



The
University
Of
Sheffield.



The Integrated Care Programme Pilot

An Interim Report

John Ratcliffe (Ma in Social Research, University of Sheffield)

Emma Kershaw (Data Analyst, Age UK Sheffield)

Assistance from Andrea Wigfield (Director, Care-Connect)

Contents

Executive Summary	3
Introduction	6
<i>Implementation of the ICP</i>	6
<i>Research Aims</i>	7
Methodology	8
<i>Referral data collection</i>	8
<i>Surveys</i>	9
<i>Semi-Structured Interviews</i>	11
Referrals	12
<i>Referrals to the ICP</i>	12
<i>Referrals from the ICP to other organisations</i>	13
Physical Health	15
Mental Health	17
Independence and Control	18
Service Users' Finances	20
Social Connections and Quality of Life	21
Conclusion	25
Bibliography	27
Appendix	28

Executive Summary

The fundamental aims of the Integrated Care Programme (ICP) are to promote the appropriate use of community resources and statutory services, facilitate improvement in the physical and mental health of its service users, promote service user's independence, and to carry these out in a person centred and financially sustainable manner. This report, then, attempts to outline how successful it has been so far in regard to these, using three methods that are summarised below.

Referrals

In order to provide information indicative of how 'integrated' the ICP has been, data on both the initial referrals to the ICP, and from the ICP to other organisations, were collated and categorised in relation to a cohort of 78 ICP service users who had finished the service on 17th February 2016. From this, four key factors were noted:

- Service users experienced an average of 9.24 referrals by ICP workers to elsewhere during their time on the ICP, representing a thorough attempt to utilise community resources and statutory services.
- 265 *different* organisations were referred to, in which there was a notable variation in the nature of the services, representing a good level of knowledge amongst ICP service deliverers about the community resources and statutory services available.
- 46% of the cohort were referred to a social/activity group, and 17% to an exercise group. Previous research has shown the benefit of both of these types of group.
- Over half of the referrals to the ICP pilot were from medical centres/general practices, a factor noteworthy as research on other third sector programmes has noted that GPs have not always effectively promoted these kinds of schemes.

Surveys

Service users were asked to fill in a survey at three time-points: immediately prior to its commencement; immediately following its completion; and a follow up two months after the service had ended. In this report, the survey responses of the same cohort of 78 individuals who had completed the service on 17th February 2016 were used. However, this survey is ongoing, therefore any future research on the efficacy of the ICP will have a

larger sample population. From the data at this stage, seven points can be noted:

- The vast majority of the survey responses showed aggregate increases in scores, suggesting the ICP has been successful in its person centred goals.
- Relatively few surveys have been completed, reducing the likeliness of statistical significance (the number of valid responses at the 'completion' stage ranges from 47-49, and at the follow up stage from 15-17). However, as this is an interim report on the ICP so far this was inevitable, but does not overly detract from the usefulness of the results.
- 'Physical health' increased more significantly following the culmination of the service, implying a long term benefit to the service.
- The overall increases in physical health scores are particularly noteworthy as Office of National Statistics data suggest that self-reported health decreases drastically in the age groups of our cohort.
- 'Mental well-being' showed similar increases at all time-points, although this change was not statistically significant when regarding the follow up (probably due to the low numbers of completed questionnaires).
- 'Independence and control' showed increases between all stages of the survey, though these were not statistically significant.
- 'Service users' finances' showed a significant positive effect during the service, which then stayed at the same higher score at the follow up, showing that the ICP has a real role in assisting people to better their economic situation.
- The one decrease in scores across the entire survey was related to the follow up for 'social relationships', and was attributable to two large outliers (in this case, two respondents who reported large decreases, when the remainder of respondents reported fairly unchanging scores).

Interviews

In order to add real life context to compliment the statistical data, three in-depth interviews were conducted. These were with a service user, a different service user's primary carer/relative, and an ICP service provider. A summary of four important points in regard to these is provided below:

- A significant aspect of promoting independence and control was in 'preventative' measures, usually by planning for future potential difficulties. The survey, then, does not adequately portray how much is done in this regard, as such preventative measures would not constitute an increase in *current* levels of independence and control.
- Some of the comments and actions discussed represented notable levels of potential savings for the NHS or the Sheffield Social Care system, as they stated how the ICP had increased fitness, possibly ensured one person could remain living at home, and had, in numerous ways, reduced the likelihood of falls.
- The interviewees also portrayed how referrals to other services were conducted in a person centred and effective manner, and further supported the notion that a wide variety of referrals were indeed made to them.
- Overall, the interviewees were very positive about the ICP, and were keen to state this, adding support to the positive survey data.

