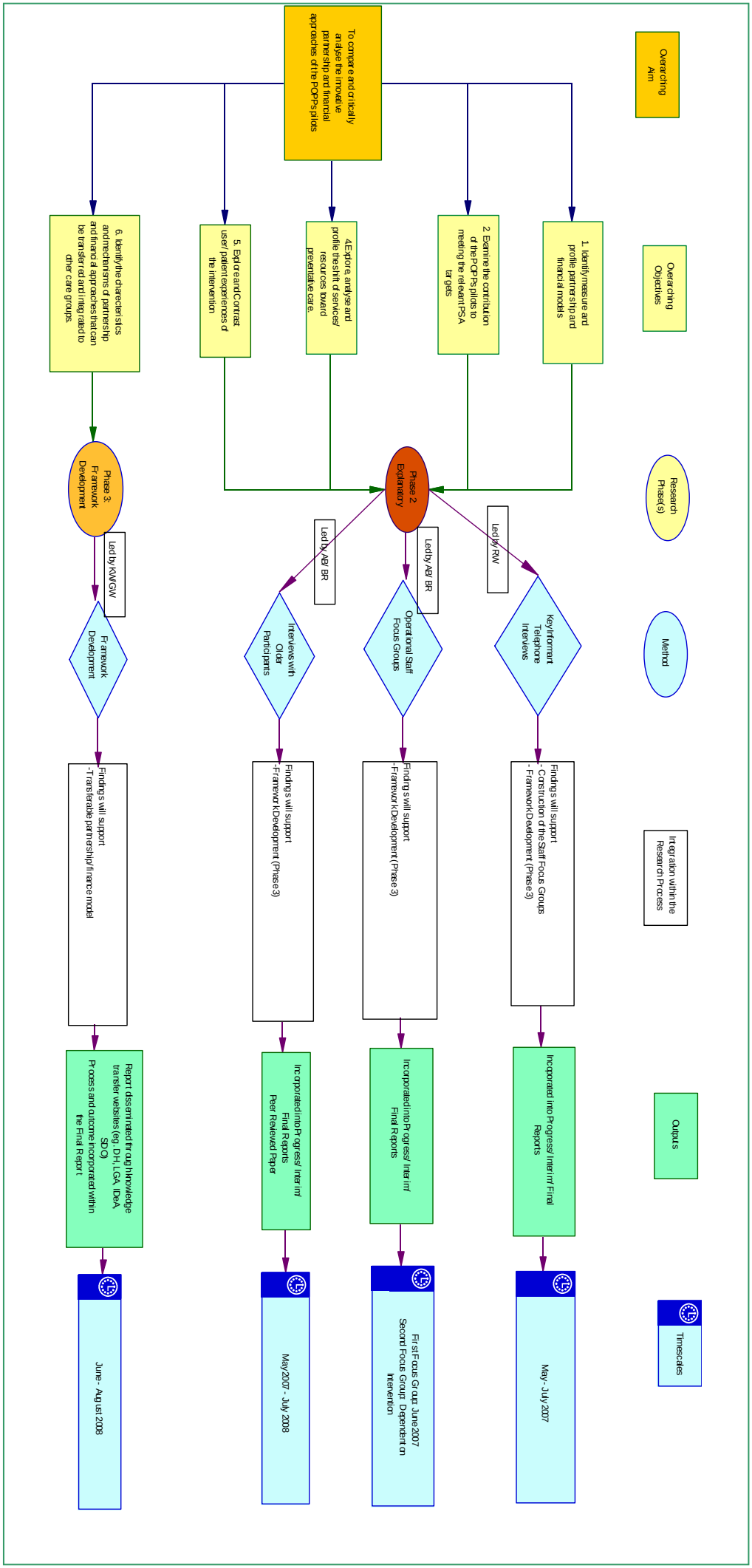


Figure 2: Summary of the Research Process: Phases 2 & 3



Within the second phase (Explanatory), six sites will be identified following the comparative analysis of the first phase work. The comparative analysis and hence site selection will be dependent on demonstrable 'differences' in demographics, service delivery models, operational structures, partnership/ financial models and progress toward targets. The third phase (Framework Development) will bring together the theory development and empirical work to select and develop a robust model that demonstrates sustainability and may inform preventative models and partnership approaches for other care groups.

Methodological Framework

The methodology will be grounded in a case study approach (Yin 1994, 1993). Such an approach will ensure that the disparate partnership models and interventions can be explored and compared across cases. Explanation of the cases will be guided through key theoretical proposition (see below) and demonstrated through narrative. The information can then be drawn together across cases to ensure a 'whole system' analysis. Within this proposal, it will be necessary to explore the conceptualisation and integration of 'prevention' and partnership, the structure process and outcome of the partnership/ financial models, the effectiveness of the PLN and shared learning, the impact of the interventions selected, the cost-effectiveness of POPPs, the integration of POPPs with other policy directives and the level of transferable learning. Given this breadth and depth of interpretation, particularly the assessment of impact, the case study is an appropriate method as it is designed to cope with *'the technically distinctive situation in which there will be many more variables of interest that data* points' (Yin 1994: 13). Such exploration also requires a range of different methods within the quantitative and qualitative paradigms, e.g., core-data set, participation observation. The need for flexibility of method and rigorous analysis within such approaches is also supported by the case study, which 'affords a broad range of sources and multiple research designs (Marinetto 1999, Keen & Packwood 1995).

The focus of this research will demand more than a simple descriptive presentation. There is a need to build explanations as to why one partnership/ financial model and subsequent intervention may be more effective than another in achieving progress toward the external (e.g., PSA) and internal (intervention objectives) outcomes. The case study is best served through the *'prior development of theoretical propositions to guide data collection and analysis'* (Yin 1994: 13). As such, the case study resides within the broad arena of 'theory-based' evaluations (Pawson & Tilley 1997,Chen 1990) ensuring that the complexity of implementation and the continual re-focusing and change that occurs throughout the process. However, from prior empirical work (e.g., see Windle 2001) it would seem that the case study allows a greater level of complexity to be incorporated and analysed as to impact than that of 'Realistic Evaluation'. As Barnes et al (2003) state *'Evaluative approaches based primarily within a realist paradigm cannot sufficiently embrace the significance of contested meanings amongst multiple actors within such complex initiatives* (274). It is argued that the evaluation of the POPPs bid has no less a level of complexity than the evaluation of the Health Action Zones (Barnes et al 2003, Sullivan et al 2002). We would therefore posit that the case study model that can *'cope with the technically distinctive situation in which there will be many more variables of interest than data points'* (Yin 1994: 3) will provide a more flexible methodological framework to measure change.

Theoretical framework

Wiess, states that theories or assumptions should be articulated at the outset of a programme. By gaining agreement of all stakeholders, the problems with causal attribution are reduced (Weiss 1995 cited Bowers et al 2003). As has been argued, the case study approach certainly favours the deductive stance. That is, a statement of the overall proposition and the subsequent *'design of [research] steps according to the relationship to the literature, policy issues or some other substantive source'* (Yin 1993: 4). Within the area of this particular bid, there are many overarching theories that could help to explore and explain why specific models or interventions are more effective than others. One framework is that of 'Theories of Change'. However, prior evaluations by Barnes et al (2003) and Sullivan (2002) have identified difficulties with such a theoretical framework. *'As our experience of the [HAZ] evaluation has developed we have found ourselves posing rather more fundamental questions about the adequacy of ToC [Theories of Change] in the evaluation of highly complex change systems'* (267). A further framework that could be used is that of the 'new ideological paradigm', built up through socio-cognitive discourse analysis (van Dijk 1998) within a case study. Here ideologies or beliefs of individuals and organisations can be made explicit thus allowing a deeper understanding of why change in implementation either continues or ceases at particular points. Further paradigms consist of 'Complexity Theory', 'New Institutional Theory' and that of 'Social Constructivism' (Barnes et al 2003). Within this proposal it will be necessary first to carry out the literature review prior to assessing and including a particular paradigm. The initial outcomes from the literature review, constructions of 'partnership' and 'prevention' and appropriate theoretical paradigm, will be presented at the initial residential Framework Development (Phase 1) to gain agreement by all stakeholders. Following this agreement, the theoretical paradigm will be further refined through the literature and a final model presented to the quarterly residential PLN meeting in September 2006. The selected paradigm will then be integrated within the research process. For example, if the 'new ideological paradigm' is selected, focus within the field work of non-participant observation, key informant interviews, etc., (Phase 1 & 2) will be on teasing out embedded 'belief' structures that may have a complementary or perverse impact on change. Targeted questions will be developed and analysed. Such empirical work will ensure the development of any paradigm. The case study approach, with its iterative requirement, each of the separate field work feeding into and affecting each other, will allow for such theory development and building.

4.1 PHASE 1: EXPLORATORY (OBJECTIVES 1, 2 & 3)

The first phase incorporates formative and summative elements. Each local authority and their partners (including users) will be treated as a unit of analysis. Thus data collected and analysed will be repeated across cases ensuring adequate evaluation and robust comparison of the structures, processes and outcomes of the pilots. It is recognised that there will be 'staged entry' by the

full 36 sites. The methods within the exploratory phase have been designed to allow flexibility and build transferable learning between case study sites.

The following overarching questions will be addressed within this stage:
1. Are there specific partnership models, financial arrangements that are supported by a strong evidence base?
2. Which theoretical paradigms enable an exploration of effectiveness of models or interventions?
3. How are the pilot sites conceptualising 'partnership' and 'prevention'?
4. What models of partnership, financial arrangements and preventative interventions have been adopted within the pilot sites?
5. Are the models adopted cost-effective?
6. Do the models reduce the usage of high-cost services?
7. Do the interventions ensure improved quality of life for older people?
8. Are the interventions effective as judged against their aims and objectives?
9. Does the process to support pilots, (PLN meetings, evaluation), facilitate integration of shared learning and subsequent changes to adopted models?
10. Does POPP complement National policies and, what is the impact (complementary and perverse) of national policies on POPP?
11. Are there changes in the overarching 'health' economy following the implementation of POPP?

Six approaches will be used to address these questions.

4.1.1 Literature Review (Led by KW)

Key questions to which the Literature Review will respond
1. Are there specific partnership models, financial arrangements that are supported by a strong evidence base?
2. Which theoretical paradigms enable an exploration of effectiveness of models or interventions?

Subject &Method
Prior work by members of the team, within the IFOP and for the Social Care Institute of Excellence (SCIE) have produced a series of brief literature reviews (see Bunn et al 2004, 2005, 2005a) and an overarching review of trends (Knapp et al 2004). As such, a great deal of information is already available on, the policy context of older people, the evidence base on preventative models of care, (what works for whom) and levels of service user satisfaction. It is suggested that a synergy will be developed from these papers. The concentration of the review will thus be on 'partnership/ financial models' and appropriate theoretical paradigms that are able to assist in the explanation of why some models and interventions are more effective than others (see 'Theoretical Framework above).. The key objectives will incorporate the identification and evaluation of the impact of specific partnership/ financial models, the successes and barriers to such collaboration or joint-working and appropriate theoretical paradigms that assist in the explanation of what works for whom and where.

To allow the necessary capture of the written material, inclusion/ exclusion criteria will be drafted, on-line databases identified (Knipschild 1995) and relevant search terms generated and built from abstracts (Egger et al 2001). Grey literature will also be included, for example, evaluations undertaken locally by health, social or the wider community base. Within the literature mapping, principles for critical appraisal will be applied to assess the literature's relevance and rigor.

Output & Timescale
Three outputs will be produced. The first is that of an initial report that will feed into the 'Framework Development' meeting of the Project Leads and researchers (PLN meeting) in June 2006. This report will summarise previous literature reviews, outline the initial findings from the partnership/ financial models and detail the theoretical paradigms to be discussed. Feedback will be sought from the Project Leads and local evaluators. The final report detailing the theoretical paradigm will be produced for the quarterly PLN meeting of September 2006 and, a final report of the literature review by October 2006. A peer review paper will also be submitted at this time.

Integration into the Research Process
The findings from the Literature Review will support the 'Framework Development', ensure focus of the Core Dataset and provide underpinning development and structure to the field work (Phases 1 & 2). Finally, the review will ensure an initial model that can be adapted and built on throughout the research process that can be used within Phase 3.

4.1.2 Documentary Analysis (Led by RB)

Key questions to which the Documentary Analysis will respond
3. How are the pilot sites conceptualising 'partnership' and 'prevention'?
4. What models of partnership, financial arrangements and preventative interventions have been adopted within the pilot sites?
5. Are the models adopted cost effective?
10. Does POPP complement National policies and, what is the impact (complementary and perverse) of national policies on POPP?

Subject & Method
Alongside the literature review on partnership models and specific theoretical paradigms, there will be a robust focus on the actual models and interventions being taken forward within the POPPs sites. Exploration and comparison (inter and intra) of the 36 sites will be carried out through documentary collation and analysis. This allows factual information to be collected on how sites are interpreting and implementing the POPPs innovations. Data collected within this stage may include details of specific processes and services that the POPPs applicants and their partners have developed to meet the DoH aims and targets. Such collation will also allow for the formulation of 'important questions to pursue through more direct interviewing' (Patton 1990:233).
The type of documentation likely to be collected includes:

a. Relevant in-house policy documentation, e.g. the POPP proposals submitted to the Department of Health and the supporting documents underpinning the submission including the economic appraisals.
b. Structural, procedural and guidance documentation, e.g. copies of partnership agreements, minutes of the project boards and team meetings where POPPs schemes are discussed. Minutes of 'central' boards and service redesign teams may also indicate the level of integration of the POPP programme and other policy initiatives.
c. Output information from the local evaluators detailing the impact of the intervention on outcomes for individual older people.

A review of these documents may also indicate the ways in which older people have been/will be involved in the development and assessment of POPP schemes.

The written documentation will be analysed through the use of 'content analysis' (Scott, 1990). Specific themes or concepts will be identified (Berg 1989) and these will then be 'tested' and 'defined' within and between the different documentation. It is argued that the documentary analysis process will need to be ongoing throughout the life-time of the project as the POPP pilot sites develop and refine the intervention, or partnership model. Close liaison with the local evaluators will ensure that 'new' documents can be incorporated.

Output & Timescale
There will be an initial three month documentary analysis incorporating both 'waves' of the pilots. The first wave analysis will be carried out from April – June 2006 whilst the second will span from May to July 2007). To ensure that 'new' documents are incorporated further collation and analysis will be carried out at quarterly intervals (see 6 below). An initial report will be produced from the documentary analysis in July 2006 (first wave) and July 2007 (second wave). The outputs will be fed into the progress report and interim reports and be incorporated within the final report. Outputs will also be posted onto the project website.

Integration into the Research Process
The outputs from the documentary analysis will assist in the refinement of the theoretical paradigm as such evidence may allow exploration of the level and extent of change within the POPPs pilot sites. Findings will also be fed into field work in Phases 1 & 2 ensuring robust and targeted questionnaires/ topic guides. The findings will also be used to select the six POPP pilot sites for Phase 2.

4.1.3 Framework Development & quarterly project leads and evaluators network (Led by GW)

Key questions to which the Framework Development will respond

3. How are the pilot sites conceptualizing 'partnership' and 'prevention?'
4. What models of partnership, financial arrangements and preventative interventions have been adopted within the pilot sites?
9. Does the process to support pilots facilitate integration of shared learning and subsequent changes to adopted models?

Subject & Method
It is envisaged that the framework development and quarterly residential PLN meetings will act as the fulcrum of the research process. That is, this meeting will enable an exploration of concepts, research tools, progress of and barriers to project development and sustainability. The initial 'Framework Development' will take place within the first meeting of the PLN. It is suggested, following consultation with the member of the Change Agent Team, Project Leads and local evaluators, that a two-day residential meeting will be set. Within this meeting a series of key tasks will be carried out, focused on the National and Local Evaluation. One of the key tasks concerns that of information sharing. For example, findings will be presented from Project Leads from the Innovation Forum detailing their structure, process, pitfalls and outcomes. Similarly, individuals from the Care Services Improvement Partnerships and the Mental Health Workforce Evaluation will be invited to share their learning. The outcomes from prior literature reviews relevant to the POPPs will be given (see Bunn et al 2004, 2005, 2005a, Knapp et al 2004) and discussion of the relevant theoretical paradigms will be facilitated. The organisation and collation of core data (see Core Data Set below) will be explored, including that of cost-effectiveness data and the roles and responsibilities of the National and Local Evaluators clarified. We expect that it will be necessary to carry out a series of training exercises with the local evaluators to ensure that they can both administer the quality of life measure (Bowling et al 2002, Gabriel & Bowling 2004) and/ or train operational staff to use such tools (see Core Data Set below). Within this forum it will be necessary to discuss and agree key milestones of the projects. Specific focus on conceptual clarification will also be carried out. That is, 'workshops' will be developed to explore how the different POPPs sites conceptualise partnership and prevention and discuss how this conceptualisation has been presented within their own local projects. This information will be used to provide support and insight to the Literature Review and Documentary Analysis. That is, to make an adequate assessment of written 'evidence', it is necessary to utilise knowledge of the participants in the field, their roles, background and likely agendas (Yanow 2000). The

further residential meetings of the PLN and evaluators, (once a quarter) will ensure flexibility as to the development and collation of tools and materials.

It is recognised that the structure of the POPPs is a staged entry model. It will be necessary to run a second Framework Development stage at the entry of the second pilot selection (May 2007). This will be structured to integrate the learning generated from the progress and outputs of the first 'wave' pilots. Similarly, it may be necessary to develop or refine the core datasets dependent on the needs and/ or wishes of the later pilots.

Timing & Output
The initial Framework Development meeting for the first wave pilots will be scheduled for June 2006 with quarterly meetings arranged from September 2006. The Framework Development Meeting for the second pilot selection will take place in June 2007. These pilot sites will then join the first wave quarterly meetings, with the final meeting being held in October 2008 to feedback the overarching findings. The outputs from the Framework Development and quarterly meetings will range from summary reports on conceptualisation of 'partnership' and 'prevention' to written information to support administration of the quality of life measures. Such outputs will be placed on the web-based discussion site hosted by the Change Agent Team or the National Evaluation Team (see 2.5 above). Key outputs (e.g., conceptualisation of 'prevention' and 'partnership') will be incorporated within the interim and final reports.

Integration within the Research Process
It has been stated that the Framework Development will act as a fulcrum within the overarching research process. There will be an exchange of outcomes between the Framework Development and PLN meetings and that of the theoretical paradigm and field work. Each of these processes (meetings, paradigm development, field work) will be refined as the POPPs pilot sites move through the management and process of the interventions.

4.1.4 Core Dataset (Led by MK & AB)

Key questions to which the Core Dataset will respond.
5. Are the models adopted cost-effective?
6. Do the models reduce the usage of high cost services?
7. Do the interventions ensure improved quality of life for older people?
11. Are there changes in the overarching health economy following the implementation of POPPs?

Subject & Method
PSA Targets
The purpose of the dataset is three-fold. The first is to evaluate the progress of the POPPs bids against the PSA targets ensuring pre/ post measures can be given. Methods to calculate the specific reduction in bed-days have already been carried out by members of the core team (see Wistow 2005). Core collected data in the IFOP evaluation includes bed days, average length of stay, admissions, emergency readmissions, zero lengths of stay. Subsidiary indicators have also been developed to incorporate profile items (demographic data, performance ratings, financial data, expenditure etc) and use of non-acute services and levels of support (intensive/ rehabilitation/ community equipment etc) (see Henderson 2005). These collections allow progress against the further PSA targets to be extrapolated. This core data set has been built up through negotiation with the members of the IF, local authorities, their health and community partners. We propose to build on this experience and on these specific data collection structures in the POPPs evaluation. We envisage negotiation will be undertaken within the 'Framework Development' (see above) to ensure that this existing database can be focused toward the needs of the POPPs sites.

It is recognised that the other activity, e.g. health and social care interventions, implementation of organisational and policy change within each of the POPP pilot sites is likely to have an impact on any progress toward the PSA targets. The challenge for the National evaluative team will be to 'pull-out' the impact of the POPPs from that of other activity. As such, Data will be used from the IFOP sites (7) to provide a comparator as to progress along with the wider information drawn from the work being undertaken by PSSRU at LSE (funded by the DoH) that is examining patterns of social care and related health service use, expenditure and performance in all English authorities (see Fernandez & Foster 2002).

Quality of Life Indicators
The focus of the IFOP core dataset is to support the progress of the member sites towards the single headline target of a 20% reduction in unscheduled bed days for older people aged 75 and over. Quality of life (QoL) indicators have not been recorded. To extend the focus of the core dataset toward the POPPs evaluation, the proposed team members within this bid (Professors' Bowling & Roe) have been invited to assist in the development of such indicators. The quantitative descriptive data on QoL in older people will be collected using the established methodologies of Bowling and colleagues developed as part of the ESRC Growing Older Research Programme (Bowling et al 2002, Gabriel & Bowling 2004). This will developed within the 'Framework Development' and incorporate the domains from key policy documents (see HM Government 2005). Pilots will then be carried out to ensure rigor and validity and a shorter version will be included within the dataset. A discussion will be held with the local evaluators within the 'Framework Development' as to the inclusion of such an indicator within their evaluations. Following agreement, they will then be trained up to administer the tool. At this stage, without full knowledge of the bids to be selected, the number and extent of the quality of life indicators cannot rigorously be set. The measures for the evaluation need to have good psychometric properties, be standardised, relevant to older people, applicable to a wide range of client groups, sensitive to change and relatively succinct to ensure professionals can deliver, administer and collect the necessary information. Similarly, they must

be acceptable to older people, with minimal burden. Prior to further negotiation with the local evaluators and integration with key policy documents (HM Government 2005), a battery of easily completed outcome scales are proposed. These incorporate measurement of broader health status (SF 12: Ware et al 1996), physical functioning (Townsend 1979), cognitive state (Hodkinson 1972), psychological health (e.g., Hospital Anxiety and Depression Scale: Zigmond & Snaith 1983) and psychological resources (e.g., self-efficacy, autonomy, growth, purpose, self –acceptance: Schwarzer 1993: Ryff 1989). Other relevant outcomes scales could incorporate, social functioning and self esteem subscales from the LEIPAD Questionnaire (de Leo et al 1998) and frequency of and changes in, loneliness (Bowling 2005) and generic quality of life. The later would be a piloted version of the Quality of Life Questionnaire developed from the views of a national sample of people aged 65 and over (Bowling 2005). The time-line for administration of the tool cannot be rigorously set as further information would be necessary from the POPPs interventions. However, it is hoped that base-line data can be collected as the individual enters the intervention and at an agreed time either within the intervention or post-'discharge'. It is recognised that self-administration of such a tool with a frail population is unlikely to be appropriate. Similarly, given the emphasis on innovations within the mental health area (Annex 2) a self-completion questionnaire is unlikely to provide the robust indicators necessary. As such, the use of the local evaluators to administer this tool, either through allowing self-completion or within a face-to-face consultation is felt to be an appropriate method. This quality of life information will be expanded upon within Phase 2, Interviews with Older Participants in the POPP sites.

Cost Effectiveness

The indicators recorded within the core data set allow for a limited direct cost analysis of the POPPs interventions. By reference to the subsidiary indicators, changes in the patterns of services and use of services can be plotted and cost measures attached. However, it is likely that other variables will impact on the changes, e.g., the activity responding to the CC(DD)A 2003. In order to ensure that the impact of the pilots can be adequately measured, two strategies will be employed. First we will draw on work being undertaken by PSSRU at LSE (funded by the DoH) that is examining patterns of social care and related health service use, expenditure and performance in all English authorities (see Fernandez & Foster 2002). Standardising for all other factors for which data are available and analysing data at an authority level, it will be possible to examine any impact (e.g., on hospital bed days or admissions) specifically associated with the POPPs sites. Second, cost-effectiveness data collected and analysed by the local evaluators will be drawn on throughout the process of the national evaluation for more 'finely grained' insights. We will discuss measuring costs in the 'Framework Development and subsequent stages of the structure questionnaires (Phase 1), Key Informant Telephone interviews and Staff Focus Groups (Phase 2). This information will be assessed by Professor Martin Knapp (Health Economist).

Outputs & Timing

The triadic nature of the Core Dataset will result in a series of outputs.

PSA Targets

It is envisaged that following the initial Framework Development (see above) meeting (June 2006 & June 2007)) the base-line data for the PSA targets will be agreed. POPPs sites will then be required to submit the required data on a quarterly basis. It is recognised that submissions will be paramount if the progress toward the targets is to be adequately plotted. As such, following negotiation with the member of the Change Agent Team and the Department, it may be that such submissions from the local sites to the National Evaluators become part of the POPPs 'contract'. That is, continuation of funding is dependent on submission of data. As with the IFOP sites, an on-line submission form will be sent to the Project Leads for entry and return. The analysis and presentation of such data will be made quarterly. At the early milestone of the Treasury Review of January 2007, the first quarter's progress on the three PSA targets will be available. The data will be presented in the progress, interim and final reports and made available on the project website.

Quality of Life Indicators.

The timescale of administration of the quality of life indicators will necessarily be dependent on the type of intervention. For example, the Hospital aftercare intervention as described by Leeds City Council may have a very short timescale. This may limit the QoL indicators to admission and discharge. In contrast, the Integrated Case Management offered by North Yorkshire County Council may allow a more longitudinal assessment with QoL indicators being applied at several time points throughout the intervention. The outputs of the QoL will thus need to be reported within the case-study approach, as part of the description and impact of the interventions. This information will be detailed in the interim (March 2007 & March 2008) and final reports (September 2008).

Cost-Effectiveness

The cost-effectiveness data will be analysed yearly and reported in the interim and final reports

Integration within the Research Process

Data will be collected throughout the life-time of the project. However, the initial data from the first phase interim findings (March 2007) will be central to the identification of the six explanatory POPPs sites (Phase 2). Similarly, it will be used to feed into the structured questionnaires, key informant telephone interviews and staff focus groups. Such data will also provide insight into the effectiveness of the partnership/ finance model to be developed in Phase 3.

4.1.5 Structured questionnaire (Led by RW)

Key questions to which the Structured Questionnaire will respond

3. How are the pilot sites conceptualizing 'partnership' and 'prevention?'
4. What models of partnership, financial arrangements and preventative interventions have been adopted within the sites?
5. Are the models adopted cost-effective?
6. Do the models reduce the usage of high cost services?
7. Do the interventions ensure improved quality of life for older people?
8. Are the interventions effective as judged against their aims and objectives?
9. Does the process to support pilots, (PLN meetings, evaluation), facilitate integration of shared learning and changes to the adopted models?
10. Does POPP complement National policies and what is the impact (complementary and perverse) of national policies on POPP?
11. Are there changes in the overarching 'health' economy following POPP?

Structure & Method

The literature review, documentary analysis and participant observation will feed in to the development of a partnership assessment tool (Hardy et.al. 2000), and, as part of this, a mailed self-completion questionnaire will be developed (de Vaus 2002, Marsh 1982) and sent to key informants within each of the 36 pilot sites. These informants will include those involved in the implementation and operation of the local POPP pilots, and the questionnaire will elicit information relevant to an understanding of the effectiveness and cost effectiveness, of their respective models of preventative care, partnership working and funding, as well as the effectiveness of the PLN and of the arrangements for the facilitation of shared learning. In addition, the questionnaires will also seek to discover any perceived obstacles and tensions that respondents identify with regard to the process of joint-working. A number of pilot sites will later be selected on the basis of these completed questionnaires and more in-depth semi-structured interviews will take place with key informants.

The construction of the questionnaire will, in the main, be constituted of closed (pre-coded) questions, but will also include some open-ended questions (e.g. perceptions of changes and tensions related to joint-working). The data will then be entered onto SPSS and analysed using appropriate statistical tests

Timing & Outputs

The staged nature of the POPPs implementation will require a two stage delivery of the questionnaire. The first wave of POPP pilot sites will receive the questionnaire in December 2006 for return by February 2007, whilst the timings for the second wave are September 2007 for return in December 2007. The analysis will be reported in the Interim and Final reports.

Integration into the Research Process

The analysis will be used to assist in the selection of the six sites for Phase 2 and will feed into the construction of the Phase 2 field work and building of the partnership/ financial model in Phase 3.

4.2 PHASE 2: EXPLANATORY (OBJECTIVES 1, 2, 4 & 5)

On the basis of the first phase interim findings, six sites will be selected for further in-depth summative exploration that demonstrate comparative demographic, partnership/ financial models, operational interventions and interim outcomes. The selection will be made in May 2007 to ensure the second wave of POPPs sites are included. Within this phase, the following overarching questions will be addressed:

1. How do the pilots work as strategic change mechanisms?
2. What are the barriers/ facilitators to sustainable integration of partnership/ financial models?
3. What are the barriers/ facilitators to mainstreaming of pilots?
4. Do professionals perceive the interventions as driving changes to implementation of preventative interventions?
5. What are the barriers/ facilitators to developing and implementing selected interventions?
6. Do older people perceive prevention as an acceptable approach to improved well-being?
7. Do older people within the interventions produce report a sustained/ improved quality of life as against those older individuals not part of the POPPs pilots?

Three specific methods will be used.

4.2.1 Key Informant Telephone Interviews (Led by RW)

Key questions to which the Key Informant Telephone Interviews will respond

1. How do the pilots work as strategic change mechanisms?
2. What are the barriers/ facilitators to sustainable integration of partnership/ financial models?
3. What are the barriers/ facilitators to mainstreaming of pilots?
4. Do professionals perceive the interventions as driving changes to implementation of preventative interventions?

Structure & Method

Telephone interviews (Shuy 2002) will be carried out with a purposive sample of key informants to explore the decision-making trail and identify the organisational drivers and barriers to integrating partnership working within the POPPs pilots. Telephone interviews are efficient, effective and convenient (for participants) in obtaining data from subjects based in geographically spread

sites versus face-to-face interviews (Wilson & Roe 1998, Wilson et al 1998) and will supplement the (postal) structured questionnaires. It is anticipated that a maximum of three participants from each site (n=18) will be interviewed. Participants will include the project lead for each site as well as those managers with responsibility for the implementation and operation of the POPP pilot initiatives.

Interviews will be carried out through the use of a semi-structured interview guide informed by the data collected during Phase 1. Each interview will be tape recorded and key passages transcribed. These transcribed excerpts will be thematically analysed (Huberman & Miles 1998) through inter and intra comparison using NUD*IST

Timing & Outputs
The telephone interviews will be carried out in May 2007 with the analysis being completed by July 2007. The findings will be given in the Interim (March 2008) and Final (September 2008) Reports.

Integration within the Research Process
It was argued within the 'Plan of Investigation' that the focus of the research will demand more than a simple descriptive presentation. There is a need to build explanations as to why one partnership model may be more effective. The Key Informant Interviews will begin to provide such an explanatory focus. The outputs will be assist in the construction of the staff focus groups and feed into the development of the partnership/ financial model in Phase 3.

4.2.2 Operational Staff Focus Groups (Led by AD/ BR)

Key questions to which the Operational Staff Focus Groups will respond
2. What are the barriers/ facilitators to sustainable integration of partnership/ financial models?
3. What are the barriers/ facilitators to mainstreaming of pilots?
4. Do professionals perceive the interventions as driving changes to implementation of preventative interventions?

Structure & Method
To explore the process of each of the interventions/ strategies, focus groups (Kreuger 1994) will be conducted with relevant members of front-line staff. The concentration of discussion will be informed by the previous stages of the project, the evolution of the theoretical paradigm and the progress of the specific pilots. Within the focus groups we will explore individuals' experiences, perspectives and ideas about the effectiveness of their respective models of partnership working, barriers and facilitators to sustainable integration of partnership and financial models and the mainstreaming of the pilots, service delivery, preventative care and health promotion, and funding. One focus group will be held at each of the six sites. Two focus groups (with a maximum of ten individuals) will be held over the 'life-time' of each intervention, one towards the beginning of the pilot and towards the end of the funding period. In that way, a total of 120 staff will be included. The focus groups will be recorded, transcribed verbatim, placed on the qualitative package NUD®IST and thematically analysed (Huberman & Miles 1998)

Timing & Outputs
The first focus groups will commence in June 2007. The second stage focus groups will be conducted at a time dependent on the length of the intervention. The findings will be reported within the Interim (March 2008) and Final reports (September 2008).

Integration within the Research Process
The findings from the focus groups will feed into the 'Framework Development' (Phase 3), the construction of the partnership/ financial model.

4.2.3 Interviews with Older Participants in the POPPs Pilot Sites (Led by AD/ BR)

Key Questions to which the Interviews will respond.
6. Do older people perceive prevention as an acceptable approach to improved well-being?
7. Do older people within the interventions report a sustained/ improved quality of life as against those older individuals not part of the POPP pilots?

Structure & Method
The interviews with older participants will incorporate a sample of individuals within and outside the specific POPP interventions. Qualitative data on what gives life quality and what takes quality away will be collected using the methodologies of Bowling and colleagues developed as part of the ESRC Growing Older Research Programme (Bowling et al 2002, Gabriel & Bowling 2004). The qualitative data will also capture older people's views on their health, well-being and satisfaction in relation to preventative approaches, the local POPP initiatives and services/ resources outside the POPP pilots. Pilot work will develop and establish the methods of data collection and recruitment of samples and will involve representation from Older People Consumer Groups such as Age Concern, Help the Aged, Local Older People'

It is recognised that if the pilot interventions are to be adequately compared within existing services it is also necessary to interview those older people who are not with the pilot interventions. There are difficulties in such a methodological approach. For example, if the pilot is developing a new intervention in response to a specific policy or practice finding in mental health (e.g., see DoH 2004a), it may be that there is no comparative service from which to draw individuals. Similarly, it would be extremely difficult to identify a resource or service that incorporates similar objectives or outputs. Given that little information is available on the structure and process of the projects, the following method of sampling is a suggestion only and, will need to be refined with the local evaluators and project staff during the 'Framework Development' (Phase 1) and subsequent PLN meetings. At this

stage, it is suggested that in order to access those individuals that do not take part in the intervention, the referral process is used. That is, along with interviews held with individuals 'accepted' into the intervention, interviews will also be held with a sample of individuals who are not accepted for the programme through specific capacity issues rather than that of inappropriate referral or personal reluctance/refusal to participate.

It is envisaged that two semi-structured guides are developed. Each will have a core built around quality of life, with further questions focused on the specific resource (POPP pilot or existing intervention). Ten semi-structured interviews will be undertaken within each selected pilot site; five individuals accessing the POPP pilot initiatives and five not accepted for capacity reasons. The total number of interviews carried out would be 60.

Interviews will be undertaken by an experienced researcher and will last no longer than one hour. Users will be invited to take part initially by the researcher, an information sheet will be given to them and time given (at least 24 hours) to consider whether they wish to participate. Interviews will be arranged at a date and time convenient to participants. Informed consent will be obtained prior to the interviews being undertaken. With the participant's permission, the interviews will be recorded. We have extensive experience of interviewing older people being supported by social care services or treated as NHS patients. We will need to approach the interviews with older people with care, but do not anticipate difficulties obtaining reliable information from them.

The audiotapes will be fully transcribed and anonymised. The process of identification of themes, developing categories, determining connections, and refining categories will then be carried out in an inductive way following the constant comparative method of grounded theory (Glaser & Strauss, 1967) using the qualitative computer package: NUD®IST. This will involve immersion in the data, i.e. reading field notes and listening to interviews in order to gain a 'general sense' of the data, followed by detailed coding. This process will enable themes to emerge inductively from the interviews. Reliability will also be addressed within the qualitative analysis by undertaking inter-rater checks on a 10% sample of interviews, themes, and categories. These categories will be compared with existing knowledge and the implications of the findings discussed for policy and practice.

Timing & Outputs
To ensure adequate capture of the views of user/ patients, the interviews will commence in May 2007 and continue until the end of July 2008. The findings will be reported within the Interim (March 2008) and Final Reports (September 2008) and a peer reviewed paper will be submitted following the Interim Report.

Integration within the Research Process
The findings from the focus groups will feed into the 'Framework Development' (Phase 3), the construction of the partnership/ financial model.

4.3 PHASE 3: FRAMEWORK DEVELOPMENT (Objective 6) (Led by KW/GW)

Key question to which the Framework Development will respond
1. What partnership/ financial model can be applied to differing structures of care groupings?

Structure & Method
The difficulties of developing sustainable partnership/ financial structures and processes have been discussed within the background. Indeed, as Goss (2001) argues, the difficulties of partnership are such that *'in some cases partnerships set up to bid for funding don't survive long enough to spend it'* (95). It is hoped that through the overarching structure of the POPPs process (the theoretical development within the National Evaluation, the Local Evaluation, support through the Change Agent Team and PLN meetings) robust models of management will have been developed that can provide learning which can be transferred to and integrated within other care groups. Consequently, the outcomes of Phase 1 & 2 will be an inductively derived explanatory framework that will create an appropriate partnership/ finance model that can be applied to the differing structures of other care groups. It is recognised that 'one-size' is unlikely to fit all. Nevertheless, if new ways of working through robust partnership/ financial 'models' have been developed, it is key that these structures derived from the theoretical and empirical work are modified to local circumstance. Following an initial development of an overarching model, two stakeholder consensus workshops (six weeks apart) will be held from participants across the 36 sites identified in Phase 1.

The stakeholder consensus workshops, (running within June/ August 2008), will function as a forum for the presentation, discussion and critique of the models identified across the POPP sites incorporated in the theoretical development (see Plan of Investigation above). Workshop 1 will refine and extend the partnership models, contextualise the models to a wider care grouping and inform operationalisation of the models through their existing structure, process and outcomes. Within Workshop 2, the final stage of the framework development will be carried out, that of identification of a partnership/ finance model that can be implemented.

The planning committee will be drawn from the research team, stakeholder group members (including users) and additional recognised experts in the field of governance and incentives. A tightly specified brief outlining the models will be sent out to individuals from Phase 1 who will be invited to participate. The workshop will have three groups to focus attention on the key aspects of the model development, namely, structure, process and outcomes. Each of these groups will have a link lead from the research team and will facilitate a written report to be presented to the second workshop. Alongside this initial phase will be a virtual time time-limited online conference (using tested technology such as Flash Meeting, KMI 2004), will take place with invited experts. The outcomes from this stage will be sent to the participants prior to the second workshop, where the brief will be to discuss the partnership/ finance model(s) that can be implemented.

The workshops will employ a nominal group technique (Jones & Hunter 1995) to identify the models that can be implemented successfully. As such, prior to the second workshop, invited participants will be sent the written material and will undertake the first stage of ranking in line with the principles of the nominal group technique. At the second workshop, prioritisation and consensus on the model will be reached. A maximum of 30 individuals will attend to ensure the working groups (3 x 10) are small enough to focus on and achieve the aims. Within each of the workshops, detailed notes will be taken and, observation field notes will be collected (Huberman & Miles 1998).

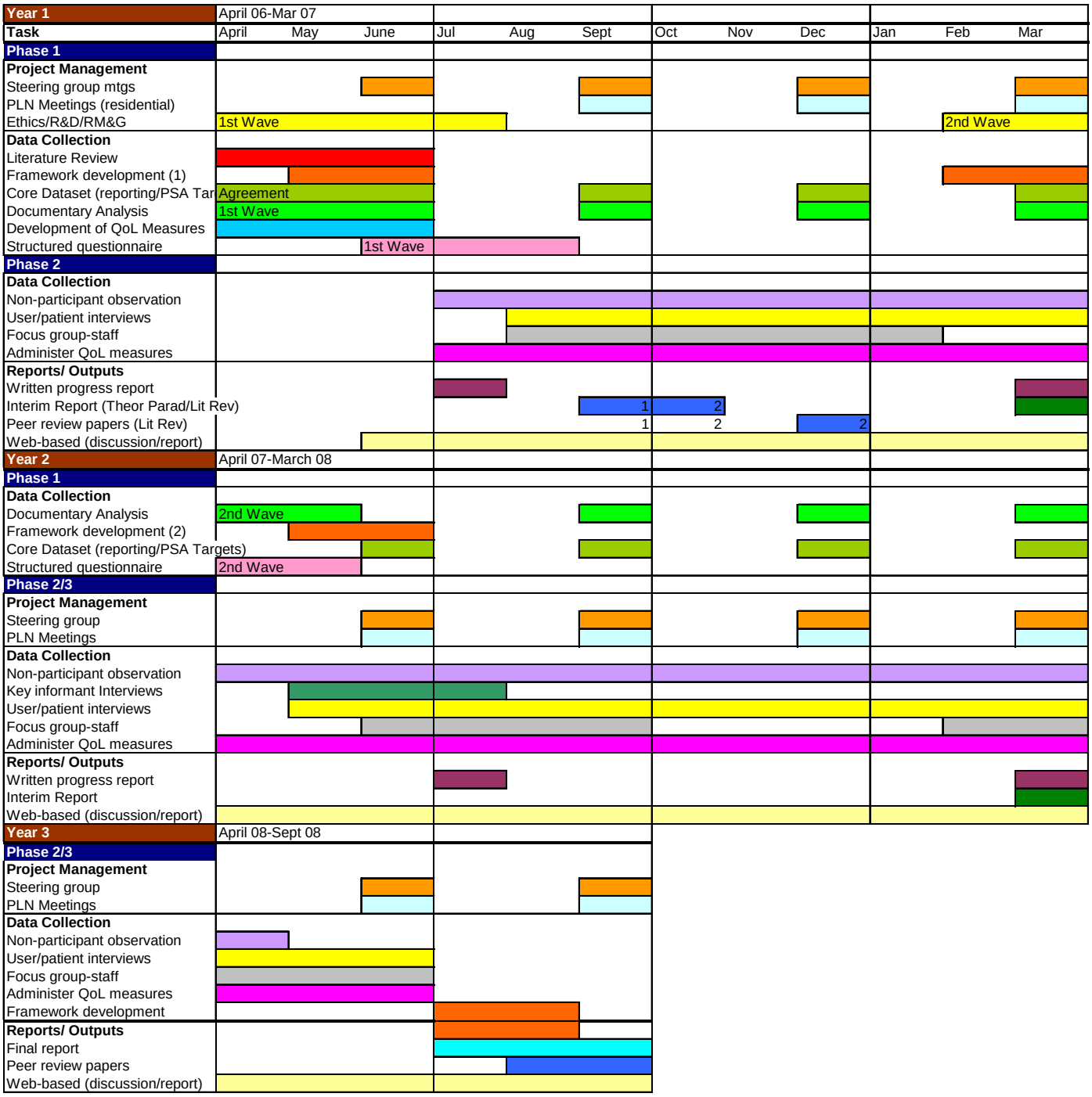
Outputs

At the end of the second workshop the framework will be written up and disseminated through 'knowledge-transfer' websites (e.g. DH, LGA IDeA, SDO) and the process and outcome will be incorporated into the Final Report (September 2008)

5. DISSEMINATION

Each aspect of the study will be led by a named researcher responsible for coordinating delivery of associated outputs and dissemination targets. In Phase 1 KW will lead on the literature review, RB on the documentary analysis, GW the Framework Development, RW the participant observation and structured questionnaire and MK/AB the Core Data Set. Each method will be used to feed into the design of the different stages. Separate reports will be produced from the Literature Review, conceptualisation of partnership and prevention, framework development and fed back to the Project Leads and DH. The core data set will produce progress reports on a quarterly basis. Within Phase 2, RW will lead on the Key Informant Telephone Interviews, AD/ BR on the Focus Groups and Interviews with Older People, GW and KW on the Framework Development. Reports will be provided to the DH on a six monthly basis with an Interim Report at the end of Years 1 & 2. A final report will be produced detailing the process, outputs and transferable model. Peer-review journal papers will be written and the model (Framework Development: Phase 3) placed on key 'knowledge' transfer networks (e.g., DoH, LGA, IDeA, SDO). Passive dissemination of study progress and results of the phases will be made available using a project website. This will be hosted under http://www.health.herts.ac.uk/cripacc with links from other participating groups' websites, and updated monthly in line with the project phases. Conference presentations will be made to health, social care and other relevant practitioners.

6. PROJECT TIMETABLE



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Appendix 1

CURRICULUM VITAE

1. Surname	Forename(s)	Age
Windle	Karen	DoB: 18/03/63

2. Degree, etc (subject, class, university and date)

2001: PhD Brunel University: Ideology into Practice: The shift from secondary to primary care
1991: MSc: University of Surrey: Social Research Methods
1984: BA(Hons): University of Sheffield: Political Theory & Institutions

3. Posts held (with dates)

2003:University of Hertfordshire: Senior Research Fellow: Health Care Policy

2002 – 2003: University of Hertfordshire: Manager/ Methodologist: Hertfordshire Primary Care Research Network

2000 – 2002: University of Hertfordshire: Methodologist/ Statistician: Hertfordshire Primary Care Research Network

1996 – 2000: Brunel University: PhD Research Student

1995 -1996: Moores Rowland Consulting: Senior Consultant

1992 – 1995: Social Services Research & Development Unit (SSRADU): University of Bath

1991 – 1992: Council for Disabled Children: National Children's Bureau: Project Manager

1988 – 1990: National Children's Bureau: Research Assistant

4. Recent publications (title and reference); papers accepted for publication (references should indicate first and last pages), and details of project management experience.

Accepted for Publication

Brooks F, Mead M, **Windle K**, Evaluation of a specialist midwifery support services in teenage pregnancy: British Journal of Midwifery (date tba)

Barnett S, Buckroyd J, **Windle K,** Using Group Therapy to Support Mothers with Eating Disorders: An Evaluation: Primary Health Care Research and Development (date tba)

Reports

Windle K, & Wagland, R: 2005: Hertfordshire & The Innovation Forum: Improving the Future for Older People, Hertfordshire: University of Hertfordshire.

Dickinson A, Cove, J, Knapp, N. & **Windle K**: (2005): The Electronic Single Assessment Process: An Evaluation of Initial Implementation, Hertfordshire: University of Hertfordshire.

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Bunn F, **Windle K**, Dickinson A: 2004: Interventions for preventing falls and fall related injuries in older people: A Mapping Exercise. University of Hertfordshire: On behalf of the Innovation Forum: IDeA Website

Dickinson A, **Windle K,** 2003: Evaluation of the Single Assessment Process Pilot Phase in Hertsmere

Brooks F, Mead M, **Windle K**, 2003: Combating Social Exclusion: Evaluation of a Specialist Teenage Pregnancy Midwifery Service

Kendall S, Sapsford L, **Windle K,** 2001, A report of the Evaluation of Relating To People

Submitted

Windle K, The impact of 'ideology' on health policy implementation: An empirical exploration utilising van Dijk's 'new' ideological paradigm.

Windle K, The shift from secondary to primary care: an achievable objective?

Brooks F, **Windle K,** Mead M, Combating Social Exclusion: Specialist Midwifery Input in Teenage Pregnancy.

1. Surname	Forename(s)	Age
Beech	Roger	51

2. Degree, etc (subject, class, university and date)

1977	BSc (Hons) Ceramic Technology 2.1	North Staffordshire Polytechnic
1981	Msc Operational Research and Management Science	University of Warwick
1988	PhD Industrial and Business Studies	University of Warwick
1991	Honorary Member of the Faculty of Public Health Medicine	

3. Posts held (with dates)

1977-1980	Production Manager Royal Worcester Spode Ltd
1984-1992	Research Fellow in Operational Research Department of Public Health Medicine United Medical and Dental Schools of Guy's & St Thomas's Hospitals
1992-1998	Senior Research Fellow in Operational Research Department of Public Health Medicine United Medical and Dental Schools of Guy's & St Thomas's Hospitals
1998- 2001	Senior Research Fellow in Health Operational Research Centre for Health Planning and Management Keele University
1998-2001	Honorary Senior Research Fellow in Operational Research Department of Public Health Medicine Guy's, King's, and St. Thomas's Medical Schools
2001-2004	Senior Lecturer in Health Operational Research Centre for Health Planning and Management Keele University
2001-2005	Director of Research Centre for Health Planning and Management Keele University
2002-	Academic Lead for Research Central Cheshire Primary Care Trust
2004-	Reader in Health Services Research Centre for Health Planning and Management Keele University
2005-	Co-Lead of Primary Care led NHS Research Programme, "Service Delivery to Older People".

4. Recent publications (title and reference); also papers accepted for publication (references should indicate first and last pages).

BEECH R. Organisational barriers to access. In: Gulliford M, Morgan M (eds.). Access to health care. Routledge 2003.

BEECH R, BELL J. The "What, who for, how much, in what way" approach to implementing the National Service Framework for Stroke: a working paper to support the development of business plans for stroke services. ***Keele papers in Geriatric Medicine and Gerontology*** 2003; Issue 8.

BEECH R, GULLIFORD MC, RODERICK P. Renal Disease. In: Stevens A, Raftery J, Mant J, Simpson S (eds). Health Care Needs assessment: The epidemiologically based needs assessment reviews. First series, second edition, volume 1. Oxford: Radcliffe Medical Press; 2004, pages 75-140.

BEECH R, McDOWELL S, WOOD G. Investigating services for palliative care in Central Cheshire PCT. ***Clinical Governance Bulletin*** 2004; 5(4): 7-9.

BEECH R, RUSSELL W, LITTLE R, SHERLOW-JONES S. An evaluation of a multidisciplinary team for intermediate care at home. ***International Journal of Integrated Care*** 2004; 4: http//www.ijic.org.

BEECH R. Identifying the need and scope for intermediate care. In: Roe B, Beech R (Eds). Intermediate and continuing care: policy and practice. Oxford: Blackwell; 2005, pages 19-32.

BEECH R. Evidence on effectiveness of intermediate care. In: Roe B, Beech R (Eds). Intermediate and continuing care: policy and practice. Oxford: Blackwell; 2005, pages 106-118.
ROE , B., BEECH, R. Intermediate and Continuing Care: Policy and Practice. Oxford: Blackwell, 2005.
VISSERS JMH, BEECH R (Eds). Health Operations Management. London: Routledge, 2005.

5. Recent/Current grants:

2002: £152,000 from National Assembly for Wales, Health Promotion Division for "Overarching evaluation of the SHARP initiative in Wales" (with Dr S Cropper and Mr R Little, Centre for Health Planning and Management, Keele University).
2002: £25,000 from Central Cheshire Primary Care Trust to "provide academic leadership to R&D capacity building within the PCT".
2003: £4,400 from Social Regeneration Board for "an evaluation of a new specialist advice service for the orthodox Jewish community in Salford: a scoping study".
2003: £25,000 from Central Cheshire Primary Care Trust "to provide academic leadership to R&D capacity building within the PCT" (continuation) .
2003: £3,960 from Keele School of Medicine for "Falls and falls prevention: narratives as the basis for service development and delivery" (with Dr B Roe, F Howell, K Riniotis, Prof. P Kingston, Prof. P Crome, Prof. B Ong).
2003: £118,117 from Action Medical Research for "Can surface neuromuscular electrical stimulation (sNMES) of the wrist and hand, in conjunction with routine therapy, facilitate recovery of arm function in people with poor prognostic indicators of functional recovery?" (with: Dr AD Pandyan, Dr S Hunter, Dr C Roffe, Prof P Jones).
2004: £100,500 from Department of Health and Office of the Deputy Prime Minister for "Reducing hospital utilisation by older people: proposals for a national evaluation". (with: Prof. G Wistow, Prof. M Knapp, Prof. S Kendall).
2004: £25,750 from Central Cheshire Primary Care Trust "to provide academic leadership to R&D capacity building within the PCT" (continuation) .
2005: £58,599 from National Assembly for Wales, Health Promotion Division for "Project to evaluate the potential to evaluate the potential "sustainability" and "transferability" of the sustainable health action research programme (SHARP)" (with Dr S Cropper, Dr S Carlisle and Mr R Little, Centre for Health Planning and Management, Keele University).
2005: £98,800 from Cheshire County Council for "Using research to support the design and evaluation of services to address Innovation Forum targets in Cheshire" (with Professor Brenda Roe, Liverpool John Moores University).

1. Surname	Forename(s)	Age
Bowling	Ann	DoB: 07/05/51

2. Degree, etc (subject, class, university and date)

1979 Phd Sociology, University of Wales (Swansea)
1976 MSc Sociology Applied to Medicine, University of London (Bedford College)
1973 BSc Economics (sociology), University of London

3. Posts held (with dates)

London School of Hygiene & Tropical Medicine	Senior Lecturer	01/01/1998 31/12/1991
St Bartholomew's Hospital Medical College	Senior Lecturer	01/02/1986 01/01/1995
The London Hospital Medical College	Senior Lecturer	01/01/1983 30/01/1986
National Children's Bureau	Research Officer	01/01/1983 31/12/1983
Ealing, Hammersmith and Hounslow AHA	Research Officer	01/02/1981 30/12/1982
Institute for Social Studies in Medical Care	Research Officer	01/01/1978 01/01/1981
Royal Postgraduate School of Medicine	Research Assistant	01/01/1976 31/12/1977

4. Recent publications (title and reference); papers accepted for publication (references should indicate first and last pages), and details of project management experience.

Selected publications

Bowling A, Grundy E. Activities in daily living: changes in functional ability. Age and Ageing 1997;26:107-114.

Bowling A, Windsor J. The discriminative power of The Health Status Questionnaire-12 (HSQ-12) in relation to age, sex and longstanding illness. Journal of Epidemiology and Community Health 1997;51:564-573.

Black NA, Bowling A, Griffiths JM, Pope C, Abel PD. Impact of surgery for stress incontinence on the social lives of women. Journal of Obstetrics and Gynaecology 1998;105:605-612.

Grundy E and Bowling A. Enhancing the quality of extended life years. Identification of the oldest old with a very good and very poor quality of life. Ageing and Mental Health 1999;3:199-212.

Bowling A. Ageism in cardiology. British Medical Journal 1999;319:1353-1355.

Bond M, Bowling A, Abery A, McClay M, Dickinson E. Evaluation of the costs and effectiveness of outreach clinics held by specialists in general practice in England. Journal of Epidemiology and Community Health 2000;54:149-156.

Bowling A, Bond M, McKee D, McClay M, Banning A, Dudley E, Elder A, Blackman I. Equity in access to cardiological investigations and interventions by age, gender and clinical indications. Heart 2001;85:680-686.

Kennelly C, Bowling A. Suffering in deference: a focus group study of older cardiac patients' preferences for treatment and perceptions of risk. Quality in Health Care 2001;10(Suppl):i23-i28 (guest co-editor A Bowling).

Dudley N, Bowling A, Bond M et al. Age- and sex- related bias in the management of heart disease in a district general hospital. Age and Ageing 2002;31:37-42.

Bowling, A. , Bannister, D., Sutton, S., Evans, O. and Windsor, J. A multidimensional model of QoL in older age. Ageing and Mental Health, 2002; 6:355-371.

Bond M, Bowling A, McKee D, Kennelly M et al. Is age a predictor of access to cardiac services?
Journal of Health Services Research and Policy 2003;8:40-47.

Bowling, A., Gabriel, Z. , Dykes, J. Marriott-Dowding, L. , Fleissig, A., Evans, O., Banister, D, Sutton, S. Let's ask them: a national survey of definitions of quality of life and its enhancement among people aged 65 and over.International Journal of Aging and Human Development, 2003; 56:269-306.

Banister D and Bowling A. Quality of life for the elderly – the transport dimension. Transport Policy, 2004; 11: 105-115,

Bowling, A., Gabriel Z. An integrational model of quality of life in older age. A comparison of analytic and lay models of quality of life. Social Indicators Research, 2004; 69:1-36.

Bowling, A. Ageing well. Quality of life in old age. Maidenhead: Open University Press, 2005.

1. Surname Forename(s) Age

Dickinson Angela DoB: 12/05/63

2. Degree, etc (subject, class, university and date)

PhD Gerontology
MMedSci (Distinction) Human Nutrition
BSc(Hons) Applied Zoology
Registered General Nurse

3. Posts held (with dates)

2002-present	University of Hertfordshire	Senior Research Fellow (Older people's health)
1999-2002	Oxford Brookes University	Senior Lecturer (Geratology)
2000-Present	Hertfordshire University	Contract Researcher
Jan 1996 – July 1999	Buckinghamshire Chilterns University College	Postgraduate Researcher (Registered for a Ph.D.)
1995	Buckinghamshire Chilterns University College	Research Assistant
1994 -1995	Family Heart Association	Nurse/ Nutritionist/Technical Officer.
1990 1992	Oxford Health Authority	Team Leader/ Senior Staff Nurse. Stroke Unit
1989 - 1990	Oxford Health Authority	Staff Nurse, Acute medical/ Haematology

4. Recent publications (title and reference); papers accepted for publication (references should indicate first and last pages), and details of project management experience.

Dickinson A (2003) The use of diaries to study the everyday food lives of older people. In: Bytheway B (Ed) Everyday living in later life. London: Centre for Policy in Ageing/Open University.

A Dickinson (2000) 'The effect of income on the food choices of older women: A quality of life issue?' In Dickinson A, Bartlett, H and Wade, S (Eds) *Old Age in a New Age*. Proceedings of the British Society of Gerontology 29th Annual Conference: 213-218.

Dickinson A, Bartlett, H and Wade, S (Eds) (2000) *Old Age in a New Age.* Proceedings of the British Society of Gerontology 29th Annual Conference.

Dickinson A (2001) Gender, food choice and quality of life. In. Tester S, Rowlings C and Turner S (Eds) *Quality in later life: Rights, rhetoric and reality.* Proceedings of the British Society of Gerontology 30th Annual Conference. Stirling: Univeristy of Stirling. 211-215.

Reports

Dickinson A, Cove J, Knapp N, & Windle K (2005): The Electronic Single Assessment Process: An Evaluation of Initial Implementation, Hertfordshire: University of Hertfordshire.

Widiatmoko D, Windle K, **Dickinson A**, Whetstone M, Cove J: 2005: Older People's Use of Accident & Emergency Services: Audit Findings: a working paper: University of Hertfordshire

Bunn F, Windle K, and **Dickinson A** (2005): Interventions for preventing falls and fall related injuries in older people: A mapping exercise. Hertfordshire: University of Hertfordshire.

Bunn F, Windle K, and **Dickinson A** (2005): Interventions for reducing unplanned hospital admissions in older people: A mapping exercise. Hertfordshire: University of Hertfordshire.

Machen I, **Dickinson A**, Widiatmoko D, Williams J, Kendall S. Nurses and Paramedics In Partnership: An Evaluation: Report

Forthcoming: Dickinson A, Welch C, Ager L and Costar A. Hospital Mealtimes: Action research for change? In Proceedings of the Nutrition Society.

Submitted: Dickinson A. The Single Assessment Process: Operationalising the policy, opportunities and challenges

1. Surname Forename(s) Age

Henderson Catherine D.o.B.: 01/09/65

2. Degree, etc (subject, class, university and date)

BA English Literature, University of Toronto, Canada, 1987

BSc Occupational Therapy, University of Toronto, Canada, 1991

MSc Health Policy, Planning and Financing, London School of Economics / London School of Hygiene and Tropical Medicine, 2002

3. Posts held (with dates)

November 2002 – December 2005: Research Officer, LSE Health and Social Care, London School of Economics
July 2002 - October 2002: Research Assistant, LSE Health and Social Care

December 1998 – September 2001: Senior I Occupational Therapist, Bridging Team, Chelsea and Westminster Hospital, London SW10
December 1996 - December 1998: Staff Occupational Therapist, Occupational Therapy Team, Waltham Forest Social Services, Chingford, London E4

June 1996 - November 1996: (Contract) Senior I Occupational Therapist, Middlesex Hospital, Camden and Islington Community Health Services NHS Trust, London

December 1994 - April 1996: Occupational Therapist – half-time Adult Team and half-time Disabled Children Team, Avon Social Services Department, Bristol, BS13

Otober 1993 - September 1994: Occupational Therapist, Geriatrics Programme, West Park Hospital, Toronto, Ontario, Canada

January - October 1993: Occupational Therapist, Continuing Care Programme, West Park Hospital (Half-time position, concurrent with COTA position, see below)

July 1992 - October 1993: Community Occupational Therapist (Part-time), Community Occupational Therapists and Associates, Toronto, Ontario

December 1991 – May 1992: Locum Occupational Therapist, Neurological Rehabilitation, West Park Hospital, Toronto, Ontario

4. Recent publications (title and reference); papers accepted for publication (references should indicate first and last pages), and details of project management experience.

Henderson, C., & Knapp, M. (2003). UK: an annotated bibliography. In H. Anheier (Ed.), *Social Services in Europe, ISS Observatory for the Development of Social Services in Europe*.

Henderson, C. (2003). *The costs of supporting people with dementia in nursing homes* (No. 9): Centre for the Economics of Mental Health and the PSSRU.

1. Surname	Forename(s)	Age
Knapp	Martin	DoB: 08/08/52

2. Degree, etc (subject, class, university and date)

BA, Economics and Pure Mathematics (first class honours), University of Sheffield, 1973

MSc, Econometrics and Mathematical Economics, London School of Economics, 1975

PhD, Social Policy, University of Kent, 1980.

Elected Academician of the Academy of Learned Societies for the Social Sciences, 2002

3. Posts held (with dates)

London School of Economics and Political Science (since 1996)
Professor of Social Policy
Director, Personal Social Services Research Unit (PSSRU)
Chair, LSE Health and Social Care
Chair, PSSRU Executive Group (covering LSE, Kent and Manchester branches of PSSRU**)**

Institute of Psychiatry, King's College London (since 1993)
Professor of Health Economics
Director, Centre for the Economics of Mental Health (CEMH)

University of Kent, 1975-1995
Research Fellow, Senior Research Fellow, Reader, Deputy Director, PSSRU
Professor of the Economics of Social Care (from 1990)
Lecturer in Economics (1979-89)

4. Recent publications (title and reference); papers accepted for publication (references should indicate first and last pages), and details of project management experience.

Wistow, Knapp, Hardy, Forder, Kendall, Manning (1996) Social Care Markets: Progress and Prospects, Open University Press, Buckingham

Knapp, Hardy, Forder (2001) Commissioning for quality: ten years of social care markets in England, Journal of Social Policy, 30, 2, 283-306.

Wittenberg, Sandhu, Knapp (2002) Funding long-term care: the public and private options, in Mossialos et al (eds) Funding Health Care: Options in Europe, Open University Press

Kendall, Matosevic, Forder, Knapp, Hardy, Ware (2003) The motivations of domiciliary care providers in England: new concepts, new findings, Journal of Social Policy, 32, 489-511.

Ware, Matosevic, Hardy, Knapp, Kendall, Forder (2003) Commissioning care services for older people - the view from care managers, users and carers, Ageing and Society, 23, 411-428.

Forder, Kendall, Knapp, Matosevic, Hardy, Ware (2004) Prices, contracts and motivations: institutional arrangements in domiciliary care, Policy and Politics, 32, 2, 307-322.

Knapp, Forder, Kendall, Pickard (2004) The growth of independent sector provision in the UK, in Harper (ed) The Family in an Ageing Society, Oxford University Press, Oxford

1. Surname Forename(s) Age

Roe Brenda 48

2. Degree, etc (subject, class, university and date)

Degree Type	Degree Class	Subject	University	Year
BSc	2:2	Human Biology	Oxford Brookes	1979
RN		General Nursing	The Nightingale School, St Thomas' Hospital	1982
MSc	Research	Geriatric Medicine	Manchester	1986
PhD	Research	Geriatric Medicine	Manchester	1989
BSc	2:1	Community Health	MMU	2002
RHV		Health Visitor	MMU	2002

3. Posts held (with dates)

Institution	Position held	Start/ End date
Liverpool John Moores University	Professor of Health Sciences	4/4/2005 -
University of Keele	Senior Lecturer in Social Gerontology	6/2001-3/2005
North Cheshire NHS Hospitals Trust	Non-Executive Director	5/2001– 1/2003
Various Contract Research	Independent Consultant	2001
University of Washington, Seattle	International Visiting Scholar	2/1999-02/2000
North Cheshire Health	Non-Executive Director	1996-1998
London School of Hygiene and Tropical Medicine	Visiting Research Fellow	2/1997-4/1997
Liverpool John Moores University	Professor of Public Health	3/1996-12/1996
University of Oxford	DoH Senior Research Fellow	1993-1996
University of Liverpool	Lecturer in Nursing	1990-1993
National Institute for Nursing, Oxford	Visiting Senior Research Fellow	1992-1993
University of Manchester	Lecturer in Nursing	1988-1990

Plus various clinical and research posts previously held

4. Recent publications (title and reference); papers accepted for publication (references should indicate first and last pages), and details of project management experience.

Selection Since 2001

Books, Chapters, Reports

Roe B., Beech R. (2005) Intermediate and Continuing Care: Policy and Practice. Oxford, Blackwells Publishing.

Fonda, D., DuBeau. C.E., Harari, D., Ouslander, J.G., Palmer, M., Roe, B. (2005) *Incontinence in the Frail Elderly.* In Abrams, P, Cardozo, L.,Khoury, S., Wein, A. (Eds) Third International Consultation on Incontinence. 26-29 June 2004 Monaco. Health Publication Ltd, Plymbridge Distribution Ltd, Plymouth. Chp18.pp1163-1239.

Roe, B. (2005) Service Development and Evaluation in Intermediate Care. In Roe B., Beech R. (Eds) Intermediate and Continuing Care: Policy and Practice. Chapter 5. Oxford, Blackwells Publishing.pp61-77.

Roe, B., Beech, R. (2005) Implications for Policy and Practice: The Future. In Roe B., Beech R. (2005) Intermediate and Continuing Care: Policy and Practice. Chapter 17. Oxford, Blackwells Publishing.pp259-270.

Papers and Systematic Reviews

Roe, B,H. Wilson, K., Doll, H. (2001*) Public Awareness and Health Education: Findings from an Evaluation of Health Services for Incontinence*. International Journal of Nursing Studies. 38, 79-89.

Roe, B., Moore, K. (2001) *Implementation of Clinical Practice Guidelines on Incontinence*. Journal of Wound Care, Ostomy and Continence Nursing. 28, 6, 297-304.

Eustice, S., Roe, B., Paterson, J. (2002) *Prompted Voiding for the Management of Urinary Incontinence in Adults (Cochrane Review)*. In The Cochrane Library. Issue 2. Update Software, Oxford

Roe, B., Whattam, M., Young, H., Dimond, M. (2001) *Elders' Needs and Experiences of Receiving Formal and Informal Care for their Activities of Daily Living.* Journal of Clinical Nursing. 10,3, 389-397.

Roe, B., Whattam, M., Young, H., Dimond, M. (2001) *Elders' Perceptions of Formal and Informal Care: Aspects of Getting and Receiving Help for Activities of Daily Living.* Journal of Clinical Nursing. 10, 398-405.
Roe, B., Whattam, M., Young, H., Dimond, M. (2001) *Healthcare Care Research Agendas for Older People: An international Comparison.* Nursing Older People. 13,9, 14-16.
Roe, B. (2002) *Protecting Older People from Abuse.* Nursing Older People. 14, 9, 14-17.
Roe, B. (2002) *Alleviating* D*epression in Older People.* Primary Health Care. 12,10, 35-37.
Roe, B., Daly, S., Shenton, G., Lochhead, Y. (2003) *Development and Evaluation of Intermediate Care.* Journal of Clinical Nursing. 12, 341-350.
Walsh, N., Roe, B., Huntington, J. (2003) *Delivering a Different Kind of Primary Care: Nurses Working in PMS Pilots.* Journal of Clinical Nursing. 12, 333-340.
Michael ,A., Roe, B. (2004) *The Social Theories of Ageing*. Geriatric Medicine. August, 11-14.
Wallace, S., Roe, B., Williams, K., Palmer, M. (2004) *Bladder Training for Urinary Incontinence in Adults (Cochrane Review).* In The Cochrane Library. Issue 1. Update Software. John Wiley and Sons Ltd, Chichester.
Ostaszkiewicz, J., Johnson, L., Roe, B. (2004) *Timed Voiding for Urinary Incontinence in Adults (Cochrane Review).* In The Cochrane Library. Issue 1. Update Software. John Wiley and Sons Ltd, Chichester.
Ostaszkiewicz, J., Johnson, L., Roe B. (2004) *Habit Training for Urinary Incontinence in Adults (Cochrane Review).* In The Cochrane Library. Issue 2. Update Software. John Wiley and Sons Ltd, Chichester.
Roe, B., Watson, N.M., Palmer, M.H., Mueller, C., Vinsnes, A.G., Wells, M (2004) *Translating Research on Incontinence Into Practice.* Nursing Research. 53 Suppl, S56-S60.

Current research funding

Roe B with Howells F, Riniotis K, Kingston P, Beech R, Ong B, Crome P. Falls and Falls Narratives as the Basis for Service Delivery. University of Keele, £3.9K. 2003/2005.

Mason, L, Kozman E, Davies J, **Roe B**, Middleton L, Eaves C, Hampshire S. The Efficacy of Pelvic Floor Muscle Exercises in Preventing Postpartum Stress Incontinence: An RCT. Liverpool John Moores University £52.3K. 2005-2007.

Shaw C, Hood K, Williams K, Abrams K, **Roe B.** Systematic Review of Respite Care for Frail Elderly. NHS Health

Technology Assessment. £79.5K. 2005-2006.

Beech R, **Roe B**. Using Research to Support the Design and Evaluation of Services to Address Innovation Forum Targets in Cheshire. Cheshire County Council. £98K. 2005-2007.

Brenda Roe has held a total of £944,137 in research grants (£702,088 external awards and £242,049 internal awards) since 1987 on 18 projects (lead applicant on 10 projects) looking at clinical practice, organisation and service delivery and people's experiences of living with chronic conditions. Awards were from the Department of Health, World Health Organisation, Mersey Regional Health Authority, Oxford Regional Health Authority, The NHS Executive, Cheshire Community NHS Trust, The National Institute for Nursing, NHS Health Technology Assessment and Cheshire County Council.

1. Surname Forename(s) Age

Wagland Richard DoB 16/07/68

2. Degree, etc (subject, class, university and date)

Phd, 'Age, Equality and Cultural Oppression', Brunel University, 2005

MA Theory and Practice of Human Rights, Essex University, 2000

BSc Politics and Modern History, Brunel University, 1998

Registered Gengeral Nurse (RGN), 1989

3. Posts held (with dates)

August 2005 – present: Research Fellow, Centre for Research in Primary and Community Care, University of Hertfordshire

September 2002 – present: Part-time Lecturer in Political Theory, Brunel University

June 2000 – August 2005: Staff Nurse (Grade E), Sainsbury Ward, St Marks Hospital, Harrow, NW London NHST

Sept 1996 – June 1998: Staff Nurse (Grade E), Fred Salmon Ward, St Marks Hospital, Harrow

August 1994 – August 1995: Staff Nurse, Male Medical, Zamil Almana Medical Consortium, Yanbu al Sania, Saudi Arabia

August 1993 – July 1994: Theatre Nurse, Friedrichsheim Orthopaedic Hospital, Frankfurt a.M, Germany

July 1991 – August 1993: Staff Nurse (Grade D), Nayland Ward, Colchester General Hospital, Essex

Sep 1989 – July 1990: Sraff Nurse (Grade D), Mersea Ward, Colchester General Hospital, Essex.

4. Recent publications (title and reference); papers accepted for publication (references should indicate first and last pages), and details of project management experience.

Accepted for Publication

Wagland, R, ' A fair innings or a complete life? Egalitarian justifications of age discrimination,' in *Age and Justice* (ed.) A.H. Lesser, Rodopi (forthcoming)

Reports

Windle, K, **Wagland R**: (2005): Hertfordshire & The Innovation Forum: Improving the Future for Older People, Hertfordshire: University of Hertfordshire.

1. Surname Forename(s) Age

Wistow Gerald D.o.B: 09/09/46

2. Degree, etc (subject, class, university and date)

BA Social Policy, University of Hull, 1968
Cert. Ed., University of Wales (Cardiff), 1970
M..Soc. Sci. (Social Policy and Polcymaking), University of Birmingham, 1977

3. Posts held (with dates)

1975-1978 Lecturer in Social Policy, Newcastle-upon-Tyne Polytechnic
1978-1988 Research Fellow, Senior Research Fellow. Founding Deputy Director, Co-Director Centre for Research in Social Policy, University of Loughborough
1988- 1992 Senior Lecturer in Health and Social Care Management and Director of Community Care Unit, Nuffield Institute for Health, University of Leeds
1992- 1997 Professor of Health and Social Care, Head of Research and Head of Community Care Division, Nuffield Institute for Health, University of Leeds
1997-2003 Director, Nuffield Institute for Health, University of Leeds
2003- Research Professor (part time), University of Leeds
2004- Visiting Professor in Social Policy, London School of Economics
2001- Chair, Hartlepool PCT

4. Recent publications (title and reference); papers accepted for publication (references should indicate first and last pages), and details of project management experience.

More than 300 publications, including 14 authored/edited books, together with numerous research reports and working papers. As a Specialist Advisor to the House of Commons Social Services and Health Committees between 1990 and1999 (continuously), I helped draft numerous reports and briefing papers on a wide range of issues relating to policy, management and public expenditure in the NHS and Social Services. As Director or the Nuffield Institute and (from January 2001) Chair of a PCT, opportunities for publishing were limited but recent publications include:

Hardy B .and Wistow G (2000), 'Changes in the private sector' in Hudson B, The Changing face of private care, Jessica Kingsley

Herbert G, Townsend J, Ryan J, Wright D, Ferguson D, and Wistow G (2000) 'Rehabilitation Pathways for Older People', Universities of Leeds and York

Wistow G, (2000) 'The NHS Plan' Health Service Journal' 5727, pp26-27

Hardy B, Mur-Veerman I, Steenburgen M and Wistow G (2001) 'La collaborazionie tra servizi sociali e sanitari'in Servizi I Sociali in Europa: carateristrche, tendenze, probleme, Carrochi, Roma

Ware P, Matosevic T, Forder J, Hardy B, Kendall J, Knapp M and Wistow G (2001), Movement and Change: independent sector domiciliary care providers between 1995 and 1999' Journal of Health and Social Care in the Community, 9, 8, pp 334-340

Wistow G (2001), 'Modernisation, the NHS Plan and healthy communities' Journal of Management in Medicine, 15, 4, pp334-351

Wistow G, Waddington E and Chiu,L (2002) Intermediate care: balancing the system', Association of Directors of Social Services

Callaghan G and Wistow G (2002), 'Public and patient participation in primary care groups: new beginnings for old power structures?', University of Leeds

Wistow G (2002) The Future Aims and Objectives of Social Care, in Kendall L & Harper L, From welfare to well-being: the future of social care, Institute of Public Policy Research

Johnson P, Wistow G, Schulz R and Hardy B (2003), 'Interagency and interprofessional collaboration in community care: the interdependence of structures and values', Journal of Inter-professional Care, 17, 1, 69-83

Mur-Veerman I, Hardy B, Steenburgen M and Wistow G (2003), 'The development of integrated care in England and the Netherlands:managing across public-private boundaries',Health Policy'

Hardy B, Godfrey M and Wistow G, (2003) 'Integrated care for people with dementia' in van Raak A et al, Integrated Care in Europe, Elsevier

Appendix Q

Tender Document

DEPARTMENT OF HEALTH

NATIONAL EVALUATION OF THE PARTNERSHIPS FOR OLDER PEOPLE PROJECTS

CALL FOR PROPOSALS

1. INTRODUCTION

1.1 The Department of Health (DH) wishes to invite proposals for a national evaluation of the Partnerships for Older People Projects (POPP) which will be operational from May 2006[i]. This specification provides the background to the POPP initiative and its central aims and objectives. It sets out the research agenda and the key research questions, and describes the way in which the research will be commissioned and the criteria against which proposals will be assessed. A maximum of £300k will be provided for the work over a period of two and a half years.

2. BACKGROUND

2.1 The POPP initiative takes forward the central government policy of promoting the independence of older people. It supports the development of services that engage, enable and empower older people within a framework of partnerships between Local Authorities through Councils with Social Services Responsibilities (CSSRs), the local NHS, voluntary and independent sector organisations, and other key stakeholders. It signifies an important strategy as it:

- supports the objectives of the National Service Framework for Older People (2001) and provides a mechanism to meet Standard 8 – the promotion of health and active life in older age.
- continues the theme of partnership work developed under the Promoting Independence Grant (LAC [2000]6) – 2001/2
- offers a process to work towards the Public Service Agreement (PSA) targets of:
  - increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008;
  - increasing by 2008, the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care; and
  - reducing emergency bed days by 5% by 2008 (from the expected 2003/04 baseline)[ii].

2.2 The POPP initiative was launched in March 2005 with ring-fenced central government funding of £60m (£20m in 2006/07 and £40m in 2007/08) for CSSRs to develop innovative pilots to help older people avoid emergency hospital visits and to live independently for longer[iii]. CSSRs were invited to submit bids for funding for either one or two years (see 2.3 below) during the period April 2006 – March 2008 (based on the Older Peoples' Formula Spending Shares[iv]) to develop council-led partnership pilots that demonstrate ways of supporting older people in leading active and healthy independent lives.

2.3 Funding for POPP pilots is to be allocated in two stages. Round 1 will fund up to twenty pilots which will be expected to be up and running by May 2006 and to be operational for two years. Guidance on applications for Round 2 pilots – to receive funding for one year only - will be issued in March 2006. It is anticipated that an additional sixteen pilots will be operational by May 2007.

2.4 The Prospectus for Grant Applications for POPP [v] reinforces the centrality of the partnership approach to ensure sustainable benefits that extend well beyond the period of the funding. It stipulates the requirement for a CSSR and a Primary Care Trust (PCT) to be co-signatories to the application and encourages the inclusion of local older people (and their 'Champions'), private and independent sector providers and NHS acute Trusts in the developmental and operational phases.

2.5 Central to the POPP ethos is the involvement of older people as key players in local partnerships which makes the initiative both important and exciting. The Prospectus acknowledges that many older people continue to enjoy a full and independent life and want to remain responsible for making the decisions that affect their lives for as long as possible; and at the same time, they want their cultural, ethnic and spiritual needs to be understood, respected and met [vi]. However, it also acknowledges that there are some older people who remain 'hidden' and unsupported; for example, older people who are isolated and live alone, those at risk of - or suffering from - mental illness, and people with specific needs based on their culture and race.

2.6 The aim of the POPP initiative is to test and evaluate innovative partnership and financial approaches which, through locally appropriate pilots, enable older people to enjoy independence and an improved quality of life, with the following outcomes:

- better health and well-being facilitated through the provision of low level care and support in the community, thus avoiding admission to hospital prematurely, and delaying the need for higher intensity and more costly care;
- reduced avoidable, emergency admissions and/or bed-days, with older people only staying in hospital for as long as clinically necessary;
- appropriate discharge from hospital and the receipt of support from community services at home or in sheltered or extra-care housing that, in turn, will prevent hospital re-admissions and/or the need for long-term institutionalised care.

2.7 The key principles of POPP are:

- a clear shift towards prevention and away from acute care, thus reducing reliance on hospital or other institutionalised care;
- a holistic partnership approach that enables the preventative focus to be sustained long-term and well beyond the duration of the grant;
- the involvement of older people and their carers within the local partnerships, so that the pilots are person-centred and integrated into existing provision;
- an approach that is inclusive of all older people, including those who are currently under-represented in - or not in touch with - local services (for whatever reason);
- the establishment of monitoring and evaluation systems which will support both local and wider learning through local and national evaluation.

2.8 In order to ensure that the maximum learning is achieved from the POPP initiative, DH has identified a budget within the £60m to support both local and national evaluation of the initiative. In this context, the following structures will be integral to POPP:

- Each pilot will be expected to build in – and allocate a budget to – a local evaluation which will assess the impact of the pilot (in the short, medium and long term) against locally agreed performance indicators and the relevant national PSA targets (see 2.1 above) [*]

[*] DH Guidance to CSSR bidders to POPP did not propose a set or pre-determined amount for the local evaluation budget: 'As with any commissioning exercise it can be approached either on the basis of a definition of the kind of research inputs required, or with a cost ceiling (e.g. 5% of the project costs available).'

- A member of DH's Change Agent Team, a member of the DH Care Services Improvement Partnership, will work with local pilots to agree a common data collection framework and reporting mechanisms. They will also be responsible for establishing a Project Lead Network (PLN) to facilitate the exchange of learning between POPP pilots and DH.
- A national evaluation, the role of which is defined later in this tender specification.

2.9 The final selection of Round 1 bids will be made in October 2005. It is anticipated that there will be a spread of pilots across England to include the spectrum of geographical locations, service delivery models, operational structures, and funding and partnership mechanisms. The inclusion of older people for whom accessing existing services is difficult will be implicit in all of them. The summary details of the forty-four bids short-listed at Round 1 bids (see Annex 2) demonstrates the innovative range of projects that have been proposed at a local level.

3. THE POLICY CONTEXT

3.1 Over the last five years, a number of policy initiatives have been introduced with the objective of improving older people's lives. POPP is important as it has been designed both to incorporate many of the key principles that support and underpin the current policy context, and also to inform it. The key policy areas are highlighted below.

3.2 The *NSF for Older People* (2001) [vii] promotes the independence and well-being of older people directly, with Standard 1 tackling age discrimination and Standard 8 promoting health and active life. The progress report (2003) reports that a greater number of people are now receiving care in their own home rather than going to a residential home or hospital; older people are being able to opt for direct payments, giving them greater choice over the services and equipment they need to enable them to stay in their home; the rate of delayed transfer of care has fallen dramatically; and substantial funding has been invested in developing integrated health and social care services through Health Act partnerships [viii] .

3.3 However, there are a small number of older people who are heavy users of NHS and social care services due to a single long-term condition, such as chronic obstructive pulmonary disease (COPD) or heart disease. The unpredictability of their condition may also result in them experiencing unscheduled or emergency care. It is recognised that dependence on - and usage of - high-cost services is unsatisfactory both for the older person who is unable to exercise choice over their life, and for service providers who face budget constraints. *The Long-term Conditions National Service Framework (NSF)*[ix] was launched in March 2005 with the aim to transform the way health and social care services support people to live with long-term neurological conditions. 'Key themes are independent living; care planning around the needs and choices of the individual; easier, timely access to services and joint working across all agencies and disciplines involved. It applies to health and social services working with local agencies involved in supporting people to live independently, such as providers of transport, housing, employment, education, benefits and pensions.'[x]

3.4 In January 2005, DH published *Supporting People with Long Term Conditions: An NHS and Social Care Model to support local innovation and integration* [xi]which provides information for local health and social care agencies on how they might successfully work towards the PSA target of reducing inpatient emergency bed days (see 2.1. above). A number of initiatives that help older people to better manage their chronic health conditions are currently being piloted. For example, nine PCTs are implementing a modified 'EverCare'

pilot (adapted from the US model) which involves nurses working together with GPs, hospital doctors and other care staff to bring the health and social care systems together to establish care pathways that can meet the complex needs of the most vulnerable older patients. An interim evaluation report was published in February 2005[xii]. In addition, eight pilot sites are developing local activity to transfer the relevant learning from the Kaiser Permanente model which has a strong focus on the holistic management of people with chronic diseases[xiii]. Other innovative schemes include an intensive case management approach, which aims to tackle a range of health and other issues; case finding, which aims to identify older people who may be approaching a time when additional input and support is needed to prevent admission to hospital; and assistive technology, which provides new opportunities for supporting people in different new ways.

3.5 In 2004, the Audit Commission produced a series of five linked reports under the title of *Older People - Independence and Well-being: the Challenge for Public Services*[xiv]. It acknowledges that 'a more proactive approach, focused on all the older person's concerns, can promote independence and well-being more effectively.' This can be achieved through focusing on 'upstream' interventions that aim to enhance well-being and to avert crises; adopting a whole-person approach which explores the issues that have an impact on older people's well-being, based on broad assessment processes; and by building a whole-system response**,** which includes the NHS, social services, housing, the pensions service and a range of other agencies.

3.6 In March 2005, two key strategic documents for the next 10 – 15 years, were published, both of which promote the principle of supporting older people (and other adults) to maintain their independence.

- *Opportunity Age - meeting the challenges of the 21st Century* [xv] (Department of Work and Pensions) emphasises the need to listen to the views of older people about the services they want and need, and to integrate the values of *active independence***,** *quality* and *choice* at all levels. Its programme includes a range of strategies that tackle inequality and support all older people to remain in their own homes. These include piloting individualised budgets; a simplified assessment process; a shifting of resources from high-level to lower-level care support; and an integrated visiting service offering a full, personal, overall check-up of their needs and entitlements.
- The DH Green Paper, *Independence, well-being and choice: our vision for the future of social care for adults in England* [xvi] sets out a vision for adult social care. Its intention is to provoke discussion on how service users can assume greater control and choice; how the whole community can be engaged in playing a full part in society and in accessing a comprehensive range of services when required; and how the skills and status of the workforce can be improved in order to deliver the vision. Complementing the DWP strategy, it calls for wider use of direct payments and individual budgets; a greater focus on preventative services and the well-being agenda to allow for early targeted interventions, greater social inclusion and improved quality of life; a partnership approach to the delivery of effective and well-targeted provision services which meet the needs of all communities; and the development of new and exciting models of service delivery.

4 THE NATIONAL EVALUATION OF POPP

4.1 The purpose of the POPP national evaluation is to provide a timely assessment of the effectiveness of the POPP initiative in achieving its aims and its contribution to meeting relevant PSA targets (see 2.1, 2.6 and 2.7 above). A central focus will be the extent to which

POPP has facilitated the establishment of effective, sustainable innovative pilots that shift the focus towards a preventative model of care and support older people through a partnership approach, thus resulting in greater independence for longer, an improved quality of life, and reduced use of high-cost hospital acute services and residential/nursing care.

4.2 The national evaluation will have a *formative* element in which the successful team will have the following roles: to support the function and evaluation of the individual POPP pilots through involvement in the PLN; to contribute to the development of a common data collection framework and reporting mechanisms; to feed back to the DH emergent findings on the processes surrounding the development, implementation and operation of POPP.

4.3 Its *summative* focus will involve an assessment of the effectiveness of the process, outputs and outcomes of the POPP pilots. It will include a rigorous analysis of data collected centrally and by the local evaluations in order to identify what factors and features of POPP work effectively and efficiently, together with answers to the questions Why? How? for Whom? And at What financial benefit?

4.4 The national evaluation will include the following activities*:*

- A brief literature review to inform and underpin the evaluation, to include a focus on older people, preventative models of care, partnership working and financial mechanisms, and the consequent benefits and satisfaction for participants[†];
- An analysis of impact and effectiveness, using data collected by the local POPP evaluation teams;
- An assessment of the critical factors that impact both positively and negatively on POPP pilots in respect of the partnership and financial approach; the engagement of 'hard to reach' older people; service delivery & operation; and organisational change;
- An account of the impact of POPP on the experience of older people, from the perspective of those using POPP pilots and those not accessing POPP pilots;
- A review of the different partnership and financial models adopted by POPP pilots, with an assessment of relative cost effectiveness, value for money, and impact on local budgets and resource allocation;
- A review of the different ways in which pilots have measured 'improved wellbeing' for older people and the effectiveness of these approaches to inform cross-government work on the development of credible well-being indicators;
- An analysis of the generalisability of different POPP models to non-POPP areas, and of transferable learning to inform preventative models and partnership approaches for other care groups;
- The outcomes from the POPP initiative and individual pilots, with an indication of how evidence of sustainable benefits beyond the lifespan of the designated funding can be captured.

5 INDICATIVE RESEARCH QUESTIONS

5.1 The following questions are indicative only. Applicants may wish to propose additional or alternative questions relevant the overall aims of the national evaluation.

5.2 <u>The effectiveness of partnership and financial arrangements:</u> How has the term 'partnership' been interpreted by the POPP pilots and to what effect on the range of different models? What are the key factors for a successful partnership and how are they achieved? How

[†] Annex 1 includes a selective bibliography of relevant reports and documentation.

effective are the partnerships and financial mechanisms in ensuring sustained investment in preventative approaches by health and social care partners?

5.3 The effectiveness of the preventative model of care: What different definitions of 'prevention' have been adopted by POPP pilots? To what extent does the POPP initiative demonstrate that prevention is both acceptable as an approach to older people, and how effective is it in reducing the burden on high cost health and social care services? Does prevention lead to 'improved well-being' for older people and how can this be measured? Does POPP as a national initiative differ from previous preventative initiatives in terms of their effectiveness? And if so, how and why? What have POPP pilots learnt/adopted from previous prevention initiatives? And to what effect?

5.4 The effectiveness of the PLN and shared learning: To what extent have the processes to support POPP pilots in integrating monitoring and evaluation been effective? Are there factors that have facilitated (and inhibited) the sharing and dissemination of learning within and beyond POPP? What lessons can be learnt for future initiatives of this nature?

5.5 The integration of POPP with other policy directives: In what way does POPP complement and support the current central government priorities (for example, a person-centred approach, integration between agencies, and shift from ill health to well-being)?

5.6 Mainstreaming and generalisability: To what extent have the CSSRs and local partnerships implemented mechanisms to mainstream and/or build on the local POPP experience? What are the key factors and hindrances to impact on the continuation or mainstreaming of pilots after the expiry of central government funding? To what degree is the learning transferable to other care groups?

5.7 The cost effectiveness of POPP: What evidence has been captured to demonstrate that POPP has led to the development and implementation of cost effective pilots that reduce the usage of high cost services? What are the strengths and limitations of the partnership models in facilitating cost effective approaches? How do POPP pilots compare with other (non-POPP) prevention pilots for older people in terms of offering value for money? What is the evidence that resources have been reallocated locally for other purposes?

6 METHODS

6.1 DH has no fixed assumptions about the nature of the evaluation to be undertaken, apart from the requirement that the methods selected are those best suited to the task outlined in this brief. Factors that applicants might take into consideration in drawing up a framework for the national evaluation are outlined below. The areas and examples are not intended to be exclusive but are offered only as guidelines.

6.2 Theoretical framework: A national evaluation of this nature requires the underpinning of a theoretic framework that is appropriate to evolving and shifting scenarios and also sensitive to the potential tension of conducting both a formative and summative evaluation. Whilst there are a variety of relevant evaluation theories, two models have been 'road-tested' in evaluations of this nature: they are the Theory of Change [xvii] and Realistic Evaluation[xviii]. Sullivan and Stewart epitomised the former thus: 'Central to a Theory of Change evaluation is the requirement that the evaluator 'surface' the implicit theory of action inherent in a proposed intervention in order to delineate what *should* happen if the theory is correct, and to identify short, medium and long term indicators of changes which can provide evidence

on which to base evaluative judgement[xix]'. Realistic Evaluation aims to clarify how a problem can be affected by an initiative. The approach considers 'the Contexts (the local, regional and national environments) within which …. projects are working; the Mechanisms or interventions involved….; and the intended Outcomes (or impact) that … projects are hoping to achieve as a result of their work[xx].' Models that combine elements of both approaches have also been used: 'The hybrid approach of realistic evaluation and the theories of change model offered a powerful combination for exploring important questions and lessons across a number of diverse pilots, contexts and populations[xxi].' Applicants need to be explicit about the theoretical underpinning for the evaluation (with a justification for their choice), and describe how they might address any tension between the formative and summative element.

6.3 Involvement of older people: Older people are partners, participants and beneficiaries of this evaluation. Consideration should be given to how older people can participate in the development of research instruments, in defining research questions, in advising on and (where appropriate) participating in the conduct of the research, and in the dissemination of its findings. Some older people may need support, additional knowledge or skills to enable them to become involved and/or to participate effectively. Within their proposals, applicants should demonstrate how older people will be involved in an appropriate way.

6.4 Pre/post intervention dimensions to assess change over time: The nature and magnitude of change is likely to vary depending on the area or topic under scrutiny, and collection of both quantitative and qualitative data will be required. A review of Hospital Episode Statistics (HES)[xxii], the 'national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere[xxiii]', may provide a useful baseline against which progress towards the POPP objectives can be measured and monitored. Similarly, rates of admissions and usage of local nursing and care homes for older people can be verified and checked with data regularly submitted by local authorities to DH and made available on its website[xxiv]. 'Ante' and 'post' interviews with older people in touch with POPP pilots can help measure the degree of satisfaction gained from involvement in POPP pilots. Proposals should include information about how change will be measured and analysed within the evaluation.

6.5 Cost-effectiveness of POPP: Since one of the aims of POPP is to reduce the use of high-cost services, the evaluation will need to assess the impact of pilots on the budgets for health and social care agencies responsible for the delivery of costly hospital inpatient and residential/nursing home facilities. The findings from the Innovation Forum Health Project evaluation - where nine 'excellent' local authorities are working to reduce emergency hospital admissions by 20% over a three 3-year period - may be useful[xxv]. DH will be looking for examples of research methods that can measure and quantify the cost-effectiveness of the POPP preventative approach.

6.6 Evaluation methodologies: It is likely that a national evaluation of this nature will require a wide range of methods and techniques in order to measure impact not just on individuals and populations but also on structures and organisations. A multi case study approach may also be necessary to examine the interplay between process and context in POPP pilot sites. The experiences of similar evaluations have shown the need for 'qualitative and quantitative measures that accurately and sensitively capture impact for individuals and populations…. (N)umber-based targets are not able to demonstrate the richness of the work that unfolds; they don't give the essential insights into the local experiences of practitioners, managers, organisations and older people – and these experiences are important aspects of developing and sustaining different approaches to improvement. 'Discovery interviews' and illustrative

case studies can however be effective in providing this kind of qualitative data[xxvi].' The proposals will need to describe and justify the choice of evaluative methods to be adopted.

6.7 The development of a minimum dataset: The development of complementary and comparable datasets will facilitate the learning from this initiative. 'It is very difficult to draw clear conclusions unless there is a common monitoring framework which yields common, comparable data. The attempt to develop a common framework is bedevilled by the tendency to require too much information and overcomplicate the exercise, which builds up resistance to cooperation in the data collection and can sometimes affect service delivery[xxvii].' The recently published DWP report, *Opportunity Age* [xxviii] includes a proposed 'Quality of Life domains' and a suggested 'balance scorecard' for older people. The Audit Commission's work around Area Profiles is testing the feasibility of producing profiles of the quality of life and public services in a local area to help bring together sources of relevant data, information and assessments. 'An Area Profile places strong emphasis on people and place and on issues that cut across traditional service boundaries - for example, a complete picture of the needs of specific sectors of the community such as children or older people [xxix].' The successful bidder will be expected to work with the Change Agent Team and the local POPP pilots (via the PLN) in defining and implementing mechanisms for the routine collection of data. The characteristics of a dataset together with the process for negotiating and agreeing its local implementation should be included in proposals.

6.8 Interface with the local evaluations: In many respects, the partnership that will need to be established between the national, local evaluation teams and the Change Agent Team will reflect the partnership work that will be central to the local POPP pilots. Recent national evaluations have demonstrated the importance of an explicit relationship between national and local evaluation teams, especially where the former has the additional role of providing support to the implementers of the latter. The HDA-funded evaluation[xxx] of eight pilots focusing on improving the health of people in their mid-life identified the need for clarity of purpose and role of the different functions, with agreed 'appropriate division of labour between national and local evaluators'. The Innovation Forum evaluation has stressed the need to invest time in developing a relationship of mutual trust and confidence with local and national evaluation teams in order to develop a partnership approach that reflects the demands and requirements of the pilots themselves[xxxi]. Proposals will need to describe the nature of the relationship between the local and national evaluation, the differentiation of roles (including the balance between the national evaluation team being 'doers' of the evaluation and 'directors' of the local evaluation teams), and the process by which the partnership will be developed and established.

6.9 Liaison with other complementary research and evaluations: In order to avoid duplication and to maximise learning, the successful team will need to liaise with other research and evaluation projects that have complementary aims, objectives and foci; for example, the evaluation of the Innovation Forum (see 6.5 above); the evaluation of the Care Services Improvement Partnerships and of the New Mental Health Workforce evaluation (both scheduled to commence in the autumn 2005); and the proposed DH research into emergency care (scheduled to commence during 2006). Other research projects are likely to come on stream during the course of the lifespan of POPP.

6.10 Flexibility: The characteristic of POPP as a new national initiative with 'built-in learning' for local pilots during their operation needs to be reflected in a flexible approach to the national evaluation. 'Having a monitoring framework and arrangements that meet central and local reporting needs is key. Having one that can change and adapt over time is

especially crucial for sustaining local enthusiasm and ownership[xxxii].' Applicants will need to demonstrate the extent to which flexibility is built into the proposed evaluation protocol.

7 THE EVALUATION TEAM

7.1 Due to the range of evaluation aims and activity, and the need for flexibility, the successful team is likely to contain a wide range of disciplines and experiences, including:

- the application of qualitative and quantitative research methods;
- case study and participative evaluative approaches;
- welfare economics;
- health and social care services research;
- service delivery and organisation;
- knowledge of the theoretical grounding of local health and social organisations, local strategic partnerships, including data systems, cultures, care pathways, and range of local services;
- working with service users as partners in developing and implementing the evaluation framework and questions.

8 RESEARCH GOVERNANCE

8.1 Day to day management of the work will be provided by the lead evaluators and they and their employers should ensure that they identify, and are able to discharge effectively, their respective responsibilities under the *Research Governance Framework for Health and Social Care* (Department of Health, 2001). All research involving NHS service users/carers, staff, data and/or premises must be approved by a NHS LREC or MREC. DH will assume the responsibility of sponsor under the RGF.

9 EVALUATION STEERING GROUP

9.1 The national evaluation will be overseen by a steering group comprising representatives from DH, the Change Agent Team and other key stakeholders. This group will meet periodically - as determined by appropriate milestones - over the lifetime of the evaluation in order to provide overall project management, advice and support to the evaluation team.

10 EVALUATION TIMETABLE AND OUTPUTS

10.1 The evaluation will be funded for two and a half years. Data collection should cover the operation of POPP pilots for two years from May 2006 to the end of March 2008. Applicants should include a time chart which identifies milestones for the evaluation.

10.2 The evaluation team will be expected to provide written progress reports to the steering group on a six-monthly basis over the lifetime of the pilot, with an interim report at the end of Year One. In addition to describing progress, these reports will indicate any significant changes to the agreed protocol. They will also report on emergent findings from the formative stage of the evaluation. This stage may also involve a series of meetings and presentations with stakeholders, as discussed and agreed with the evaluation steering group (see 9 above).

10.3 A final report of the evaluation, with an accessible executive summary, will be required on an agreed date, following the completion of the data analysis and within the period of funding. This will be peer reviewed. Efforts should be made by the evaluation team to ensure that all outputs, apart from those that are to appear in academic texts, should be comprehensible to an informed lay audience.

11 COMMISSIONING AND SUBMISSION PROCESS

11.1 The commissioning process will be a single stage process in which applicants will submit a *full proposal*. These will be sent for external peer review and the completed assessment reports will inform the recommendations of the independent Commissioning Panel (comprising external experts, DH policy and Policy Research Programme colleagues) as to which proposals fundable. Service users will be involved as peer reviewers and members of the Commissioning Panel. Applications should therefore include a separate one-page (maximum) accessible lay summary to accompany their proposal. Proposals will be judged against the following criteria:

- scientific excellence;
- ethical soundness;
- policy and service relevance;
- feasibility;
- the track record and experience of the proposed team;
- value for money;
- quality of service user involvement.

11.2 Applicants with direct involvement in a local POPP pilot will need to be explicit about how they would manage any conflict of interest.

11.3 DH is unable to answer individual questions and queries concerning this tender. However, a briefing seminar has been organised for potential applicants on Friday, 16 September in Leeds. Details and registration form can be found on the automated electronic acknowledgement received with this document attached (prp-call@dh.gsi.gov.uk).

11.4 Twelve copies of the full proposal, together with an electronic application, must be received by **2pm on Wednesday, 26 October 2005.** One copy must have original signatures.

11.5 The email application may be sent in advance but must be followed up within two days by the paper copies. They must differ in no way from the electronic submission. Late applications, and applications via fax or in hand writing, will not be acceptable.

11.6 The outcome of the commissioning process will be made available in January 2006 and the successful team should be able to start the evaluation by 1 April 2006.

September 2005

[i] See the POPP website:
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/OlderPeopleArticle/fs/en?CONTENT_ID=4099198&chk=5OV7NB
[ii] See http://www.hm-treasury.gov.uk/performance
[iii] Department of Health, Press release 3 March 2005

[iv] Formula Spending Shares (FSS) were introduced in 2003/04 and replaced the Standing Spending Assessments (SSAs).
[v] Department of Health, Partnerships for Older People projects, A Prospectus for Grant Applications, March 2005, Page 4 – 5.
[vi] Department of Health, Partnerships for Older People projects, A Prospectus for Grant Applications, March 2005, Page 5 - 6.
[vii] Department of Health (2001), **National Service Framework for Older People**, Executive summary
[viii] Department of Health (2003), **National Service Framework for Older People**, Progress, page 22
[ix] Department of Health (2005), **The Long Term Conditions National Service Framework**
[x] http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/LongTermConditions/fs/en
[xi] Department of Health (2005), **Supporting People with Long Term Conditions: An NHS and Social Care Model to support local innovation and integration**
[xii] Boaden, R. *et al* (2005), **Evercare evaluation interim report: implications for supporting people with long-term conditions, t**he National Primary Care Research and Development Centre, 19 January 2005.
[xiii] See Matrix research and consultancy, (2004) **Learning distillation of Chronic Disease Management programmes in the UK,** The Modernisation Agency
[xiv] Audit Commission (2004), **Older People - Independence and Well-being: The Challenge for Public Services** (www.audit-commission.gov.uk/older people)
[xv] Department of Work and Pensions (2005), **Opportunity Age – meeting the challenges of the 21st Century,** March 2005
[xvi] Department of Health, **Independence, well-being and choice: our vision for the future of social care for adults in England,** March 2005
[xvii] Chen, H.T. (1990) **Theory Driven Evaluations**, London, Sage
[xviii] Pawson, N, & Pawson, R, (1997), **Realistic Evaluation,** London, Sage
[xix] Sullivan. H, & Stewart, M. (2004), **Who owns the Theory of Change?**, paper submitted to Evaluation, 2004
[xx] The Older People's Programme (2003) **A Journey of Improvement: Lessons and experiences from using the collaborative methodology in improving older people's services across 12 London boroughs,** Institute for Applied Health and Social Policy, Kings College, London
[xxi] Bowers, H, *et al*, (2003) , **The gap years: rediscovering mid-life as the route to healthy active ageing**, London, Health Development Agency, page 35
[xxii] http://www.hesonline.nhs.uk
[xxiii] http://www.dh.gov.uk/PublicationsAndStatistics/Statistics/HospitalEpisodeStatistics/fs/en
[xxiv] http://www.dh.gov.uk/PublicationsAndStatistics/Statistics/fs/en
[xxv] Reference IDeA Website/Wistow
[xxvi] Lessons from the London Older People's Service Development Programme. See: http://www.london.nhs.uk/modernising/olderpeople.htm
[xxvii] Private communication between Help the Aged and the Department of Health
[xxviii] See Annex 1 for details
[xxix] http://www.areaprofiles.audit-commission.gov.uk/
[xxx] Bowers, H, *et al*, (2003) , **The gap years: rediscovering mid-life as the route to healthy active ageing**, London, Health Development Agency
[xxxi] Private communication with lead researcher.
[xxxii] Lessons from the London Older People's Service Development Programme. See: http://www.london.nhs.uk/modernising/olderpeople.htm

ANNEX 1

Selected Bibliography

This annex includes details of a selection of recent reports and documents which are relevant to POPP and its evaluation. Reference to other relevant reports can be found in the main section of this Call for Proposals. It is not intended to be an exhaustive list.

A Journey of Improvement: Lessons and experiences from using the collaborative methodology in improving older people's services across 12 London Boroughs, Bowers, H., et al, Institute for Applied Health and Social Policy, Kings College, London, 2003

All Our Tomorrows: A joint discussion document on the future of services for older people, ADSS and LGA, October 2003

Better health in Old Age: Report from Professor Ian Philp, National Director of Older People's Health to the Secretary of State, 2 November 2004

Breaking down barriers: integrating health and care services for older people in England, Glendinning, C., Health Policy, 65: 139 – 151, 2003

Conceptualising 'successful' partnerships, Bowling, B., Glendinning, C., Powell, M., Health and Social Care in the Community, 12, 4: 309 – 317, 2004

Excluded Older People, Social Exclusion Unit Interim Report, ODPM, 2005

Learning from Health Action Zones¸ Judge K., and Bauld, L., Aeneas Press, Chichester, 2004

Leaving Hospital – the price of delays, Commission for Social Care Inspection, October 2004

Living well in later Life: From Prevention to Promotion, Wistow, G. et al, 2003

Older People - Independence and Well-being: The Challenge for Public Services, Audit Commission, 2004

Older people and their Use of Services (OPUS): National evaluation of costs and outcomes of intermediate care services for older people, Department of Health Policy Research Programme

Opportunity Age – meeting the challenges of the 21st Century: *Annex 1: Assessing the quality of life of older people: the outcomes we want and the indicators that matter*, Department of Work and Pensions, March 2005

Outcomes of Social Care for Adults (OSCA) projects: Messages for policy and practice, Henwood, M., and Waddington, E., Nuffield Institute for Health, 2002

Partnership working in public policy provision: A framework for evaluation, Asthana, S., Richardson, S. and Halliday, J., Social Policy and Administration 36/7, pp. 780 – 797, 2002

Promoting Wellbeing and Independence with Older People, Audit Commission and Better Government for Older People, 2003

Reducing Hospital Admissions of Older People, Innovation Forum Health Theme, Wistow, G., 2005

Strong Theory, Flexible Methods: Evaluating complex community-based initiative, Judge, K. & Bauld, L., Critical Health Policy, 11, 1, 19 - 38

Supporting People with Long Term Conditions – An NHS and Social Care Model to support local innovation and integration, Department of Health, January 2005

The gap years: rediscovering mid-life as the route to healthy active ageing, Bowers et al, 2003

The Working Partnership, Markwell, S., Watson, J., Speller, V., Platt, S., and Younger, T., Health Development Agency, 2003

What is a Successful Partnership and How Can it be Measured?, Hudson, B., & Hardy, B., in Glendinning, C., Powell, M., & Rummery, K. (eds), Partnerships, New Labour and the Governance of Welfare, pp. 51 – 65, The Policy Press, Bristol, 2002.

ANNEX 2

POPP INITIATIVE
Summary of POPP project bids short-listed at Round 1

The purpose of this paper is to provide flavour of the approaches proposed by the forty-four applications that were short-listed for POPP Round 1 (May 2006 – March 2008). It is not intended to be exhaustive. Twenty applications will be selected for funding in October 2005.

The Client Group
Many of the bids have focussed specifically on addressing the needs of older people with mental health problems. One bid has focussed on those at risk of experiencing a stroke. The rest are targeted at older people in general.

Examples of how POPP projects will improve access through partnership work:

- through single points of access
- proactive approaches (e.g. case finding)to identify those likely to be at risk
- establishment of special pro-active 'prevention teams' to identify those at risk and to undertake care planning / case co-ordination to address people's needs
- different approaches to assessment (e.g. extension / development of SAP)

Examples of how partnership work will impact on new approaches to Service Delivery in POPP projects:

- integration of teams or services
- organising services with a neighbourhood focus
- increased partnership working, including extending partnerships beyond health and social care to include housing, fire, police etc
- bringing about a cultural change through the training of staff – often including users and carers in order to provide an inter-generational focus
- involving older people in planning and/or managing services
- provision of volunteering / employment opportunities for older people and by providing 'services for older people by older people'
- creating links with Long Term Conditions work, including the new Community Matrons
- training of mainstream services to meet the needs of older people with mental health problems
- development of more effective, often integrated, pathways
- development of generic health/social care domiciliary workers

Examples of preventative services to be developed in partnerships:

- intermediate care (e.g. rapid response/step down)
- resource centres
- practical help (gardening, small tasks etc)
- extra care housing
- telecare / telemedicine
- healthy living / lifestyle programmes
- Peer support, including Expert Patient / Carer, befriending schemes
- Supporting People services
- specialist home care (esp in relation to older people with mental health)

- day service reconfiguration
- information, advice, advocacy, benefits/income maximisation
- home safety / environmental checks
- falls prevention
- web access (e.g. silver surfers)
- inter-generational programmes (e.g. reminiscence work, community safety/fear of crime etc)
- assisted discharge / settling in schemes
- Emergency Practitioner Service (i.e. triage and diversion from Ambulance and A&E usage)

Examples of innovation within POPP projects:

- 'whole systems re-focussing
- recruitment of network of volunteer senior mentors to provide peer support
- work with universal service providers to promote take up of mainstream services
- new model of social care based on entitlement (eg individual budgets, assisted brokerage, and self directed care)
- entitlement model to accessing universal services (advice, transport, lifelong learning, leisure etc)
- electronic self assessment and 'assisted self assessment' provided by range of voluntary organisations
- mixed tenure extra care housing
- developing voluntary sector capacity
- staff exchange programme between agencies
- paid support to develop a network of older people to advise on service development and monitoring of delivery
- creation of an 'expert' multi-disciplinary community based team to facilitate transfer of 'expert knowledge and skills' in acute hospitals and mental health trusts into the community
- incentivising nursing homes to provide short term care that supports people to return home after spell in hospital
- model based on Sure Start model
- proactive approach to helping people at times of difficulty through use of a Life Events pathway
- Carers 'chat room'
- 'rewarding innovation' annual award
- 'twinning' of experienced social workers with Community Matrons
- telephone club / virtual day centre
- 'fresh start centres' with high street / extra care housing presence with case finding and outreach and deliver of clinical assessment on site for equipment and telecare
- multi-agency 'service re-design team' jointly managed by health and social care
- 'Volunteer Community Warden' to act as "a front line trigger for health and social care intervention"
- integrated locality teams with staff seconded from statutory sector to work alongside voluntary sectors organisations
- locality based project steering groups comprising older people with remit to plan a two year strategy for each locality
- peer sign posting service with 'person centred planning' approach and a 'method of tracking' the health and well being of older people
- Intergenerational Active Ageing Programme to encourage younger and older people to be involved in same activities
- engage leisure and fitness industry to develop exercise programmes for high risk housebound

- ‘navigator service’ (commissioned from the voluntary sector) to visit those not meeting higher end eligibility criteria, to assess (using SAP and home safety checklist), with the ability to commission directly from a pre-agreed menu of preventative services
- older people’s leadership project by developing ‘community neighbourhood leaders’ to act as focus of community sector and to provide critique and support to service development with statutory sector
- ‘Ward in the Community’ model, which expands beyond Community Matron to facilitate multi-disciplinary approach, bringing different disciplines together in the community
- social enterprise scheme offering wide range of preventative support (eg from accompanying to hospital appointment through to putting up curtains)
- provision of ‘talking therapies’ to older people suffering from anxiety, depression and dementia with particular emphasis on recruitment and training of people from BME to enable talking therapy to be provided in appropriate language
- expansion of programme of older volunteers who pass information by word of mouth thus creating a ‘network’ of information to increase participation in local community
- investment in sustainable community networks beyond health and social care to include those whose work includes regular contact with older people (housing, pension service, fire service, post office, utilities and retail)
- in partnership with RoSPA, the development of accreditation schemes for care and support providers and others, promoting ‘fitness involvement, safety (emphasising accident and falls prevention work) and health’ - to apply to hospital settings; care homes; GP Practices; community health and social care; housing and support.

September 2005

Appendix R

Community / Hospital Facing Projects

Number of projects categorised as hospital/ community facing: Round 1 sites

Pilot Site	Community Facing	Hospital Facing	Total Projects
Bradford	3	2	5
Brent	1	0	1
Camden	6	2	8
Dorset	3	0	3
East Sussex	7	7	14
Knowsley	6	0	6
Leeds	7	3	10
Luton	3	1	4
Manchester	3	0	3
Norfolk	5	4	9
North Lincolnshire	1	0	1
North Yorkshire	4	5	9
Northumberland	5	1	6
Poole	1	1	2
Sheffield	5	1	6
Somerset	2	0	2
Southwark	0	2	2
Wigan	14	0	14
Worcestershire	3	0	3
Total	79 (72%)	29 (28%)	108 (100%)

Number of projects categorised as hospital/ community facing: Round 2 sites

Pilot Site	Community Facing	Hospital Facing	Total Projects
Calderdale	5	1	6
Croydon	1	0	1
Devon	3	1	4
Gloucestershire	5	1	6
Kent	2	1	3
Leicestershire	0	1	1
North Somerset	4	1	5
Rochdale	7	0	7
Tameside	2	0	2
West Sussex	3	0	3
Total	32 (86%)	6 (14%)	37 (100%)

Appendix S

Number of POPP projects within each pilot site that address each level of need

No. of projects within each Round 1 pilot site that address each level of need

Pilot Site	Level 1	Level 2	Level 3	Underpinning	Total Projects
Bradford	1	1	2	1	5
Brent	0	1	0	0	1
Camden	1	4	1	2	8
Dorset	2	0	0	1	3
East Sussex	5	4	5	0	14
Knowsley	1	3	2	0	6
Leeds	0	2	6	2	10
Luton	0	1	1	2	4
Manchester	2	0	0	1	3
Norfolk	4	2	3	0	9
North Lincolnshire	1	0	0	0	1
North Yorkshire	0	4	5	0	9
Northumberland	1	2	1	2	6
Poole	1	0	1	0	2
Sheffield	2	1	1	2	6
Somerset	1	1	0	0	2
Southwark	0	0	2	0	2
Wigan	7	6	0	1	14
Worcestershire	3	0	0	0	3
Total	**32 (30%)**	**32 (30%)**	**30 (28%)**	**14 (13%)**	**108 (100%)**

Number of projects within each Round 2 pilot site that address each level of need

Pilot Site	Level 1	Level 2	Level 3	Underpinning	Total Projects
Calderdale	2	2	1	1	6
Croydon	1	0	0	0	1
Devon	2	2	0	0	4
Gloucestershire	2	0	2	2	6
Kent	1	1	1	0	3
Leicestershire	0	0	1	0	1
North Somerset	1	3	0	1	5
Rochdale	4	0	0	2	7
Tameside	1	0	0	1	2
West Sussex	2	0	0	1	3
Total	**17 (34%)**	**8 (27%)**	**5 (13%)**	**8 (21%)**	**38 (100%)**

Appendix T

EQ-5D User Guide

User Guide

Basic information on how to use EQ-5D

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Version 2.0

March 2009

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Table of contents

1. Introduction

This guide has been developed in order to give users basic information on how to use EQ-5D. Topics include administering the instrument, setting up a database for data collected using EQ-5D as well as information about how to present the results. Also included are some frequently asked questions dealing with common issues regarding the use of EQ-5D and a list of currently available EuroQol Group products.

EuroQol Group

- The EuroQol Group is a network of international multidisciplinary researchers devoted to the measurement of health status. Established in 1987, the EuroQol Group originally consisted of researchers from Europe, but nowadays includes members from North America, Asia, Africa, Australia, and New Zealand. The Group is responsible for the development of EQ-5D, a preference based measure of health status that is now widely used in clinical trials, observational studies and other health surveys.

- The EuroQol Group has been holding annual scientific meetings since its inception in 1987.

- The EuroQol Group can be justifiably proud of its collective scientific achievements over the last 20 years. Research areas include: valuation, EQ-5D use in clinical studies and in population surveys, experimentation with the EQ-5D descriptive system, computerized applications, interpretation of EQ-5D ratings and the role of EQ-5D in measuring social inequalities in self-reported health.

- The EuroQol Group's website (www.euroqol.org) contains detailed information about EQ-5D, guidance for users, a list of available language versions, EQ-5D references and contact details.

EQ-5D

EQ-5D is a standardised measure of health status developed by the EuroQol Group in order to provide a simple, generic measure of health for clinical and economic appraisal[1]. Applicable to a wide range of health conditions and treatments, it provides a simple descriptive profile and a single index value for health status that can be used in the clinical and economic evaluation of health care as well as in population health surveys (Figure 1).

EQ-5D is designed for self-completion by respondents and is ideally suited for use in postal surveys, in clinics, and in face-to-face interviews. It is cognitively undemanding, taking only a few minutes to complete. Instructions to respondents are included in the questionnaire.

EQ-5D essentially consists of 2 pages - the EQ-5D descriptive system (page 2) and the EQ visual analogue scale (EQ VAS) (page 3). The EQ-5D descriptive system comprises the following 5 dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each dimension has 3 levels: no problems, some problems, severe problems. The respondent is asked to indicate his/her health state by ticking (or placing a cross) in the box against the most appropriate statement in each of the 5 dimensions. This decision results in a 1-digit number expressing the level selected for that dimension. The digits for 5 dimensions can be combined in a 5-digit number describing the respondent's health state. **It should be noted that the numerals 1-3 have no arithmetic properties and should not be used as a cardinal score.**

The EQ VAS records the respondent's self-rated health on a vertical, visual analogue scale where the endpoints are labelled 'Best imaginable health state' and 'Worst imaginable health state'. This information can be used as a quantitative measure of health outcome as judged by the individual respondents.

[1] EuroQol Group. EuroQol-a new facility for the measurement of health-related quality of life. Health Policy 1990;16:199-208

Figure 1: EQ-5D (UK English version)

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

Mobility

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

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	❑

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	❑

Pain/Discomfort

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

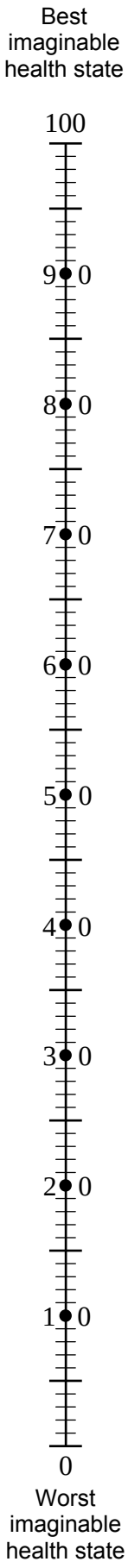
Anxiety/Depression

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

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 a health state?

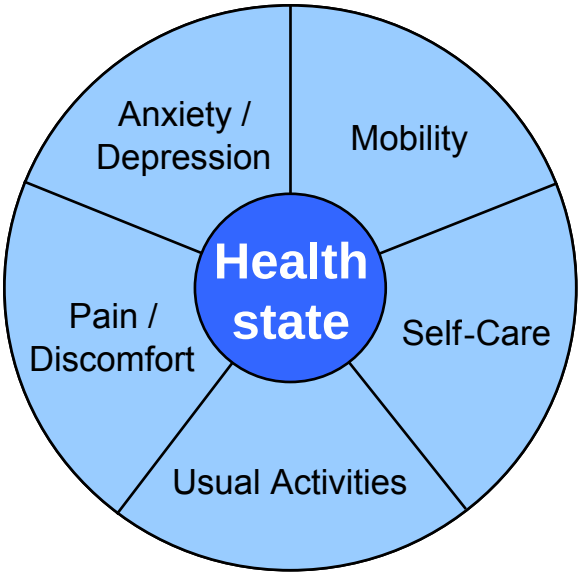
Each of the 5 dimensions comprising the EQ-5D descriptive system is divided into 3 levels of perceived problems:

Level 1: indicating no problem

Level 2: indicating some problems

Level 3: indicating extreme problems

A unique health state is defined by combining 1 level from each of the 5 dimensions.



A total of 243 possible health states is defined in this way. Each state is referred to in terms of a 5 digit code. For example, state 11111 indicates no problems on any of the 5 dimensions, while state 11223 indicates no problems with mobility and self care, some problems with performing usual activities, moderate pain or discomfort and extreme anxiety or depression.

Note: Two further states (unconscious and death) are included in the full set of 245 EQ-5D health states, but information on these states is not collected via self-report.

Versions of EQ-5D

EQ-5D in different languages

Currently there are more than 100 translated versions of EQ-5D. If you want to know if there is an EQ-5D version appropriate for your country, please consult the website.

All translations/adaptations of EQ-5D are produced using a standardised translation protocol that conforms to internationally recognized guidelines. These guidelines aim to ensure semantic and conceptual equivalence and involve a forward/backward translation process and lay panel assessment. Only the EuroQol Group Executive Office can give permission for a translation to be performed and translations can only be stamped as official if they are performed in cooperation with EuroQol Group reviewers.

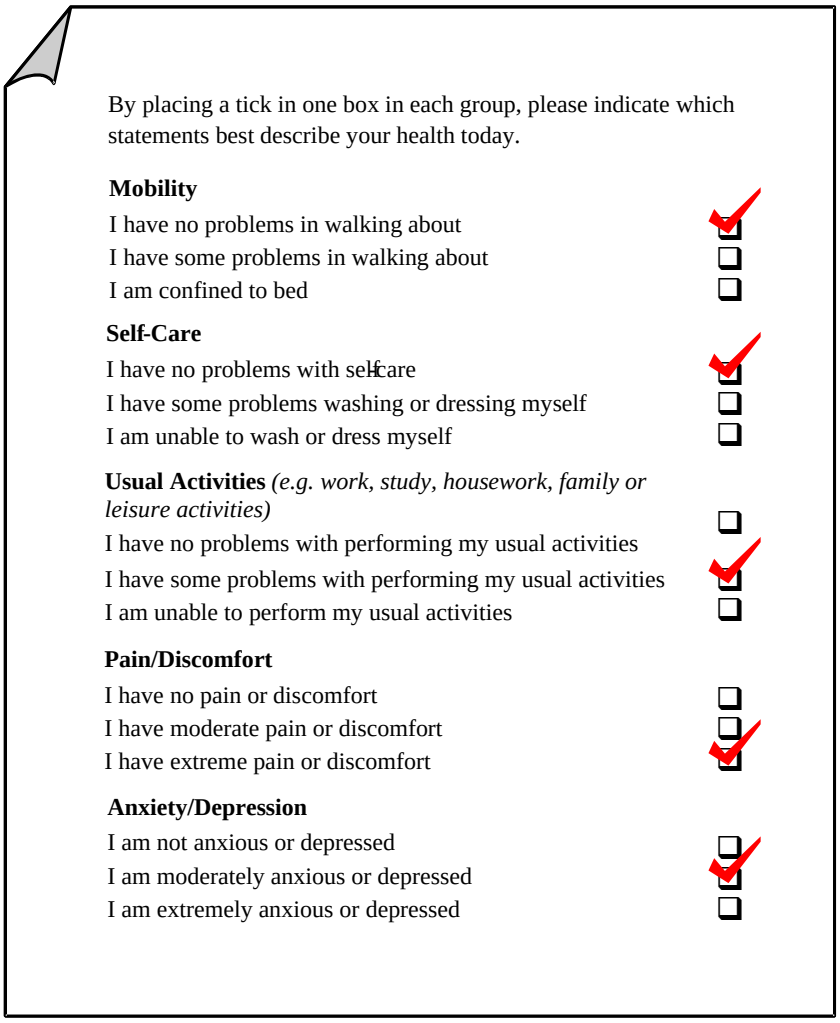
Alternative modes of administration

EQ-5D was primarily designed for self-completion by the patient or respondent. However EQ-5D self-report data can also be collected using the following alternative modes of administration:

(i) Face-to-face
(ii) Self-completion in the presence of an interviewer
(iii) Telephone interview
(iv) Interactive Voice Response (IVR) versions (available through a preferred vendor - Perceptive Informatics)
(v) Proxy (asking the proxy to rate how he or she, (i.e. the proxy), would rate the subject's health)

2. Scoring the EQ-5D descriptive system

The EQ-5D descriptive system should be scored as follows:



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

Mobility

- I have no problems in walking about ☑
- I have some problems in walking about ☐
- I am confined to bed ☐

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 ☐

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 ☐

Pain/Discomfort

- I have no pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have extreme pain or discomfort ☑

Anxiety/Depression

- I am not anxious or depressed ☐
- I am moderately anxious or depressed ☑
- I am extremely anxious or depressed ☐

Levels of perceived problems are coded as follows:

☑ ☐ ☐ Level 1 is coded as a '1'

☐ ☑ ☐ Level 2 is coded as a '2'

☐ ☐ ☑ Level 3 is coded as a '3'

NB: There should be only <u>one</u> response for each dimension.

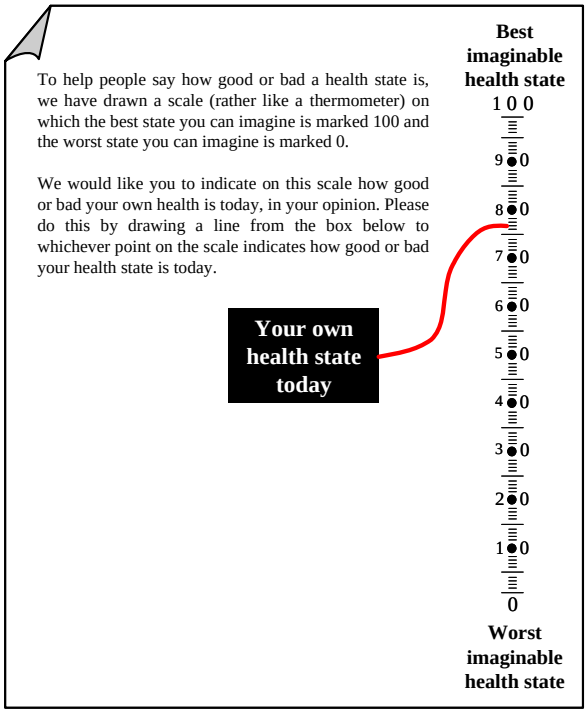
This example identifies the state 11232.

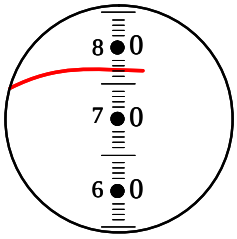
Missing values can be coded as '9'.

Ambiguous values (e.g. 2 boxes are ticked for a single dimension) should be treated as missing values.

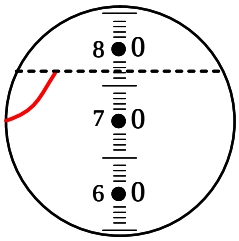
3. Scoring the EQ VAS

The EQ VAS should be scored as follows:





For example this response should be coded as 77



Even though the line does not cross the VAS this response can still be scored by drawing a horizontal line from the end point of the response to the VAS. In this example the response should be coded as 77

Missing values should be coded as '999'.

Ambiguous values (e.g. the line crosses the VAS twice) should be treated as missing values.

4. Converting EQ-5D states to a single summary index

EQ-5D health states, defined by the EQ-5D descriptive system, may be converted into a single summary index by applying a formula that essentially attaches values (also called weights) to each of the levels in each dimension. The index can be calculated by deducting the appropriate weights from 1, the value for full health (i.e. state 11111). Information in this format is useful, for example, in cost utility analysis.

Value sets have been derived for EQ-5D in several countries using the EQ-5D visual analogue scale (EQ-5D VAS) valuation technique or the time trade-off (TTO) valuation technique. The list of currently available value sets with the number of respondents and valuation technique applied is presented in table 1. Most of the EQ-5D value sets have been obtained using a representative sample of the general population, thereby ensuring that they represent the societal perspective. For anyone working with EQ-5D data, an essential guide to the Group's available value sets can be found in: EuroQol Group Monograph series: Volume 2: EQ-5D value sets: inventory, comparative review and user guide, recently published by Springer (see section 8 for more information).

Table 1: List of available value sets (references available on the website)

Country	N	Valuation method
Belgium	722	EQ-5D VAS
Denmark	1686	EQ-5D VAS
Denmark	1332	TTO
Europe	8709	EQ-5D VAS
Finland	1634	EQ-5D VAS
Germany	339	EQ-5D VAS
Germany	339	TTO
Japan	621	TTO
Netherlands	309	TTO
New Zealand	1360	EQ-5D VAS
Slovenia	733	EQ-5D VAS
Spain	300	EQ-5D VAS
Spain	1000	TTO
UK	3395	EQ-5D VAS
UK	3395	TTO
US	4048	TTO
Zimbabwe	2440	TTO

Documents containing the scoring algorithms, information on the valuation studies, tables of values for all 243 health states and SPSS and SAS syntax files can be ordered from the EuroQol Executive Office (userinformationservice@euroqol.org).

5. Organising EQ-5D data

Data collected using EQ-5D can be entered in a database according to the following schema:

Variable name	ID	COUNTRY	YEAR	MOBILITY	SELFCARE	ACTIVITY	PAIN	ANXIETY
Variable description	patient ID number			1=No Problems, 2=Some problems, 3=Extreme problems, 9=Missing value	1=No Problems, 2=Some problems, 3=Extreme problems, 9=Missing value	1=No Problems, 2=Some problems, 3=Extreme problems, 9=Missing value	1=No Problems, 2=Some problems, 3=Extreme problems, 9=Missing value	1=No Problems, 2=Some problems, 3=Extreme problems, 9=Missing value
Data row 1	1001	UK	2006	2	1	2	2	1
Data row 2	1002	UK	2006	1	1	1	1	1

Variable name	STATE	EQ_VAS	SEX	AGE	EDU	METHOD	SOC_ECON
Variable description		999= Missing value	1=male, 2=female, 9=Missing value	999= Missing value	1=low, 2=medium, 3=high, 9=Missing value	0=postal, 1=interview, 2=telephone, 9=Missing value	1=employed, 2=retired, ….., 9=Missing value
Data row 1	21221	80	1	43	1	0	1
Data row 2	21111	90	2	24	2	0	4

NB: The variable names are just examples. However, the variables for the 5 dimensions of the EQ-5D descriptive system should be named 'mobility', 'selfcare', 'activity', 'pain', and 'anxiety'. If they are given different names the syntax codes containing the value sets that are distributed by the EuroQol Group will not work properly.

6. Presenting EQ-5D results

Data collected using EQ-5D can be presented in various ways. A basic subdivision can be made according to the structure of the EQ-5D:

1. Presenting results from the descriptive system as a health profile
2. Presenting results of the EQ VAS as a measure of overall self-rated health status
3. Presenting results from the descriptive system as a weighted index

However, the way results are presented is partly determined by what message you, as a researcher, wish to convey to your audience.

Health profiles

One way of presenting data as a health profile is by making a table with the frequency or the proportion of reported problems for each level for each dimension. These tables can be broken down to include the proportions per subgroup, such as age, before vs. after treatment, treatment vs. comparator, etc.

Sometimes it is more convenient to dichotomise the EQ-5D levels into 'no problems' (i.e. level 1) and 'problems' (i.e. levels 2 and 3), thereby changing the profile into frequencies of reported problems. This can be the case, for example, in a general population survey where the numbers of reported level 3 problems are very low. Tables 2 and 3 are examples of how to present EQ-5D data in tabulated form. The data for the tables originates from a general population survey in the UK[2].

[2]Kind P, Dolan P, Gudex C, Williams A. Variations in population health status: results from a United Kingdom national questionnaire survey Bmj 1998;316 (7133): 736-41.

Table 2: Proportion of levels 1, 2 and 3 by dimension and by age group

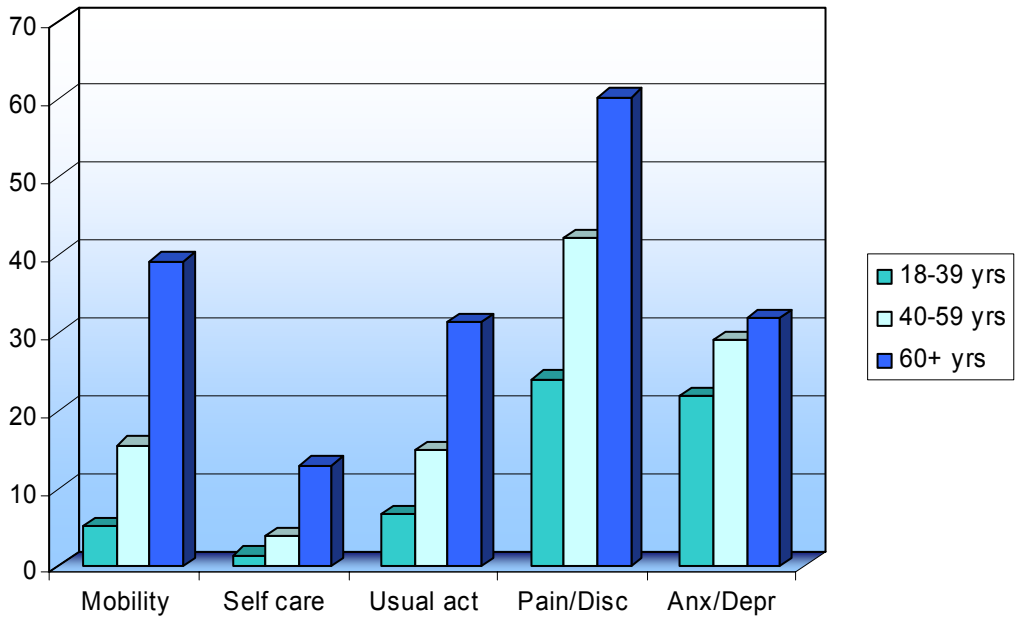
EQ-5D DIMENSION		AGE GROUPS 18-29	30-39	40-49	50-59	60-69	70-79	80+	TOTAL
MOBILITY	Level 1	95.4	92.2	89.7	78.1	70.7	60.2	43.3	81.6
	Level 2	4.6	7.6	9.9	21.9	29.3	39.8	56.7	18.3
	Level 3	0.0	0.1	0.4	0.0	0.0	0.0	0.0	0.1
SELF-CARE	Level 1	99.1	98.4	95.8	94.8	94.3	92.6	83.7	95.7
	Level 2	0.9	1.5	4.0	5.2	5.5	7.1	15.6	4.1
	Level 3	0.0	0.1	0.2	0.0	0.2	0.2	0.7	0.1
USUAL ACTIVITIES	Level 1	93.3	91.4	89.2	78.1	75.3	73.7	56.0	83.7
	Level 2	6.3	7.9	9.4	18.8	21.6	22.1	38.3	14.2
	Level 3	0.4	0.7	1.5	3.0	3.1	4.2	5.7	2.1
PAIN / DISCOMFORT	Level 1	83.9	80.7	74.1	56.3	53.8	44.0	39.7	67.0
	Level 2	15.8	17.7	22.8	38.1	40.6	48.4	49.6	29.2
	Level 3	0.3	1.6	3.1	5.6	5.6	7.6	10.6	3.8
ANXIETY / DEPRESSION	Level 1	86.5	82.6	81.3	72.8	72.0	74.7	75.2	79.1
	Level 2	12.6	16.4	16.9	24.4	25.1	22.6	24.1	19.1
	Level 3	0.9	1.0	1.8	2.8	2.9	2.7	0.7	1.8

Table 3: Frequency of reported problems by dimension and age group

EQ-5D DIMENSION		AGE GROUPS 18-29	30-39	40-49	50-59	60-69	70-79	80+	TOTAL
MOBILITY	No problems	643	631	489	362	339	246	61	2770
	Problems	31	53	56	101	140	162	81	625
SELF-CARE	No problems	668	673	522	439	452	378	119	3251
	Problems	6	11	23	24	27	30	23	144
USUAL ACTIVITIES	No problems	629	625	486	362	361	301	80	2842
	Problems	45	59	59	101	118	107	62	553
PAIN / DISCOMFORT	No problems	566	552	404	261	258	179	56	2275
	Problems	108	132	141	202	221	229	86	1120
ANXIETY / DEPRESSION	No problems	583	565	443	337	345	305	107	2684
	Problems	91	119	102	126	134	103	35	711

In addition to presenting the results in tabulated form, you can also use graphical presentations. Two or 3 dimensional bar charts can be used to summarise the results in 1 graph, (see figure 2). Figure 2 shows the sum of the proportion of reported level 2 and level 3 problems for each of the 5 EQ-5D dimensions for 3 distinct age groups. Older people reported more problems on all dimensions but the effect of age was strongest for mobility and weakest for anxiety/depression.

Figure 2: Profile of the population (% reporting problem)



EQ VAS

In order to present all aspects of the EQ VAS data, you should present both a measure of the central tendency and a measure of dispersion. This could be the mean values and the standard deviation or, if the data is skewed, the median values and the 25th and 75th percentiles. An example is presented in table 4. The data for the table originates from a general population survey in the UK[3].

Table 4: EQ VAS values by age – mean + standard deviation and median + percentiles

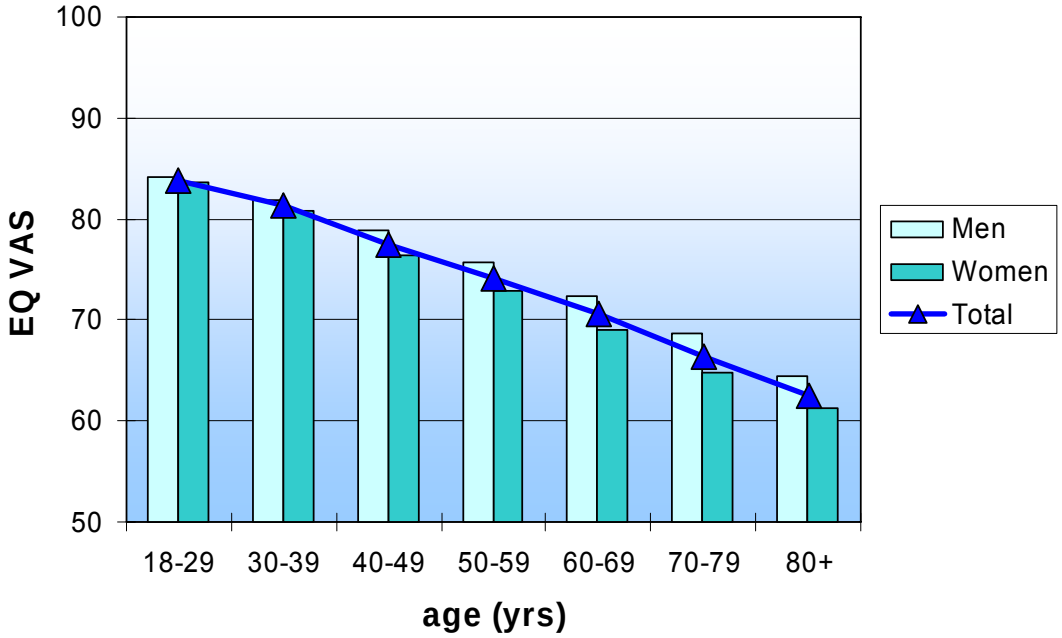
	AGE GROUPS							
EQ VAS	*18-29*	*30-39*	*40-49*	*50-59*	*60-69*	*70-79*	*80+*	*TOTAL*
Mean	87.0	86.2	85.1	81.3	79.8	75.3	72.5	82.8
- Std dev	13.8	14.6	15.5	46.8	17.5	18.5	18.2	23.1
Median	90	90	90	86	85	80	75	90
- 25th	80	80	80	70	70	65	60	75
- 75th	98	95	95	95	93	90	88	95

You can present a graphical representation of the data by using bar charts, line charts, or both (see figure 3). Figure 3 shows the mean EQ VAS ratings reported by

[3] Kind P, Dolan P, Gudex C, Williams A. Variations in population health status: results from a United Kingdom national questionnaire survey Bmj 1998;316 (7133): 736-41.

men, women and both for 7 distinct age groups. The mean EQ VAS ratings are seen to decrease with increasing age. Also, men of all age groups reported higher EQ VAS ratings than women.

Figure 3: Mean population EQ VAS ratings by age group and sex



EQ-5D index

Information about the EQ-5D index can be presented in much the same way as the EQ VAS data. This means that for the index, you can present both a measure of the central tendency and a measure of dispersion. This could be the mean values and the standard deviation (or standard error). If the data is skewed, the median values and the 25th and 75th percentiles could be presented. Tables 5 and 6 and figures 4 and 5 contain 2 examples of how to present EQ-5D index results. Table 5 and figure 4 present the results from a study where the effect of a treatment on health status is investigated. Table 6 and figure 5 show results for a patient population and 3 subgroups (the tables and figures are based on hypothetical data and for illustration purposes only).

Table 5: EQ-5D index values before and after treatment – mean + standard deviation and median + percentiles

EQ-5D index	before treatment	after treatment
Mean	0.59	0.76
- Std error	0.012	0.015
Median	0.60	0.70
- 25th	0.50	0.65
- 75th	0.70	0.80
N	120	110

Figure 4: EQ-5D index values before and after treatment – mean values and 95% confidence intervals

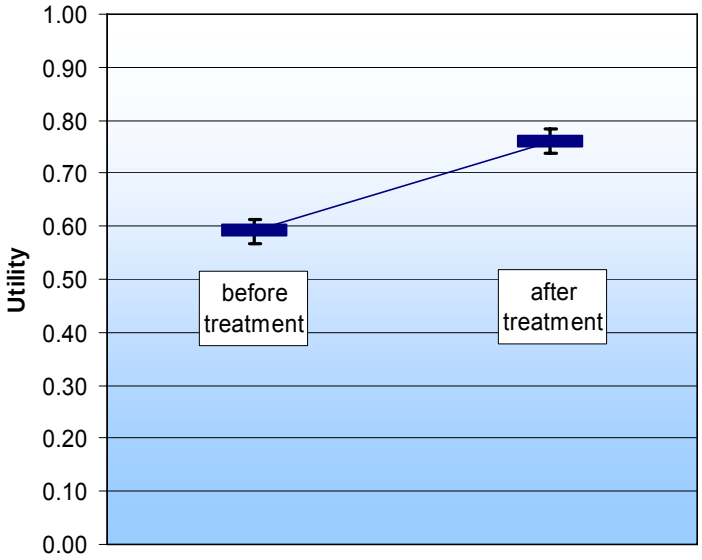
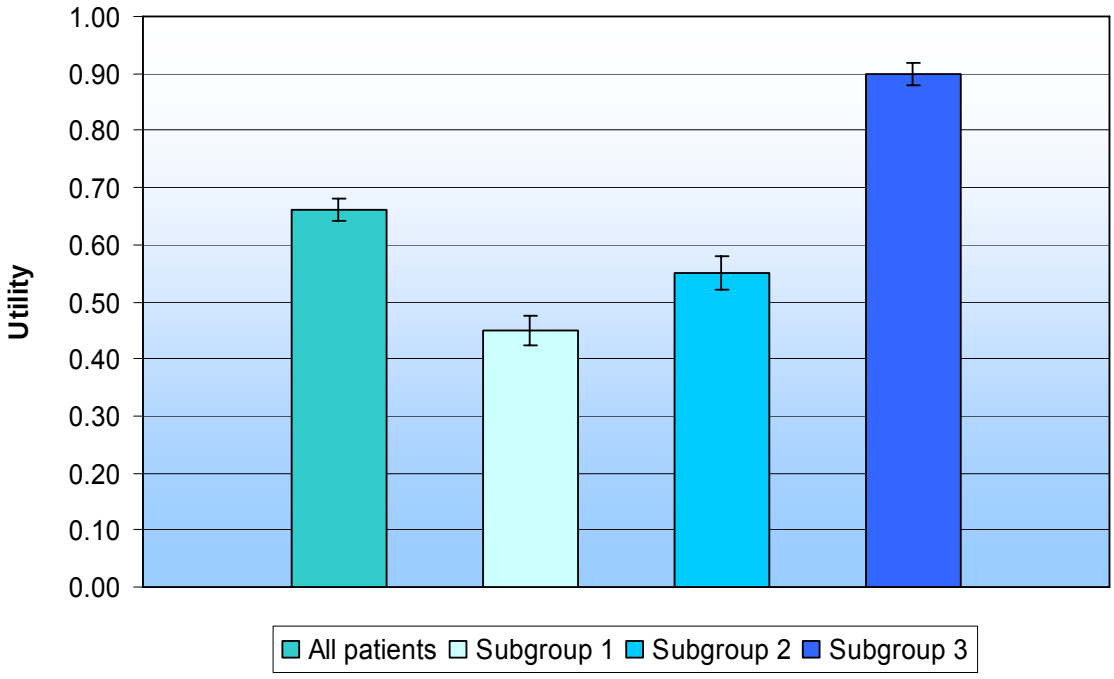


Table 6: EQ-5D index values of the total patient population and the 3 subgroups – mean + standard deviation and median + percentiles

EQ-5D-index	All patients	Subgroup 1	Subgroup 2	Subgroup 3
Mean	0.66	0.45	0.55	0.90
- Std error	0.010	0.013	0.015	0.010
Median	0.55	0.40	0.55	0.95
- 25th	0.50	0.30	0.50	0.80
- 75th	0.70	0.50	0.60	1.00
N	300	100	75	125

Figure 5: EQ-5D index values of the total patient population and the 3 subgroups – mean values and 95% confidence intervals



7. EQ-5D: Frequently asked questions

For what period of time does EQ-5D record health status?

Self-reported health status captured by EQ-5D relates to the respondent's situation at the time of completion. No attempt is made to summarise the recalled health status over the preceding days or weeks, although EQ-5D has been tested in recall mode. An early decision taken by the EuroQol Group determined that health status measurement ought to apply to the respondent's immediate situation - hence the focus on 'your own health state today'.

General population value sets vs patient population value sets

If you want to undertake a utility analysis you will need to use a value set. Generally speaking utility analysis requires a general population-based value set (as opposed to a patient-based set). The rationale behind this is that the values are supposed to reflect the preferences of local taxpayers and potential receivers of healthcare. Additionally, patients tend to rate their health states higher than the general population because of coping etc, often underestimating their need for healthcare. The EQ-5D value sets are therefore based on the values of the general population.

Difference between the EQ-5D descriptive system and the EQ VAS

The descriptive system can be represented as a health state, e.g. health state 11212 represents a patient who indicates some problems on the usual activities and anxiety/depression dimensions. These health states can be converted to a single index value using (one of) the available EQ-5D value sets. These value sets have been derived using VAS or TTO valuation techniques, and reflect the opinion of the general population. The EQ VAS scores are patient-based and are therefore not representative of the general population. The EQ VAS self-rating records the respondent's own assessment of their health status. The EQ VAS scores however are anchored on 100 = best imaginable health and 0 = worst imaginable health, whereas the value sets are anchored on 11111 = 1 and dead = 0 and can therefore be used in QALY calculations.

Difference between the VAS and TTO techniques

The difference between the value sets based on TTO and those based on VAS is that the techniques used for the elicitation of the values on which the models are based differ. In the TTO task, respondents are asked, for example, to imagine they live in a health state (e.g. 22222) for 10 years and then asked to specify the amount of time they are willing to give up to live in full health instead (i.e. 11111). For example, someone might find 8 years in 11111 equivalent to 10 years in 22222. The VAS technique on the other hand, asks people to indicate where, on a vertical thermometer-like scale ranging from best imaginable health to worst imaginable health, they think a health state should be positioned.

Multinational clinical trials

Information relating to EQ-5D health states gathered in the context of multinational trials may be converted into a single summary index using one of the available EQ-5D value sets. There are different options available to do this using appropriate value sets-however the choice depends on the context in which the information will be used by researchers or decision makers. In cases where data from an international trial are to be used to inform decision makers in a specific country, it seems reasonable to expect decision makers to be interested primarily in value sets that reflect the values for EQ-5D health states in that specific country. So for example, if applications for reimbursement of a drug are rolled out from country to country, country-specific value sets should be applied and reported in each pharmaco-economic report. This is no different from the requirement to use country-specific costs. In the absence of a country-specific value set, the researcher should select another set of values for a population that most closely approximates that country. Sometimes however, information about utilities is required to inform researchers or decision makers in an international context. In these instances, 1 value set applied over all EQ-5D health states data is probably more appropriate.

The decision about which value set to use will also depend on whether the relevant decision making body in each country specifies any requirements or preferences in regard to the methodology used in different contexts (e.g. TTO, standard gamble (SG), VAS or discrete choice modelling (DCM)). These guidelines are the topic of an international ongoing debate but the EuroQol Group website is planning to provide a summary of health care decision-making bodies internationally, and their stated requirements regarding the valuation of health states.

Detailed information regarding the valuation protocols, guidelines on which value set to use and tables of all available value sets has recently been published by Springer in: EuroQol Group Monograph series: Volume 2: EQ-5D value sets: inventory, comparative review and user guide' (see section 8 for more information). Chapter 4 by Nancy Devlin and David Parkin will be of special interest to researchers pondering the issue of which value set to use.

Can I use only the EQ-5D descriptive system or only the EQ VAS?

We cannot advise this. EQ-5D is a 2-part instrument so if you only use 1 part you cannot claim to have used EQ-5D in your publications.

How long should the EQ VAS be?

Officially, for paper versions, the EQ VAS scale should be 20cms. All methodological and developmental work has been carried using this length. To ensure that you print the correct length, make sure your paper size is set at A4 and the box in your printing instructions labelled 'scale to paper size' is set at 'no scaling'.

Can I publish our study using EQ-5D?

Yes, you are free to publish your results. If you are reproducing the EQ-5D in an appendix we request that you use the sample version of EQ-5D and that the following text is included in the footer: *© 1990 EuroQol Group. EQ-5D™ is a trade mark of the EuroQol Group.*

8. Additional information

Key EuroQol Group references

1. The EuroQol Group (1990). EuroQol-a new facility for the measurement of health-related quality of life. Health Policy 16(3):199-208.

2. Brooks R (1996). EuroQol: the current state of play. Health Policy 37(1):53-72.

3. Dolan P (1997). Modeling valuations for EuroQol health states. Med Care 35(11):1095-108.

4. Roset M, Badia X, Mayo NE (1999). Sample size calculations in studies using the EuroQol 5D. Qual Life Res 8(6):539-49.

5. Greiner W, Weijnen T, Nieuwenhuizen M, et al. (2003). A single European currency for EQ-5D health states. Results from a six country study. Eur J Health Econ; 4(3):222-231.

6. Shaw JW, Johnson JA, Coons SJ (2005). US valuation of the EQ-5D health states: development and testing of the D1 valuation model. Med Care; 43(3): 203-220.

Referring to the EQ-5D instrument in publications

When publishing results obtained with the EQ-5D, the following references can be used:

1. The EuroQol Group (1990). EuroQol-a new facility for the measurement of health-related quality of life. Health Policy 16(3):199-208.

2. Brooks R (1996). EuroQol: the current state of play. Health Policy 37(1):53-72.

If you used a value set in your study you can also include a reference to the publication regarding that value set. The appropriate references for the value sets can be found in the EQ-5D Value Sets Monograph and in the value set summary documents that can be ordered from the EuroQol Executive Office.

Products available from the EuroQol Executive Office

EQ-5D language versions (self-report and alternative modes of self-report)

All self-report and alternative modes of self-report versions in different languages must be obtained exclusively from the EuroQol Executive Office. Normally only the language(s) appropriate to the country where the research request originates will be supplied. Licensing fees are determined by the EuroQol Executive Office on the basis of information provided by the user. Whether a fee is appropriate depends upon the type of study, size and/or number of patients/respondents and requested languages.

The Measurement and valuation of health status using EQ-5D: A European perspective. Eds Brooks R, Rabin R, de Charro F. Kluwer Acacemic Publishers, 2005

This book reports on the results of the European Union-funded EQ-net project which furthered the development of EQ-5D in the key areas of valuation, application and translation. The book can be obtained from Springer at www.springeronline.com at a cost of €107.95.

Measuring self-reported population health: An international perspective based on EQ-5D. Eds Szende A, Williams A. EuroQol Group Monographs Volume 1. SpringMed publishing, 2004.

This booklet provides population reference data for a number of different countries and is available on request from the EuroQol Executive Office.

EQ-5D concepts and methods: a developmental history. Eds Kind P, Brooks R, Rabin R. Springer, 2005.

This book is a collection of papers representing the collective intellectual enterprise of the EuroQol Group and can be obtained from Springer at www.springeronline.com at a cost of € 85.00.

EQ-5D value sets: Inventory, comparative review and user guide. Eds. Szende A, Oppe M, Devlin N. EuroQol Group Monographs Volume 2. Springer, 2006.

This book provides an essential guide to the use of the EuroQol Group's value sets for anyone working with EQ-5D data and can be obtained from Springer at www.springeronline.com at a cost of € 49.95.

Future developments

Since 2002, the EuroQol Group Foundation has provided modest funding for EuroQol Group members to carry out innovative EQ-5D-related research. Since 2004, the Group has been establishing specific task forces to:

- Investigate the use of EQ-5D in different disease areas
- Develop a 5-level version of EQ-5D
- Explore different valuation methodologies for valuing EQ-5D health states

- Develop an EQ-5D version for young people and children in different languages
- Investigate the use of EQ-5D in population health
- Explore the use of electronic versions of EQ-5D in pc and web-based applications as well as palm pilots and (in the future) cell phones. This task force will also investigate the eliciting of values via the computer

Please check the EuroQol Group website for up-to-date information on the availability of current and future EuroQol Group products.

Contact information:

For more information please look at the EuroQol Group website at www.euroqol.org or e-mail us at userinformationservice@euroqol.org

Acknowledgements:

Part of this user guide was taken from and is based on the UK user guide that was developed by Professor Paul Kind from York University, UK in 1998.

Appendix U

Full Coding Framework for the Key Informant Telephone Interviews

Full Coding Framework for the Key Informant Telephone Interviews

1 Introduction

From the Key Informant Telephone Interviews (KITIs), 14 'Parent' nodes have been suggested with concurrent 'child' nodes. This information has been drawn from an initial analysis of two KITIs. As the analysis moves forward, it is likely that further 'child nodes' and indeed 'parent nodes' may need to be incorporated into the analysis.

The 'parent' nodes include the following:

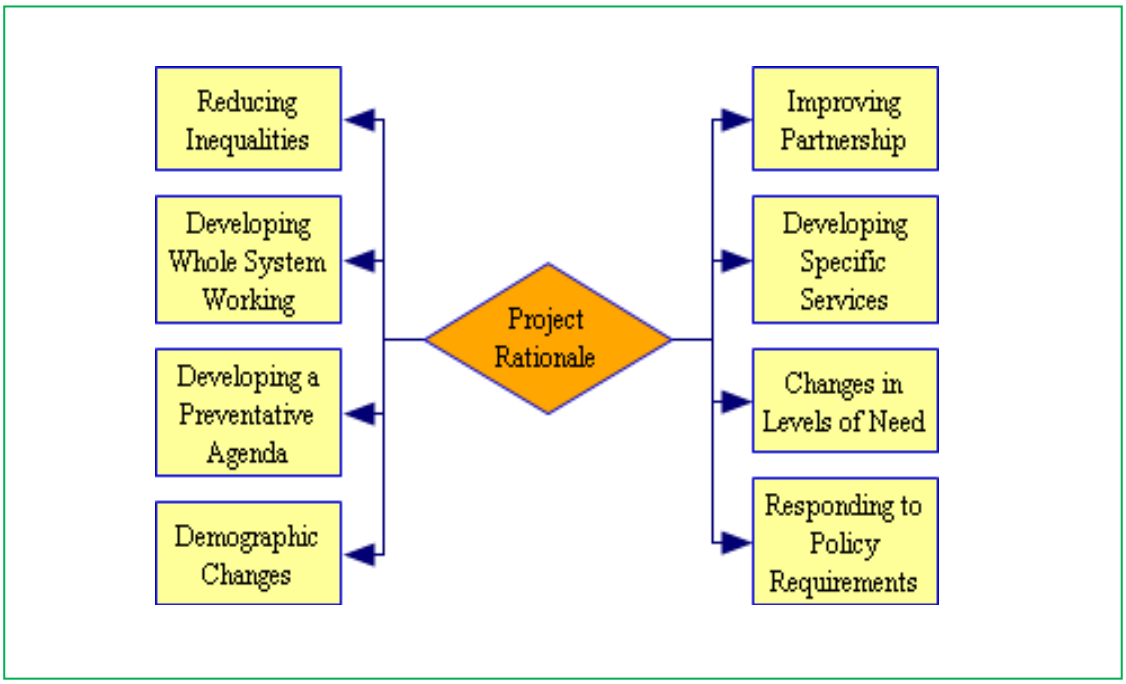
- Project Rationale
- Partnerships
- Prior Partnership Arrangements
- Equality of Partnerships
- Partnerships across the POPP Project
- Impact of POPP on partnerships
- POPP Programme
- POPP Interventions
- POPP Learning
- Commissioning
- Older People's Involvement
- BME Involvement
- Involvement of the Third Sector
- Sustainability

These will need to be further 'tested' across the whole KITI sample and it is very likely that further parent and child nodes will need to be developed. Similarly, it will be necessary to develop such nodes for the Focus Groups and Older People Interviews.

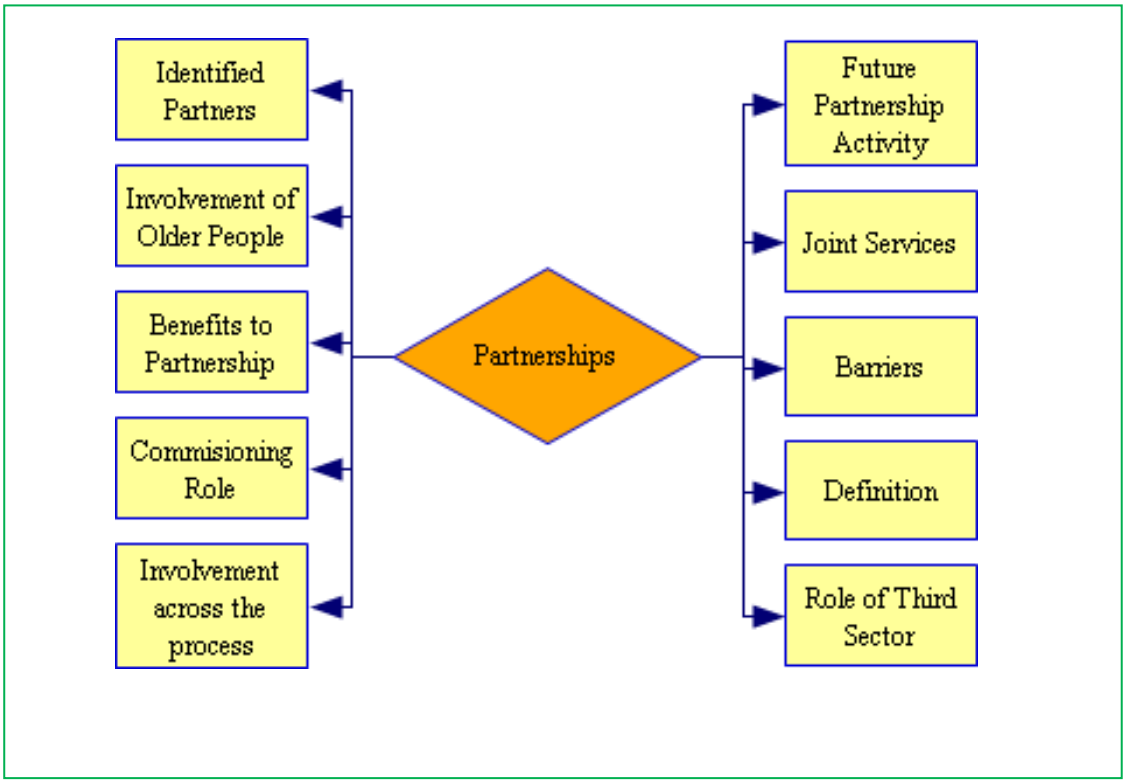
We will need to discuss the following as, good practice within NUD®IST demands only 5/6 child nodes and, as you will see, we have a lot more!

2 Key 'Parent' Nodes

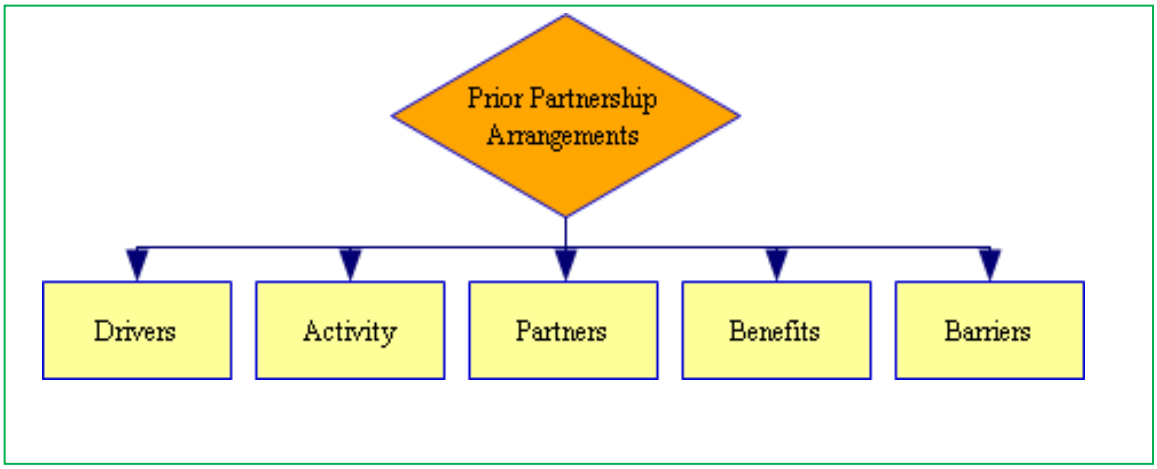
2.1 Project Rationale



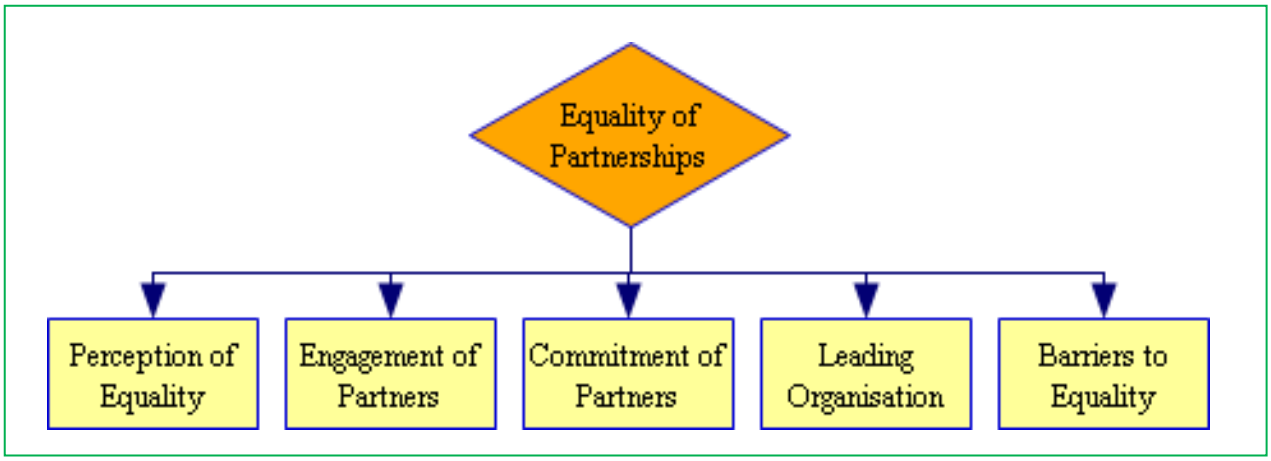
2.2 Partnerships



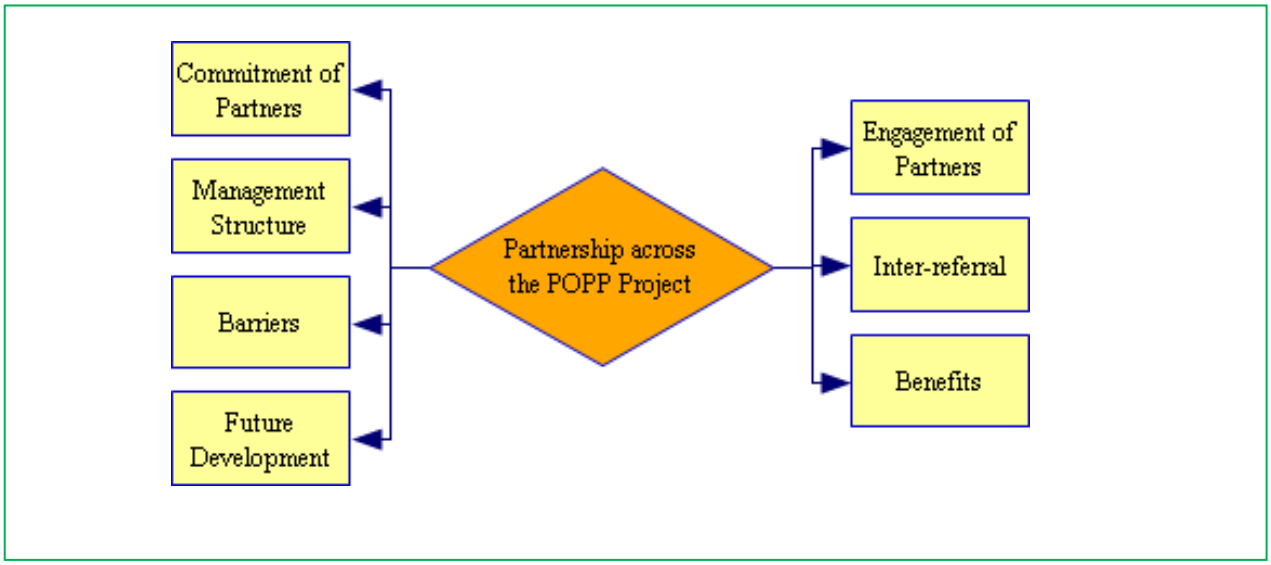
2.3 Prior Partnership Arrangements



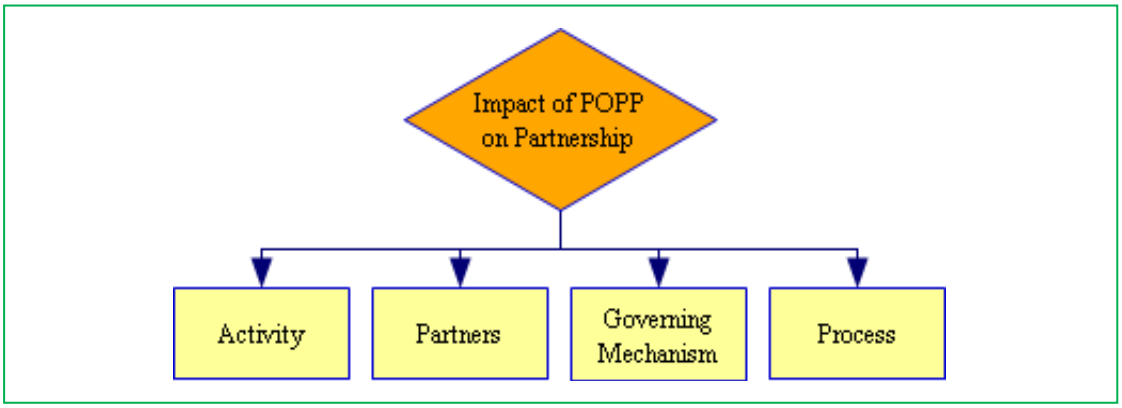
2.4 Equality of Partnerships



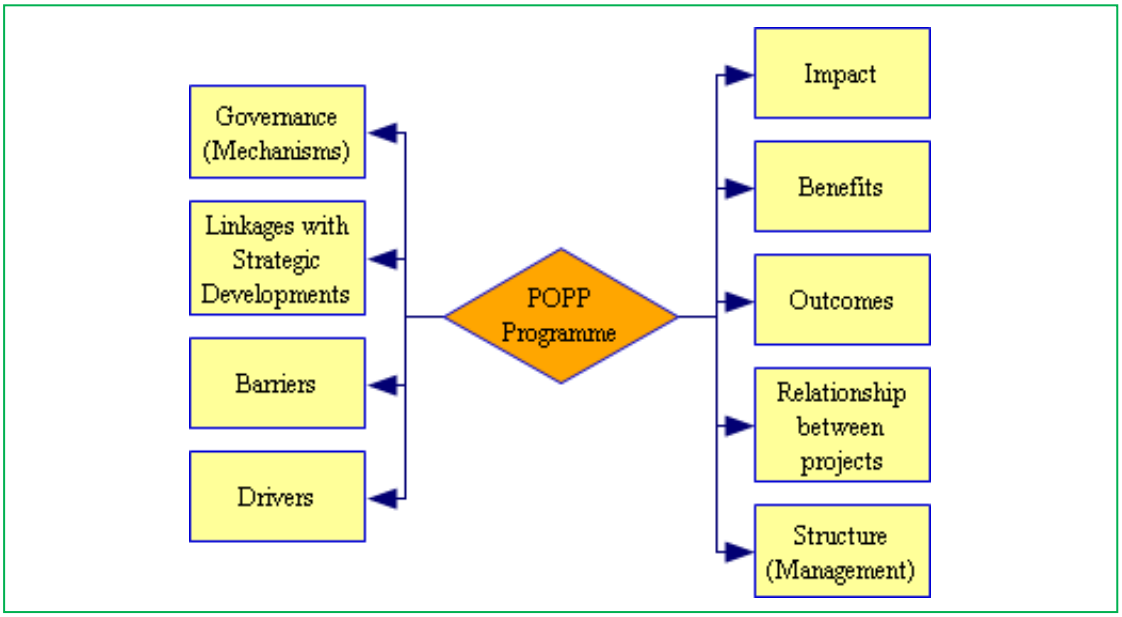
2.5 Partnerships across the POPP Project



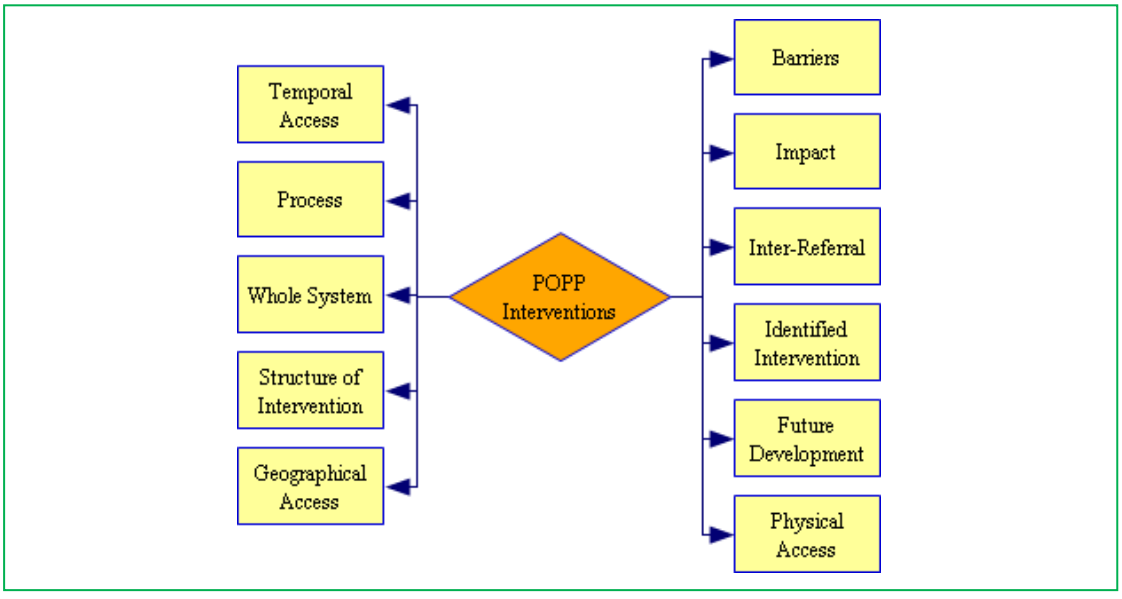
2.6 Impact of POPP on partnerships



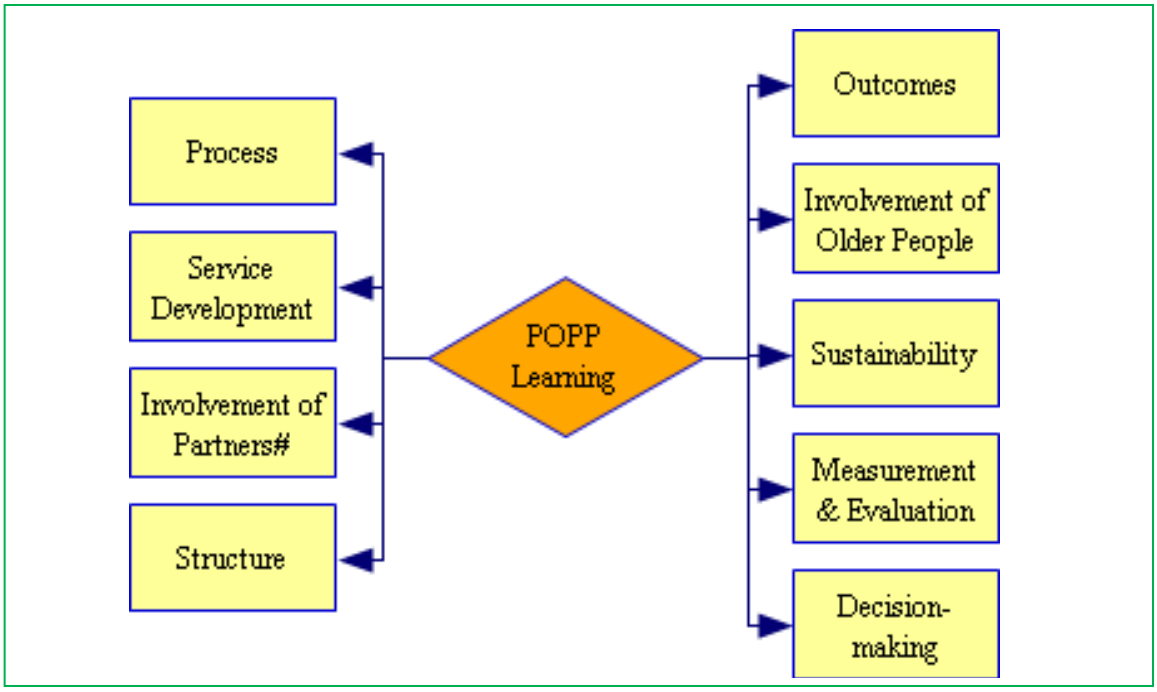
2.7 POPP Programme



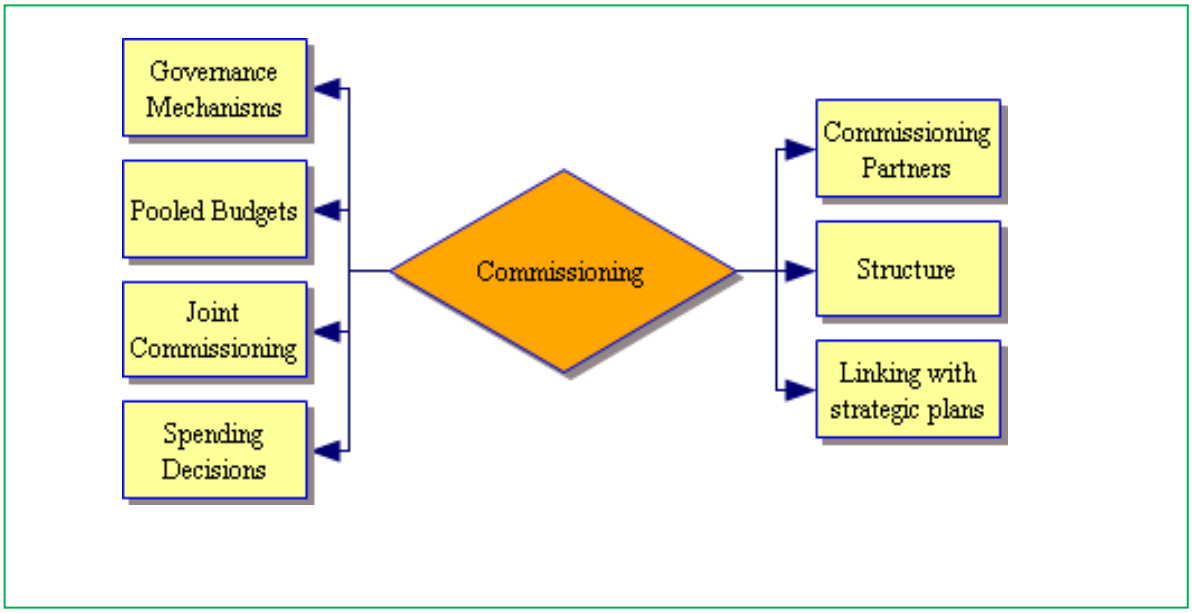
2.8 POPP Interventions



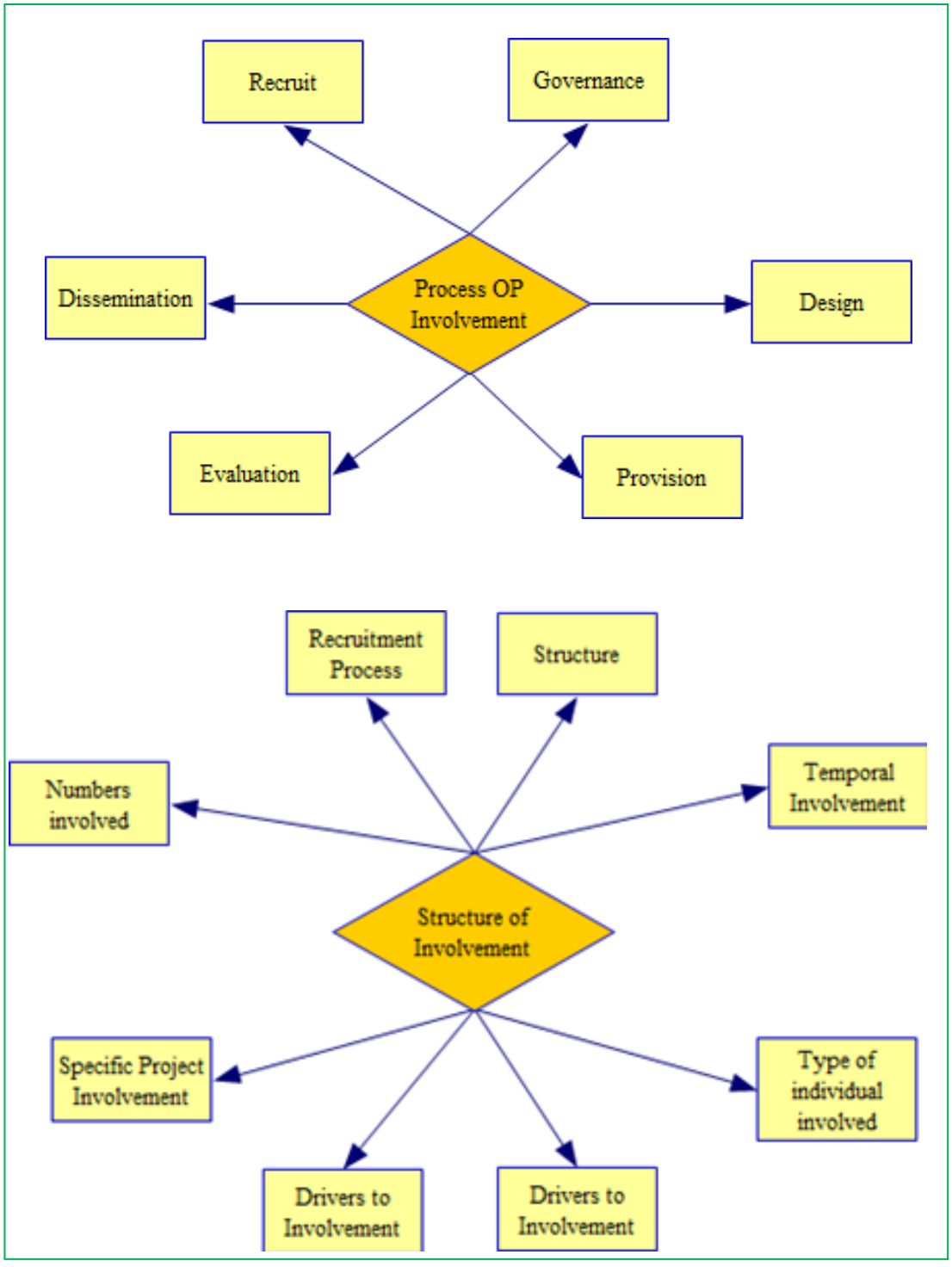
2.9 POPP Learning

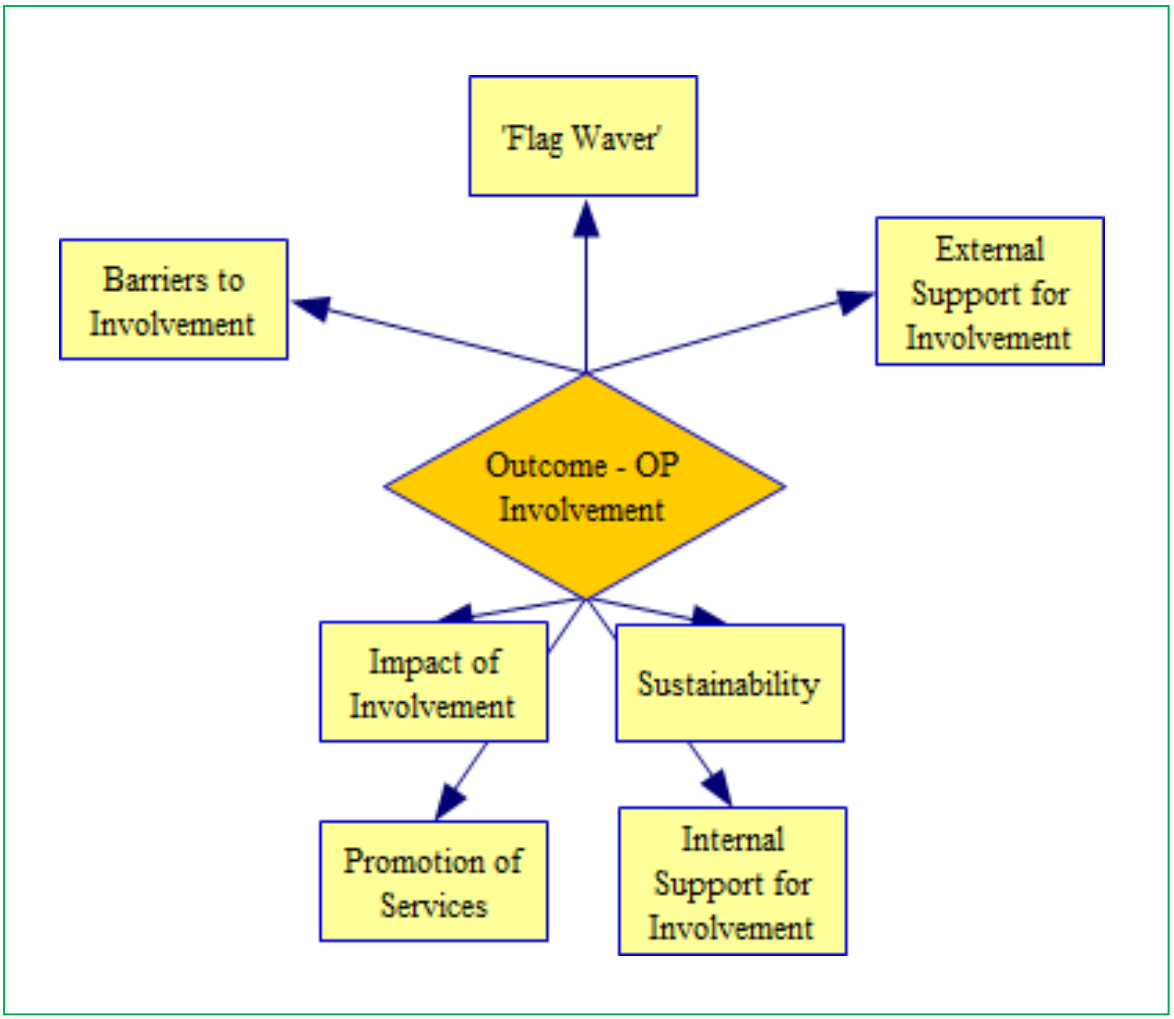


2.10 Commissioning

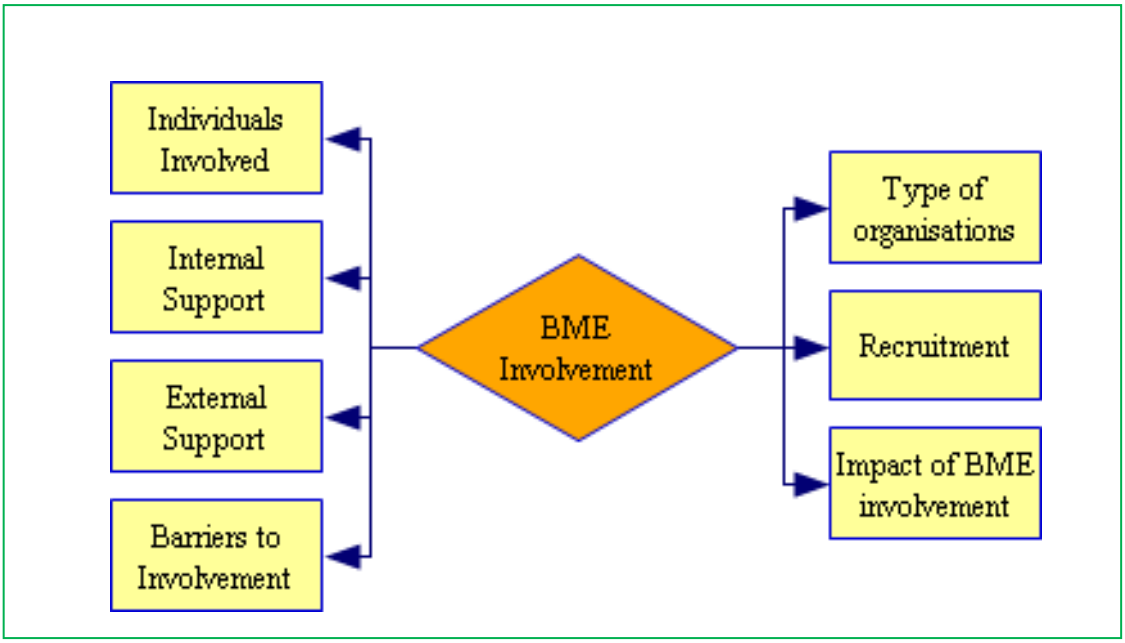


2.11 Older People's Involvement

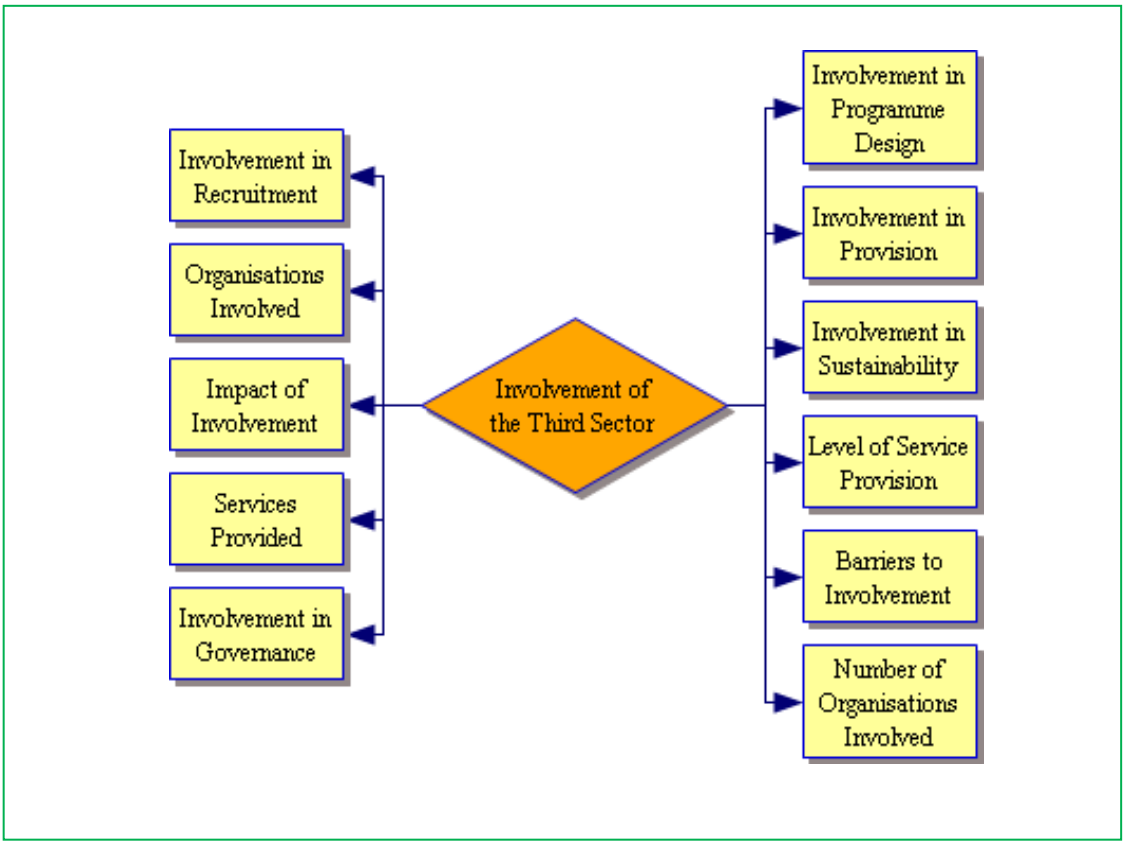




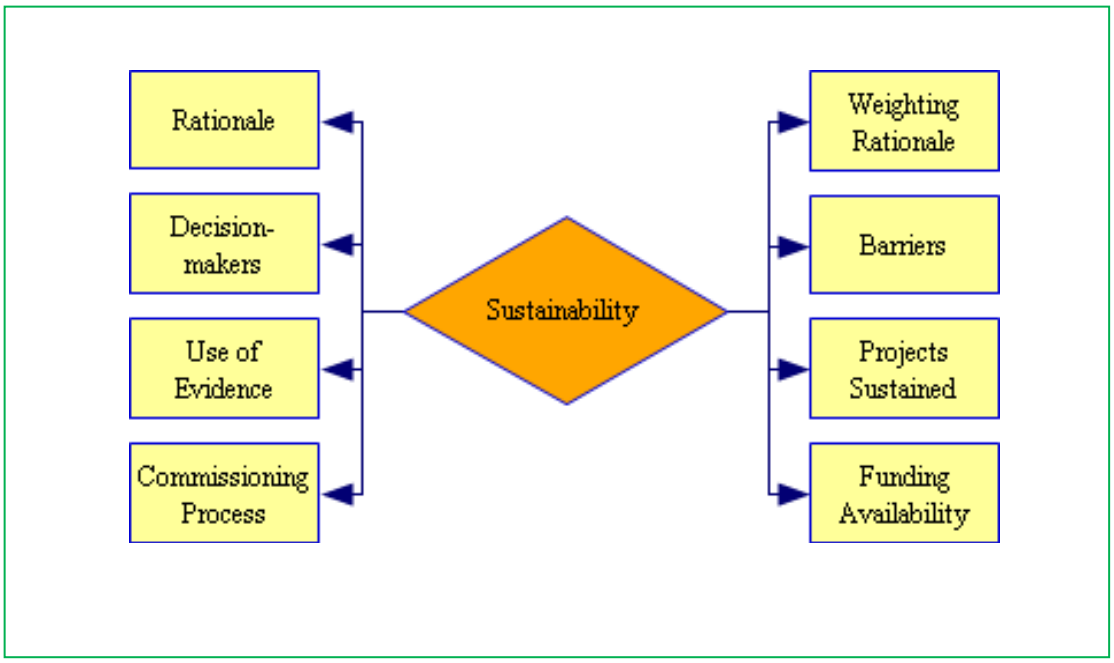
2.12 BME Involvement



2.13 Involvement of the Third Sector



2.14 Sustainability



Appendix V

Coding Framework for the Node ‘Involving Older People’ within the Key Informant Telephone Interviews: Guide on Analysis with the PIR Group

Coding Framework for the Node 'Involving Older People' within the Key Informant Telephone Interviews: Guide on Analysis with the PIR Group

1 Introduction

Within the National Evaluation of POPP, a qualitative phase has been carried out. Interviews with Key Informants (20/20) and Older People (26/40 td) have been undertaken, whilst a series of Focus Groups with operational Staff and volunteers (12/12) have been run.

In working with the PIR Group around the analysis, we would be grateful if you could look at the suggested breakdown for the key 'parent' node of 'Involvement of Older People' (see 3 below), juxtaposing the suggested 'child' nodes against the provided anonymised excerpts (see 4 below). The following pages give the key nodes for older people's involvement in the POPP project.

2 Key Nodes

From the Key Informant Telephone Interviews (KITIs), 13 'Parent' nodes have been suggested with concurrent 'child' nodes. This information has been drawn from an initial analysis of two KITIs. As the analysis moves forward, it is likely that further 'child nodes' and indeed 'parent nodes' may need to be incorporated into the analysis.

The 'parent' nodes include the following:

- Project Rationale
- Partnerships
- Prior Partnership Arrangements
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- POPP Programme
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- Commissioning
- Older People's Involvement
- BME Involvement
- Involvement of the Third Sector
- Sustainability

These will need to be further 'tested' across the whole KITI sample. Similarly, it will be necessary to develop such nodes for the Focus Groups and Older People Interviews.

3 Work with the PIR Group: Guidance on work prior to the PIR Group meeting: 15 July 2008.

3.1 'Breaking down the 'node''

In using the PIR Group to support our analysis and, provide inter-rater reliability, we would wish you to concentrate on the node of 'involvement of older people. You will see that this has 21 'child nodes'. Good practice within NUD®IST suggests that we should have no-more than five or six child nodes. This node first needs to be broken down. Suggested categories could include:

- Older People Involvement – Process
- Older People Involvement – Structure
- Older People Involvement – Outcome

For example, Older People Involvement - Process would then incorporate the 'sub' or child nodes of:

- Involvement in Design
- Involvement in Governance
- Involvement in Recruitment
- Involvement in Provision
- Barriers to involvement
- Temporal Involvement

Similarly, if the overall node of 'Older People Involvement – Outcome' is explored, this could include:

- Impact of older people involvement
- Involvement in sustainability
- Involvement in Dissemination
- Cascading information to wider audiences
- Promotion of Services

It would be helpful if some thought could be given to these divisions, although discussion will be held on the day.

3.2 Exploring the extracts

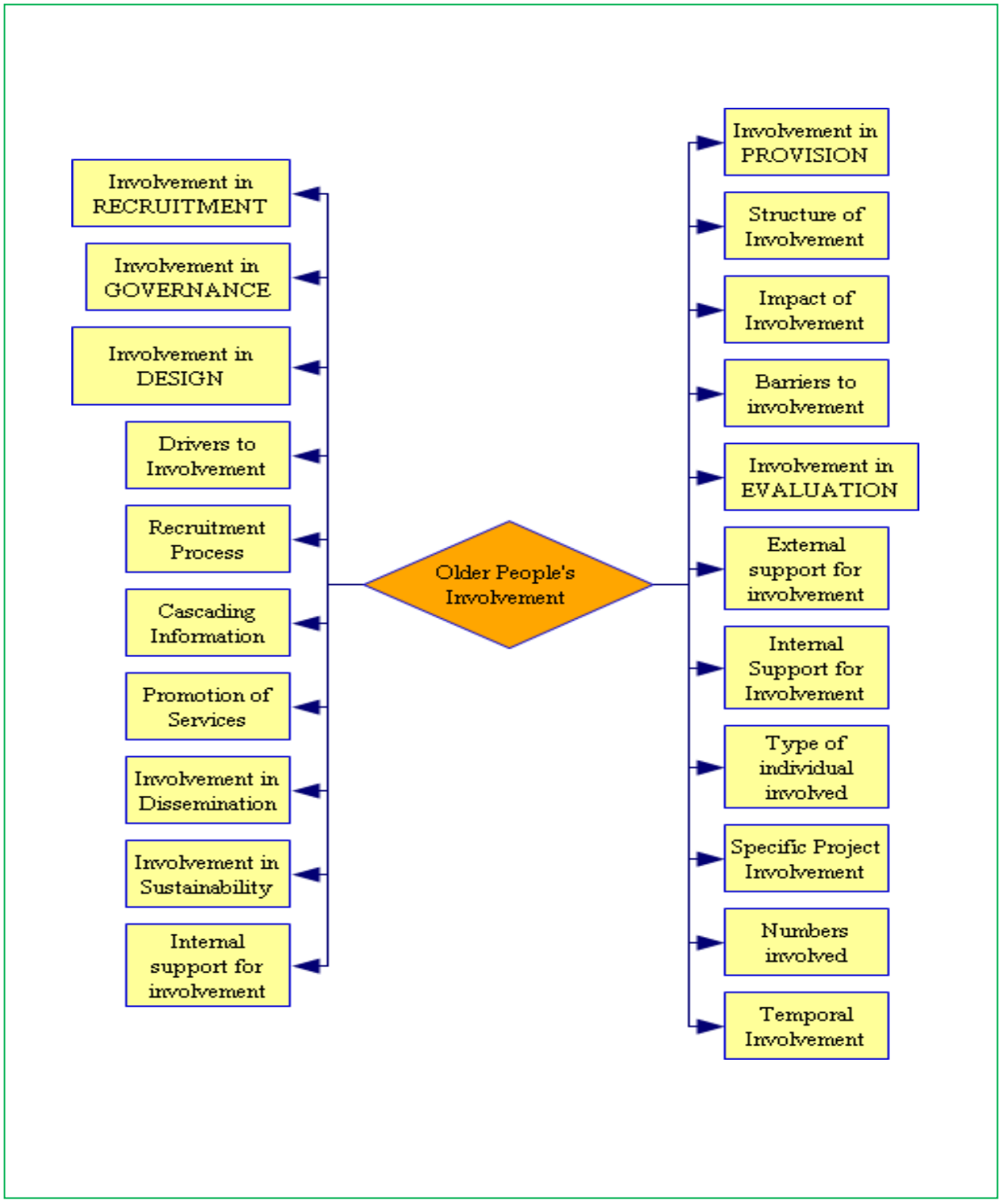
Below, anonymised extracts have been copied into the document. These are drawn from two interviews only and relate to the questions on involvement of older people. **Please do look at the different nodes and, you may wish to highlight some of the areas where you feel the nodes fit**. However, you may also want to think about the following questions:

Do you feel that we have included all the necessary nodes?

From your initial reading, what do you think are they key points?

These will be discussed at the next PIR Group meeting.

3.3 Nodes for 'Older People's Involvement'



4 Anonymised Excerpts from transcripts

4.1 Interview Excerpt: KITI1_DICT074

Interviewer: **Definitely, brilliant, okay we're going to move on now to older people's involvement and we mentioned this slightly previously but we'll kind of go in to more depth here, so can you tell me in what key areas older people have been involved within the POPP programme in your area?**

Respondent: Okay, well they interviewed both me and [Programme Manager], they're on the interview panel obviously with people from health and social care as well, they were part of the commissioning group which set out what was required, not so much, well this is my understanding because I wasn't involved at the beginning but not so much I don't think for the health and specialist services, sort health and social care run services but for the low level services so things like the Navigator Service and the associated Handyperson Service and the ?? Advice Service, they were part of the commissioning group to help determine what was required, so a small example was things like they wanted to make sure that the people, the Handyperson Service were all CRB checked which is something that is necessarily as standard so it's those kinds of things they started to influences and in terms of the Navigator Service what kind of was their role and they obviously highlighted that [County] being quite rural in a lot of areas, there needed to be some provision for transport which is why we've got transport grants as part of the Navigator Service, so it was those kind of things that they started to influence and then when the services were sort of established and up and running we set up a reference group and older people involvement reference group which is mainly representatives from the local older people's groups, the sort of senior forums and there's a number of them around the County but what we do with them is we sort of tend to provide them with an update on progress often and they meet quarterly and often we focus on say a specific service so they can understand more about say the Navigator Service or the MASS Service, the two that spring to mind, and we kind of have the team come and visit and give more of talk, the last project group we went through in detail the sustainability plan that [the county] put together so they could really understand the process that these decisions are being made on and how they can then influence those decisions but it's kind of a good opportunity for them to provide feedback to us about what we're doing and the process we're taking so it's things like because one of the key concerns in [the county] as I said is the rurality and that we've got a lot of towns in sort of the [the county] and a lot of it's villages to the north of the County and it's more difficult to access services from those kinds of rural areas so one of the things they said they wanted to do was look at where service users are, where the services are being delivered to so as a result of that part of our performance monitoring is I produce maps of where all the service users live and I also produce

maps on rate per 10,000 population of service users for that area so we can start to really see well where does there seem to be inequity in service delivery and actually it's been really useful for the actual projects to look at that visually and say it's obviously we're not actually doing enough to promote the service in rural [area] so let's see which organisations or teams we can go and revisit and promote to, so that's come directly out of the feedback from the reference group so it's that kind of stuff and also from that group they've been very supportive and they then feedback to their own older people, like a senior forum, and promote services to them and they distribute our newsletters and they've been part of sort of, they've been involved in informing what that newsletter would look like so we've linked up with them in that way, they attended our planning event in October for 07/08 and as a result we put together an action plan for older people involvement and also again part of that is well, how can we continue this momentum after POPP ends, so we've started to think about that and as a result of that was the POPP party that we held on Thursday which was hosted by [locality] Seniors Forum, and so they've kind of been involved in you know, in helping to promote the services as well and then in terms of evaluation we have through the reference group and through also advertising in our newsletter which we circulate far and wide in [the county], we've got volunteers to carry out telephone interviews, for our local evaluation two of the services we're doing a more in-depth evaluation in and so for those we've got older people involved in doing telephone interviews with service users and also facilitating focus groups, and we've also kind of started in the last couple of months we've got, we've allocated some of the service, an older people's service champion to each of the projects and the Navigator Service has actually had one for quite a while and we're kind of using that as the basis that he attends to contract reviews that [Programme Manager] and I, the programme team have with the Navigator Service, he's been out on a visit with one of the navigators to see a client, he's facilitator for the focus group and he's really helped influence how we promote the service, he said he's given advice on the best way to market in certain areas locally, so they've kind of been involved in that as well so that's sort of the service champion.

Interviewer **Brilliant, so in terms of them becoming involved and you said they're on various boards etc. and they come from senior forums, how have they been recruited to be involved with POPP? Has it kind of been through advertising or…**

Respondent Mainly through the senior forums to be honest, we tend to have a couple or one or two representatives from each of the senior forums and that's how the reverence group was established, what we have done is sent two newsletters out now, one in the summer and one in January and we've sort of advertised in there for further people to get involved either as an interviewer evaluating or just to be part of the reference group membership so it, but what we do recognise is that

they tend to be affiliated to older people's senior forums rather than actually necessarily service users.

Interviewer **And you feel like they really, are they really giving an input in to POPPs?**

Respondent Yeah, yeah certainly and you know, that opportunity is given at the reference group so I see it as very much an open discussion and things like where the POPP party on Thursday seemed to really work, I then discussed with some of the other members of the reference group how we can a similar event at their, where they are in their part of the County so it does feel like that they have, they obviously are listened to, certainly we do very much take on board their feedback but again there is kind of a caveat that these are , you know, they are talking for their local community because they represent a forum but obviously we're talking to an individual so how far that lets them, that kind of gets widened out to the other members of their forum I guess does depend on the individual.

4.2 Interview Excerpt: KITI2_DICT077

Interviewer: **Right, just moving on now to older people's involvement, so firstly just a ?/ question, can you tell m e in what key areas older people have been involved in the within the POPP programme in East Sussex?**

Respondent: Yeah, they've been involved first of all in service design so right from the very beginning we had these broad areas like falls, ambulance service, older people's mental health, we went to local citizens and said, "If we were spending some money in these areas what would be a good idea to focus on?" and "How would you like the service designed? What would make it most effective for you?" so then they've been continuously involved through reference group, we're investing in a survey which will survey I think about 15 or 20,000 people on their views of older people's services and services for people with long term conditions and this is a follow-up survey on a survey that was done 3 years ago by another project but they did an initial survey and said 3 years down the line follow it up and they didn't because they didn't exist anymore, they disappeared when PCTs were reorganised, but some of us were around in the local system and remembered about this and said, "Well, let's go back and do the repeat surveys", so we've actually commissioned that, it hasn't happened yet, but that will be an important thing in terms of gathering the views of local people, we also will survey referring bodies and staff from health and social care as well, then local people were involved in terms of service uses and carers were involved in terms of we've arranged focus groups, we've arranged, and those were citizen led focus groups so they weren't run by consultants or by…

Interviewer: **[Are Older People involved in] doing the evaluation as well ??**

Respondent A couple of citizens were involved in the evaluation through the focus groups through service user and carer interviews so we've had local citizens phoning up who have had, local older people phoning up the people that have enjoyed our services and getting involved in interviews with them, we've developed a quality of life tool where we survey service users before they have the service and then survey them after they've had the service and look at a number of key change areas and the results, the surveys, are very, very, very revealing, numbers aren't great we're in the hundreds not the thousands but some of the things that are emerging are kind of exactly what you would want to see, people are reporting that we haven't cured their illness, we haven't made any difference to their long term health condition but then we didn't set out to do that so that was okay but they now feel much better able to live with health condition they've got, they're able to cope much better, they're more confident, they know more about the condition they've got, they feel more engaged in their own care planning, they feel more in control of their life, they, I mean, they go to hospital less often, well they go to the hospital for on an emergency basis, they might go for outpatients appointments more because they actually know more about what's wrong with them now so they go and pester the GP ?? and so the folks are involved through that process and oh yes, we hold some open consultation and marketing events the local people are involved in that…

Interviewer: In terms of the older people having sort of a real voice in inverted commas, to what extent do you think that your POPP programme has ensured that that is the case?

Respondent I think by having a good long list of things, of different ways that we try and achieve that is one way so just simply, we haven't just done one thing, you know we've done a survey, we've set up a telephone line where people can ring in, we've done lots of different things so we stand more of a chance of hitting a wider audience, getting feedback from more people…

Interviewer: But do you think they're more leading the development of POPP rather than being led in POPP, I mean that seems to be the case from what you said about their kind of citizen's involvement, it seems to be the case…

Respondent Yes, I think, I mean the reference group has continued all the way through and they're a very powerful driver to the whole programme even now towards the end if anything the reference group is stronger as it goes on rather than trailing off towards the end, we got more people coming to the meetings, they're more vocal, they're more kind of, "What's happening with this, what's happening with that?", I mean this is just one tiny example of how they've pushed our practice and made us think of doing things in a different way, the reference group have been saying that they're very concerned about the rural reach, the

reach in to rural services so our performance manager designed a series of maps to illustrate and show and to report on the rural reach of our services and these have really caught on now we've got s supporting people one, we've got, we wouldn't have done it unless they'd raised the issue and pushed us a little bit further forward and now that's something that you know, may become routine in terms of how services have to report, you know the chief executives love it, the head of service love it, local people love it because as I say rurality is a big issue.

Interviewer: In terms of the involvement of older people within the programme, what ways if any do you feel that their involvement has impacted upon this programme?

Respondent: Well, they've told us the sorts of services they wanted the money invested in and that affected what we spent the money on so I mean the real test to me of engagement or involvement is that you have to affect one of the two big important things, it has to affect what you do or what you spend your money on, if it doesn't impact on those two things then it's lip service simple as that, and the involvement of older people in this programme has affected both things directly.

Interviewer: And in what way has the involvement of older people have an impact on the sustainability of the programme or the projects?

Respondent: That's more marginal I think because for all that they can provide pressure and some of our reference groups sit on for instance the Older People's Partnership Board so they sit on the board either recommending or not recommending continued investment, for all that and for all that we can sneakily involve major government Minister type pressure, the fact is that the corporate responsibility for how the money is spent still rests with the body corporate and with the elected representatives so you know, it's always going to be an influence thing I think rather than a, they actually decided about what actually would be, unless in some future scheme we can actually get the powers that be to delegate some money to for instance maybe a village or something, one of the things that I'm suggesting with the social care reform grant we might actually try, actually try getting some money to a community and saying, "What would you address in terms of health and social care here with this money?" and trust our citizens with a little bit of their own cash.

Appendix W

Analysis of Emergency Bed Day Use

Annex W. Analysis of emergency bed-day use

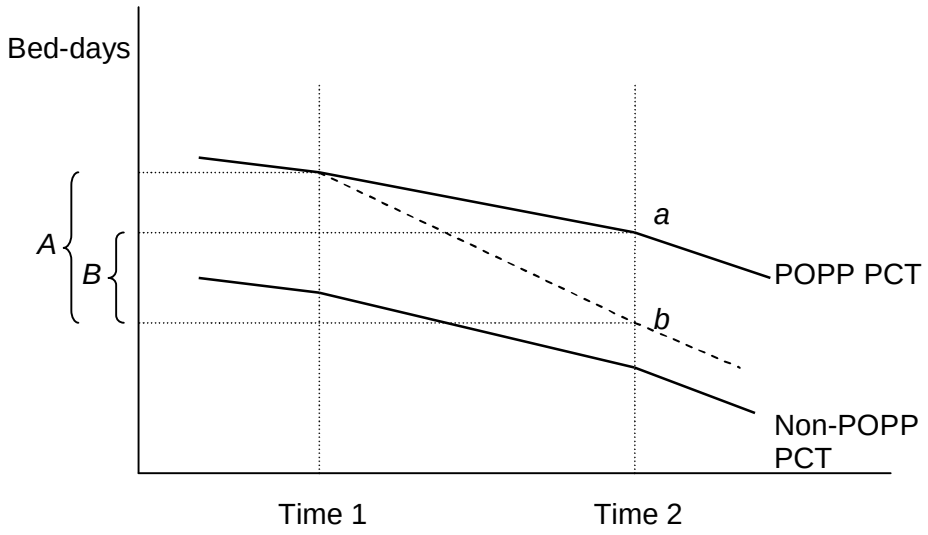
Introduction

POPP potentially brings benefits by reducing the (inappropriate) use of hospital bed-days. Benefits accrue from the savings that could be released from a reduced use of hospital services. In this analysis we consider the impact of POPP on the use of emergency bed days (EBDs). This analysis uses aggregated data. We have available a panel dataset of EBD use for a time period of 60 months (April 2004 to March 2009) across 303 PCT areas (using old boundaries for PCTs). The data were drawn from HES by the Health and Social Care Information Centre. We include both round 1 POPP projects (48 PCTs), which started after April 2006, and round 2 projects (29 PCTs) that started a year later. As well as mapping the existence of POPP projects on to the panel dataset, i.e. POPP PCT sites at the times they were active, we also have information about level of expenditure on each project through the lifetime of the project. We use information on population at PCT and council level to calculate per capita rates for bed use and POPP expenditure.

Methods

The analysis of emergency bed-day use can be illustrated in figure W1 below. The solid lines are the bed-day use of two PCTs. Both are diminishing through time. Cross-sectional effects are the vertical differences between the lines for each PCT. The slope represents the change in emergency bed-days (EBDs) through time. If we accounting for just these two effects then EBD use of the POPP PCT would be estimated at point *a* at time 2. But if we include a dummy variable that identifies just the POPP PCT at the time of the POPP intervention (Time 2) we can potentially detect a POPP effect if one exists. In the example, this deviation is represented by the dashed line, where actual bed-day use in the POPP PCT is at a level *b*. The size of the POPP effect is the vertical difference at time 2 i.e. the amount B, the difference between *actual* EBD use and where the POPP PCT would have been at time 2 without a POPP effect. In this case, we would find the POPP PCT dummy to be significant (and negative).

Figure W1: Stylised POPP effect



To further refine this approach, instead of using a 0 or 1 dummy (POPP site or not) in the estimation, we can use the level of expenditure for the POPP site at any given time. This 'expenditure difference' approach allows us to further differentiate between POPP PCTs where we hypothesise that bigger POPP projects (as measured by their level of expenditure per capita) will have larger effects on EBDs, other things equal.

To this end, we estimate a regression model over a panel dataset where we have 303 cross-sectional units (PCTs) over 60 month time-units (i.e. 18180 observations all together). Suppose EBDs are denoted by *B* and each PCT is identified by a 0/1 dummy *Y* with the month given by a dummy *T*. Then we can fit a model:

(1) $$B_{it} = \alpha + \beta_1 Y_1 + .. + \beta_{303} Y_{303} + \sigma_1 T_1 + .. + \sigma_{60} T_{60} + \theta_{11} Y_1 T_1 X_{11} + .. + \theta_{303,60} Y_{303} T_{60} X_{303,60} + e_{it}$$

The *X*'s are project spend measured in monetary terms and are drawn from a continuous distribution for any non-negative value, which we call: $x_{it} \geq 0$. We can then simplify the notation to:

(2) $$B_{it} = \alpha + \beta_1 Y_1 + \cdots + \beta_N Y_N + \sigma_1 T_1 + \cdots + \sigma_M T_M + \Theta x_{it} + e_{it}$$

At time 1, EBD use in the *i'th* PCT is:

(3) $$B_{i1} = \alpha + \beta_1 Y_1 + \cdots + \beta_N Y_N + \sigma_1 T_1 + \Theta x_{i1} + e_{i1}$$

and at time 2:

(4) $$B_{i2} = \alpha + \beta_1 Y_1 + \cdots + \beta_N Y_N + \sigma_2 T_2 + \Theta x_{i2} + e_{i2}$$

and so on. We can take the difference as:

(5) $$B_{i2} - B_{i1} = \sigma_2 T_2 - \sigma_1 T_1 + \Theta(x_{i2} - x_{i1}) + e_{i2} - e_{i1}$$

or again, more generally,

(6) $B_{it} - B_{it-1} = \sum_{t=2}^{60} \sigma_t T_t - \sigma_{t-1} T_{t-1} + \Theta(x_{it} - x_{it-1}) + e_{it} - e_{it-1}$

in which case the PCT level dummies drop out.

These are equivalent forms. Equation (2) can be directly estimated as a fixed effects model, or as a random effects model writing (2) as:

(7) $B_{it} = \alpha + \sigma_1 T_1 + \cdots + \sigma_M T_M + \Theta x_{it} + e_{it} + u_i$

where u_i is a time-invariant error term.

Alternatively with regard to (6) we can use OLS to estimate over differences:

(8) $B'_{it} = \mu_1 T_1 + \cdots + \mu_{60} T_{60} + \Theta x'_{it} + v_{it}$

where a prime denotes the difference in the variable between time periods.

In each case, finding that the coefficient $\Theta < 0$ indicates that each £1 spent on POPP is associated with a reduction in EBD use relative to the expected level (where the expected level is the 'triangulation' of cross-sectional and time effects). In other words, if the coefficient Θ is significantly negative then there is some process operating in POPP PCTs that results in lower use of EBDs in that PCT at POPP times. Moreover, the impact of this process is directly correlated with the size of spend on the POPP project at that time. We cannot say definitively that POPP is causing these deviations but we can say that this result is consistent with our hypothesis that POPP projects do lower EBD use.

In the estimations that were conducted, the dependent variable was expressed as a cost (rather than number of beds used) by applying a per-bed-day cost. A range of specifications of the above functions were tried. We included lags to account for the lead time between projects setting up and recruiting service users and therefore having an effect. This specification is also useful in minimising the potential for endogeniety (broadly, the direction of causation issue). We also estimated a model accounting for auto-correlation through time – since current bed use is linked to use in previous months (not least because some people stay in hospital for extended periods) – we used an auto-regressive estimator (with a 1 month lag).

We also sought to allow for a non-linear relationship between EBD cost (*B*) and POPP spend (*x*), with the expectation that economies of scale might apply. We model with both squared terms on POPP expenditure and also run a model with a squared dependent variable.

We have a choice of assumptions about costs. Project cost data were available by quarter year and we used this data when looking at within-project-time trends. However, when looking at overall average impacts of POPP, we used a period average value for POPP project expenditure. This approach removed some of the volatility in the expenditure data through the time of the projects. In the models that follow we assume that a fixed management cost overhead of 10% applies (unless stated) i.e. total POPP costs are (averaged) project costs plus a 10% management overhead.

The cost of an emergency bed-day will depend on the nature of the admission, that is, the health problems of the person being admitted. We do not have specific information on this so we need

to use an average figure. Given the uncertainties we therefore used different scenarios for unit costs of EBDs. For the estimations we used a figure of £158 per day based on an average across all admissions. This figure is likely to be low-end estimate. If we use the 08/09 tariff value for non-elective inpatient short stay admission for unexplained symptoms without complications, then unit cost are £274 per day. Our assumption regarding this unit cost does not affect estimates of the impact of POPP on the number of beddays saved. It affects the size of the financial savings that might accrue. A larger unit cost assumption will mean the financial impact of POPP on EBD costs is higher compared to a lower unit cost assumption.

Results

A range of different estimators were tried. For the estimation of (7) – the *levels* model – a random effects estimator with robust standard errors (in light of the heteroskedasticity in the data) was used. A fixed effects model was also used and this produced very similar parameter estimates, as did a random effects model with an auto-regressive error assumption. We also estimated a version with a squared dependent variable. In view of potential re-transformation problems we used a generalised estimating equations (GEE) population averaged estimator with a Gaussian distribution and an AR(1) correlation structure. For the estimation of the *differences* model (8) we used an OLS estimator with robust standard errors. All models were fitted using STATA MP10.1.

Descriptive analysis uncovered a small number of very low bedday rates in the HES data. As a precaution we excluded 0.1% of observations at the bottom and top of the distribution (36 cases) and in doing so reduced the distribution kurtosis to below 4 – see Table W1.

Table W1. Descriptive statistics

Variable	Obs	Mean	Std. Dev.	Min	Max	skew	Kurtosis
EBD per capita 65+	18144	31.40	9.35	3.43	71.32	0.75	3.93
POPP av spend per capita 65	2269	0.85	0.39	0.15	2.15	0.58	4.41

Non-linear relationships

Table W2 gives the estimation results (the parameters) and Table W3 gives the estimation characteristics for the non-linear estimations. These tables report four models:

- the Random effects (RE) estimation and the RE estimation with AR error. Here the dependent variable, *B*, is EBD cost per month per PCT and we use linear and squared powers of POPP expenditure, *x*, lagged 2 months. This function is a version of (7): $B_{it} = \alpha + \sigma_1 T_1 + \cdots + \sigma_M T_M + \Theta_1 x_{it} + \Theta_2 x_{it}^2 + e_{it} + u_i$.
- the OLS estimation of the difference in EBD cost between the current month and the same month 1 year ago. POPP expenditure (linear and squared terms) are also expressed as 12-month differences and also lagged 2 months. This estimation is a version of (8), that is: $B'_{it} = \mu_1 T_1 + \cdots + \mu_{60} T_{60} + \Theta_3 x'_{it} + \Theta_4 x'^2_{it} + v_{it}$.
- the GEE model with squared dependent variable, i.e. a version of (7) such that: $B_{it}^2 = \alpha + \sigma_1 T_1 + \cdots + \sigma_M T_M + \Theta_5 x_{it} + \Theta_6 x_{it}^2 + e_{it} + u_i$.

We can calculate marginal effects from the results. Marginal effects indicate how spending on EBDs changes as a result of a small increase in POPP expenditure. This is useful for understanding whether projects should be expanded or contracted. When the relationship between cause and effect (POPP and EBDs) is non-linear, then the size of marginal effects will depend on the size of the project. We choose the average level of expenditure per POPP PCT among those PCTs in the pilot, $\bar{x}$, i.e. the £0.85 per person 65+ per PCT per month for this calculation. For the RE levels model marginal effects are $\frac{\partial B_{it}}{\partial x_{it}} = \Theta_1 + 2\Theta_2\bar{x}$. For the difference model we are looking at the impact of a *change* of POPP expenditure equal to $\bar{x}$. In this case, the marginal effect is calculated in the same way, $\frac{\partial B_{it}}{\partial x_{it}} = \Theta_3 + 2\Theta_4\bar{x}$.

Other things equal we would expect the marginal effects from the levels models and the difference models to be the same, as indicated above. In practice, however, difference models put more weight on the impact of POPP during the first year of projects. Because, POPP projects are heterogeneous and it is likely that effectiveness will differ through time (e.g. because people being referred will have different characteristics), we might expect to see some difference.

For the squared EBD model the marginal effect is: $\frac{\partial B_{it}}{\partial x_{it}} = \frac{\Theta_5 + 2\Theta_6\bar{x}}{2\bar{B}}$, which we estimate at the sample average EBD spend – see Table W1 above.

Table W2. Model results – non-linear models

	Random effects (RE)		RE, AR(1)		Diff, OLS		GEE, sqr *B*	
	Co-eff	Prob	Co-eff	Prob	Co-eff	Prob	Co-eff	Prob
POPP av expenditure								
- Linear, lag 2	1.11	<0.005	1.00	0.062				
- Squared lag 2	-1.38	<0.005	-1.21	<0.005			-47.15293	<0.005
12 month difference in POPP av expd								
- Linear, lag 2					0.53	0.29		
- Squared lag 2					-0.78	0.05		
Month 4	0.50	0.12	0.50	0.054			83.88	<0.005
Month 5	-0.69	0.02	-0.69	0.021			62.55	<0.005
Month 6	1.12	<0.005	1.12	<0.005			207.89	<0.005
Month 7	0.16	0.63	0.23	0.476			196.18	<0.005
Month 8	1.27	<0.005	1.27	<0.005			296.26	<0.005
Month 9	2.23	<0.005	2.27	<0.005			386.87	<0.005
Month 10	4.03	<0.005	4.03	<0.005			543.27	<0.005
Month 11	0.81	0.02	0.81	0.011			340.62	<0.005
Month 12	4.37	<0.005	4.37	<0.005			602.89	<0.005
Month 13	-13.37	<0.005	-13.38	<0.005			-377.31	<0.005
Month 14	-2.99	<0.005	-3.00	<0.005			135.52	<0.005
Month 15	-0.42	0.16	-0.43	0.176	-3.53	<0.005	303.12	<0.005
Month 16	-1.98	<0.005	-2.00	<0.005	-5.59	<0.005	218.11	<0.005
Month 17	-1.55	<0.005	-1.56	<0.005	-3.97	<0.005	251.35	<0.005
Month 18	-1.74	<0.005	-1.75	<0.005	-5.97	<0.005	250.44	<0.005
Month 19	-1.60	<0.005	-1.62	<0.005	-5.08	<0.005	250.45	<0.005
Month 20	-0.75	0.02	-0.76	0.017	-5.20	<0.005	311.44	<0.005
Month 21	-0.08	0.80	-0.10	0.762	-5.56	<0.005	357.58	<0.005
Month 22	1.36	<0.005	1.34	<0.005	-5.82	<0.005	463.80	<0.005
Month 23	-1.44	<0.005	-1.47	<0.005	-5.39	<0.005	272.50	<0.005
Month 24	1.68	<0.005	1.65	<0.005	-5.80	<0.005	501.50	<0.005
Month 25	-14.86	<0.005	-14.88	<0.005	-4.59	<0.005	-391.00	<0.005
Month 26	-3.54	<0.005	-3.57	<0.005	-3.66	<0.005	158.86	<0.005
Month 27	-2.35	<0.005	-2.37	<0.005	-5.04	<0.005	226.49	<0.005
Month 28	-3.59	<0.005	-3.63	<0.005	-4.71	<0.005	144.08	<0.005
Month 29	-3.03	<0.005	-3.06	<0.005	-4.58	<0.005	191.34	<0.005
Month 30	-3.36	<0.005	-3.39	<0.005	-4.73	<0.005	162.11	<0.005
Month 31	-2.85	<0.005	-2.88	<0.005	-4.35	<0.005	196.52	<0.005
Month 32	-2.85	<0.005	-2.88	<0.005	-5.27	<0.005	202.16	<0.005
Month 33	-4.12	<0.005	-4.15	<0.005	-7.14	<0.005	125.24	<0.005
Month 34	-0.30	0.36	-0.32	0.323	-4.76	<0.005	361.92	<0.005
Month 35	-3.41	<0.005	-3.44	<0.005	-5.19	<0.005	168.37	<0.005
Month 36	-1.41	<0.005	-1.43	<0.005	-6.36	<0.005	293.28	<0.005
Month 37	-15.79	<0.005	-15.80	<0.005	-3.93	<0.005	-417.84	<0.005
Month 38	-5.07	<0.005	-5.09	<0.005	-4.59	<0.005	79.58	<0.005
Month 39	-4.81	<0.005	-4.83	<0.005	-5.40	<0.005	95.02	<0.005
Month 40	-4.08	<0.005	-4.10	<0.005	-3.48	<0.005	136.22	<0.005
Month 41	-4.24	<0.005	-4.26	<0.005	-4.20	<0.005	124.07	<0.005
Month 42	-6.52	<0.005	-6.54	<0.005	-6.15	<0.005	4.26	0.78
Month 43	-3.12	<0.005	-3.14	<0.005	-3.26	<0.005	198.59	<0.005
Month 44	-3.49	<0.005	-3.51	<0.005	-3.55	<0.005	173.85	<0.005
Month 45	-3.72	<0.005	-3.70	<0.005	-2.51	<0.005	159.70	<0.005
Month 46	0.52	0.11	0.50	0.119	-2.19	<0.005	430.90	<0.005
Month 47	-2.64	<0.005	-2.66	<0.005	-2.24	<0.005	230.54	<0.005
Month 48	-2.66	<0.005	-2.68	<0.005	-3.97	<0.005	223.10	<0.005
Month 49	-14.37	<0.005	-14.39	<0.005	-1.64	<0.005	-361.31	<0.005
Month 50	-5.15	<0.005	-5.17	<0.005	-3.13	<0.005	77.86	<0.005
Month 51	-4.30	<0.005	-4.32	<0.005	-2.55	<0.005	132.83	<0.005
Month 52	-2.98	<0.005	-3.01	<0.005	-1.92	<0.005	217.24	<0.005
Month 53	-5.34	<0.005	-5.39	<0.005	-4.15	<0.005	74.29	<0.005
Month 54	-3.48	<0.005	-3.57	<0.005			182.74	<0.005
Month 55	-1.99	<0.005	-2.00	<0.005	-1.90	<0.005	281.60	<0.005
Month 56	-4.06	<0.005	-4.12	<0.005	-3.63	<0.005	145.82	<0.005
Month 57	0.87	0.01	0.85	0.009	1.54	<0.005	462.48	<0.005
Month 58	1.45	<0.005	1.44	<0.005	-2.00	<0.005	503.02	<0.005
Month 59	-2.29	<0.005	-2.31	<0.005	-2.61	<0.005	250.54	<0.005
Month 60	-0.28	0.39	-0.30	0.347	-0.58	0.15	381.82	<0.005
Pop 65	-4.54E-04	<0.005	-4.21E-04	0.014	9.58E-06	0.63		
Pop 65 (sqrd)	4.40E-09	0.04	4.60E-09	0.086	-1.63E-10	0.58		
Cons	42.82	<0.005	41.77	<0.005	2.93	<0.005	757.10	<0.005

Table W3. Model results – non-linear models (characteristics)

	Random effects (RE)		RE, AR(1)		FD, OLS		GEE, sqr *B*	
	Co-eff	Prob	Co-eff	Prob	Co-eff	Prob	Co-eff	Prob
N	17538		17538		13907		17400	
Groups	303		303				290	
Wald	20070.16	<0.005	21138.73	<0.005			1923.52	<0.005
F					33.27	<0.005		
R sqrd								
- within	0.52		0.52					
- between	0.02		0.02					
- overall	0.19		0.19		0.11			
Reset test					1.52	0.21		

The four models produce a range of marginal effects that are reported in Table W4 (rounded to the nearest 10p). We present the point estimate and the upper and lower 95% confidence interval for the marginal effect. As anticipated, the difference model produces slightly different results.

Table W4. Marginal effects - non-linear relationship models

Model	Marginal effect £s)		
	Point estimate	High	Low
Random effects (RE)	-£1.20	-£0.70	-£1.60
RE, AR(1)	-£1.10	-£0.50	-£1.60
FD, OLS	-£0.80	-£0.20	-£1.40
GEE, sqr *B*	-£1.30	-£0.90	-£1.70

Linear relationships

Marginal effects in non-linear models depend on the level of expenditure. Therefore, the first £1 spent will have a different (lower) marginal effect than an additional £1 spent relative to the average level of expenditure. If we fit a linear model, marginal effects are held constant and therefore this analysis gives us an approximation of the *average* effect of each £1 spent on POPP. We estimate two models, a random effects model and a difference model. These estimations are reported in Table W5 and Table W6.

Table W5. Model results –linear models (dependent var = *B*)

	Random effects (RE)		FD, OLS	
	Co-eff	Prob	Co-eff	Prob
POPP av expenditure				
- Linear, lag 2	-0.55	<0.005		
12 month difference in POPP av expd				
- Linear, lag 2			-0.40	0.03
Month 4	0.49	0.13		
Month 5	-0.67	0.03		
Month 6	1.12	<0.005		
Month 7	0.16	0.65		
Month 8	1.29	<0.005		
Month 9	2.22	<0.005		
Month 10	4.02	<0.005		
Month 11	0.81	0.02		
Month 12	4.37	<0.005		
Month 13	-13.36	<0.005		
Month 14	-2.97	<0.005		
Month 15	-0.42	0.17	-3.53	<0.005
Month 16	-1.97	<0.005	-5.59	<0.005
Month 17	-1.57	<0.005	-3.97	<0.005
Month 18	-1.73	<0.005	-5.97	<0.005
Month 19	-1.62	<0.005	-5.08	<0.005
Month 20	-0.76	0.02	-5.20	<0.005
Month 21	-0.07	0.82	-5.56	<0.005
Month 22	1.37	<0.005	-5.82	<0.005
Month 23	-1.49	<0.005	-5.39	<0.005
Month 24	1.67	<0.005	-5.80	<0.005
Month 25	-14.85	<0.005	-4.59	<0.005
Month 26	-3.53	<0.005	-3.66	<0.005
Month 27	-2.34	<0.005	-5.03	<0.005
Month 28	-3.55	<0.005	-4.70	<0.005
Month 29	-3.00	<0.005	-4.57	<0.005
Month 30	-3.35	<0.005	-4.72	<0.005
Month 31	-2.83	<0.005	-4.34	<0.005
Month 32	-2.80	<0.005	-5.26	<0.005
Month 33	-4.09	<0.005	-7.13	<0.005
Month 34	-0.30	0.37	-4.75	<0.005
Month 35	-3.40	<0.005	-5.18	<0.005
Month 36	-1.40	<0.005	-6.35	<0.005
Month 37	-15.78	<0.005	-3.92	<0.005
Month 38	-5.06	<0.005	-4.58	<0.005
Month 39	-4.75	<0.005	-5.39	<0.005
Month 40	-4.04	<0.005	-3.46	<0.005
Month 41	-4.19	<0.005	-4.18	<0.005
Month 42	-6.49	<0.005	-6.13	<0.005
Month 43	-3.08	<0.005	-3.24	<0.005
Month 44	-3.45	<0.005	-3.53	<0.005
Month 45	-3.64	<0.005	-2.49	<0.005
Month 46	0.55	0.09	-2.18	<0.005
Month 47	-2.59	<0.005	-2.22	<0.005
Month 48	-2.59	<0.005	-3.96	<0.005
Month 49	-14.31	<0.005	-1.62	<0.005
Month 50	-5.08	<0.005	-3.11	<0.005
Month 51	-4.24	<0.005	-2.55	<0.005
Month 52	-2.90	<0.005	-1.92	<0.005
Month 53	-5.28	<0.005	-4.15	<0.005
Month 54	-3.42	<0.005		
Month 55	-1.95	<0.005	-1.90	<0.005
Month 56	-4.00	<0.005	-3.63	<0.005
Month 57	0.91	0.01	1.54	<0.005
Month 58	1.49	<0.005	-2.00	<0.005
Month 59	-2.26	<0.005	-2.61	<0.005
Month 60	-0.23	0.49	-0.58	0.15
Pop 65	-4.27E-04	0.01	8.97E-06	0.65
Pop 65 (sqrd)	3.81E-09	0.09	-1.48E-10	0.62
MFF	10.29	0.11		
Cons	32.31	<0.005	2.94	<0.005

Table W6. Model results –linear models (characteristics)

	Random effects (RE)		FD, OLS	
	Co-eff	Prob	Co-eff	Prob
N	17306		13907	
Groups	299			
Wald	19548.42	<0.005		
F			-	
R sqrd				
- within	0.52			
- between	0.03			
- overall	0.19		0.11	
Reset			0.55	0.64

Table W7 gives the (constant) effects in the linear model, which equate to the average impact of £1 POPP spend on EBD costs. These results suggest that, on average, projects demonstrate economies of scale – marginal effects at the mean project spend are about twice as large as the average effect. Using a cubed term in the non-linear estimations, there is a tentative suggestion that for much bigger projects, diminishing returns will eventually set in.

Table W7. Marginal effects - linear relationship models

Model	Marginal effect £s)		
	Point estimate	High	Low
Random effects (RE)	-£0.60	-£0.30	-£0.80
FD, OLS	-£0.40	-£0.09	-£0.70

Varying project spend

The above estimations use the averaged POPP expenditure. We also estimated models where quarterly expenditure was allowed to vary. These results are more tentative, due to the volatility of the data. Best results were found from a GEE model with a squared dependent variable – see Table W8. With a 10% management overhead, as above, marginal effects are very similar as before (a point estimate of -£1.20 and a range of (-£0.90 to -£1.60). Because it uses varying project spend, this model was used to produce the trend figures in the main text.

Table W8. Model results – GEE varying costs models (dependent var = B^2)

GEE population-averaged model		
Number of obs	18180	
Number of groups	303	
Obs per group: min	60	
avg	60	
max	60	
Wald chi2(58)	1877.92	
Prob > chi2	<0.001	
	Coeff	**prob**
POPP project spend	-76.52	<0.001
monthdum4	83.21	<0.001
monthdum5	62.06	<0.001
monthdum6	213.58	<0.001
monthdum7	203.76	<0.001
monthdum8	293.73	<0.001
monthdum9	396.08	<0.001
monthdum10	541.20	<0.001
monthdum11	337.53	<0.001
monthdum12	606.68	<0.001
monthdum13	-388.68	<0.001
monthdum14	136.78	<0.001
monthdum15	308.83	<0.001
monthdum16	217.38	<0.001
monthdum17	252.29	<0.001
monthdum18	246.64	<0.001
monthdum19	260.45	<0.001
monthdum20	323.53	<0.001
monthdum21	369.00	<0.001
monthdum22	473.03	<0.001
monthdum23	292.10	<0.001
monthdum24	509.34	<0.001
monthdum25	-402.61	<0.001
monthdum26	162.90	<0.001
monthdum27	229.03	<0.001
monthdum28	155.93	<0.001
monthdum29	191.47	<0.001
monthdum30	180.66	<0.001
monthdum31	212.50	<0.001
monthdum32	206.34	<0.001
monthdum33	128.42	<0.001
monthdum34	375.90	<0.001
monthdum35	173.50	<0.001
monthdum36	280.85	<0.001
monthdum37	-425.30	<0.001
monthdum38	80.49	<0.001
monthdum39	98.32	<0.001
monthdum40	144.32	<0.001
monthdum41	137.61	<0.001
monthdum42	8.52	0.595
monthdum43	216.61	<0.001
monthdum44	194.83	<0.001
monthdum45	183.13	<0.001
monthdum46	452.66	<0.001
monthdum47	245.94	<0.001
monthdum48	245.60	<0.001
monthdum49	-359.86	<0.001
monthdum50	91.60	<0.001
monthdum51	141.42	<0.001
monthdum52	217.72	<0.001
monthdum53	75.83	<0.001
monthdum54	182.32	<0.001
monthdum55	292.84	<0.001
monthdum56	152.54	<0.001
monthdum57	469.81	<0.001
monthdum58	524.57	<0.001
monthdum59	272.67	<0.001
monthdum60	404.88	<0.001
_cons	771.23	<0.001

Interaction effects

Thus far we have been concerned with the average impact of POPP projects. However, the projects themselves varied considerably in their aim, scope and intended effect. Around 70% of the POPP PCTs had projects that can be classified as secondary or tertiary prevention services, rather than primary prevention support. In the short run especially, we would expect secondary and tertiary prevention programmes to have a more direct impact on hospitalisation rates. Indeed, some of these projects were specifically aimed at reducing inappropriate hospital admissions or facilitating discharge from hospital. We can use an interaction dummy to mediate the relationship between POPP expenditure and EBD use. In particular, we can specify a variant of (7):

(9) $$B_{it} = \alpha + \sigma_1 T_1 + \cdots + \sigma_M T_M + \Theta_7 x_{it} + \Theta_8 x_{it}^2 + \Theta_9 x_{it} Z_i + e_{it} + u_i.$$

where Z_i is a dummy variable taking a value of one when the project in PCT *i* is classified as secondary or tertiary prevention (this dummy does not change over the period of the project). Again we used lagged values of the POPP expenditure variable x_{it}. We estimate this function using a Random effects model with robust standard errors (as before). If we used a mean value of Z_i across all POPP sites, then the marginal effects from (9) i.e. $\frac{\partial B_{it}}{\partial x_{it}} = \Theta_7 + 2\Theta_8\bar{x} + \Theta_9\bar{Z}$, should equate to the marginal effects from the RE estimation of (7). We can also differentiate the marginal effect of secondary or tertiary prevention projects, $\left.\frac{\partial B_{it}}{\partial x_{it}}\right|_{Z_i=1} = \Theta_7 + 2\Theta_8\bar{x} + \Theta_9$, from primary prevention projects, , $\left.\frac{\partial B_{it}}{\partial x_{it}}\right|_{Z_i=0} = \Theta_7 + 2\Theta_8\bar{x}$, assuming that other things are equal (including the level of expenditure on the projects).

The estimation results are presented in Table W9. The interaction term is significant ($p = 0.034$) and negative which supports our hypothesis. Table W10 gives the marginal effects by project type. Given the more complicated form of the interaction terms, we used a bootstrapping approach to calculate the confidence intervals on each marginal effect estimate. Primary prevention projects do not have a statistically significant marginal effect, whereas secondary and tertiary projects have an effect about 20% greater than the mean effect.

Table W9. Model results – non-linear interaction models (dependent var = *B*)

Random effects (RE)					
	Co-eff	Prob		Co-eff	Prob
POPP av expenditure			N	17538	
- Linear, lag 2	1.49	<0.005	Groups	303	
- Squared lag 2	-1.22	<0.005	Wald	20120.14	<0.005
- Linear (lag 2) × Sec & Tertiary project PCTs	-0.71	0.034	F		
Month 4	0.50	<0.005	R sqrd		
Month 5	-0.69	<0.005	- within	0.52	
Month 6	1.12	<0.005	- between	0.01	
Month 7	0.17	<0.005	- overall	0.18	
Month 8	1.27	<0.005	Reset		
Month 9	2.23	<0.005			
Month 10	4.03	<0.005			
Month 11	0.81	<0.005			
Month 12	4.37	<0.005			
Month 13	-13.37	<0.005			
Month 14	-2.99	<0.005			
Month 15	-0.42	<0.005			
Month 16	-1.98	<0.005			
Month 17	-1.55	<0.005			
Month 18	-1.74	<0.005			
Month 19	-1.60	<0.005			
Month 20	-0.75	<0.005			
Month 21	-0.08	<0.005			
Month 22	1.36	<0.005			
Month 23	-1.44	<0.005			
Month 24	1.68	<0.005			
Month 25	-14.85	<0.005			
Month 26	-3.54	<0.005			
Month 27	-2.35	<0.005			
Month 28	-3.59	<0.005			
Month 29	-3.03	<0.005			
Month 30	-3.35	<0.005			
Month 31	-2.85	<0.005			
Month 32	-2.85	<0.005			
Month 33	-4.11	<0.005			
Month 34	-0.30	<0.005			
Month 35	-3.40	<0.005			
Month 36	-1.40	<0.005			
Month 37	-15.79	<0.005			
Month 38	-5.07	<0.005			
Month 39	-4.81	<0.005			
Month 40	-4.08	<0.005			
Month 41	-4.24	<0.005			
Month 42	-6.52	<0.005			
Month 43	-3.12	<0.005			
Month 44	-3.49	<0.005			
Month 45	-3.72	<0.005			
Month 46	0.52	<0.005			
Month 47	-2.64	<0.005			
Month 48	-2.66	<0.005			
Month 49	-14.37	<0.005			
Month 50	-5.15	<0.005			
Month 51	-4.30	<0.005			
Month 52	-2.98	<0.005			
Month 53	-5.34	<0.005			
Month 54	-3.48	<0.005			
Month 55	-1.99	<0.005			
Month 56	-4.06	<0.005			
Month 57	0.87	<0.005			
Month 58	1.45	<0.005			
Month 59	-2.29	<0.005			
Month 60	-0.28	<0.005			
Pop 65	-1.78E-04	<0.005			
Cons	39.04	<0.005			

Table W10. Marginal effects – distinguishing project type.

	Marginal effects		
	Point estimate	High	Low
All POPP PCTs	-£1.10	-£0.70	-£1.50
Secondary and Tertiary prevention	-£1.30	-£0.90	-£1.70
Primary prevention	-£0.60	£0.10	-£1.30

Concluding remarks

Overall, POPP projects have a significant effect on hospital emergency bed-day use. Using a variety of estimation approaches we found a significant, negative relationship between POPP expenditure and (the cost of) EBDs. Furthermore, using interaction effects in the estimation, PCTs with projects classified as secondary or tertiary prevention had a significantly greater (reduction) effect of EBDs than primary prevention POPP PCTs.

Although the results vary somewhat, there is a strong suggestion that the impact of an extra £1 spending on POPP (from the average level of expenditure) is a reduction of between £0.80 and £1.60 in the cost of emergency bed days in hospital.

There are a range of caveats we need to make explicit in this analysis. There are issues with data quality that we cannot fully mitigate. Also, although we have taken steps to minimise this problem (using POPP expenditure data, lagging and project classification) there remains a chance that the effects on EBDs seen in POPP PCTs might be as a result of other, non-POPP, measures in those PCTs. This is a potential problem with aggregated data that can only be fully mitigated by conducting full randomised control trials at individual level. The final (related) issue is the substantial heterogeneity of POPP projects. This adds complexity and also makes the interpretation of results more difficult.