1. Introduction

The Integrated Care Programme (ICP) is a project developed at a national level by Age UK, and delivered in nine pilot sites, of which Sheffield is one. The project is delivered by Age UK Sheffield Independent Living Co-ordinators (ILCs). The funding partners are NHS Sheffield Clinical Commissioning Group and Age UK. Other local partners are Sheffield Hospitals NHS Foundation Trust, Sheffield City Council, and Primary Care Sheffield. It is currently being piloted in Sheffield, with the stated aims of:

- Improving the physical health, mental health and social care outcomes and experiences of older people and encouraging people to be active citizens so they can lead a healthier life.
- Increasing the independence of older people with high level of health and social care needs to enable a more appropriate use of services.
- Reducing avoidable emergency admissions to acute care among older people.
- Reducing the dependency of older people upon social care services including delaying the use of high intensity social care (residential and domiciliary care).
- Ensuring more appropriate use of statutory services for older people with different kinds of need (allocative efficient use of resources).
- Supporting financial sustainability in the Sheffield health and social care economy and local sustainability through the building and strengthening of community assets.

Implementation of the ICP

To qualify for the ICP pilot, service users were initially required to have had at least two long term health conditions, and at least two unplanned acute hospitalisations within the last 12 months. However, this was felt to be too limiting with regard to who can access the service, so in Autumn 2015 it was changed to three possible criteria for qualification (these may be subject to further change for the same reason):

1. As above
2. At least two long term health conditions, at least one unplanned acute hospitalisation/s within the last 36 months, and a high NHS risk stratification score from a GP.
3. At least two long term health conditions, at least one unplanned acute hospitalisation/s within the last 36 months, and at least one unplanned admission to a community hospital

or use of a health service with a demonstrably significant cost.

Once an individual has been successfully referred to the ICP, they are assigned an Age UK Sheffield ILC, who will meet with them to discuss their needs. Using a flexible and person centred approach, the Age UK ILC then provides the service user with information and assistance enabling them to access community resources, statutory services, and informal support, with the aim of facilitating a healthier, active, more independent life.

Research aims

As the pilot scheme is still in progress, the aim of this research is to provide an *interim* report on the efficacy of the ICP so far. In line with the above aims, the report is divided into six sections. Firstly, 'referrals' are discussed, as they are an integral aspect of the service in two distinct ways; in terms of how service users came to be on the ICP, and in relation to what information Age UK ILCs are providing services users about community resources and statutory services.

The remaining sections are 'Physical Health', 'Mental Health', 'Independence and Control', 'Service Users' Finances', and Social Connections and Quality of Life. The former three all relate directly to areas which the ICP aims to facilitate improvements in amongst its service users. 'Service Users' Finances' was then utilised as a specific area to research as evidence has long suggested that people in better financial circumstances have better physical and mental health (Bartley 2004). Finally, 'Other issues' is a separate section as the survey included several potentially relevant questions which could not be coded according to the previous sections.

2. Methodology

This research consists of three methods: a collation of data regarding referrals both *to* and *from* the ICP; a quantitative survey of 78 service users (carried out at three comparative time-points); and three qualitative interviews with a service user, a different service user's relative/carer, and an Age UK Sheffield Independent Living Co-ordinator involved in delivering the ICP.

Referrals

As noted above, 'integration' with other service providers is a key aim of the ICP, as it can enable the provision of the best services possible for its service users. To provide an overview of this, Age UK Sheffield's database of recorded referrals was collated into two separate collections of categorised information, using a cohort of 78 service users who were listed as having completed the ICP on 17th February 2016.

The first collection, which is sub-headed '*Referrals to the ICP*', relates to which organisation or individual referred the service user to the ICP, and therefore amounts to precisely 78 referrals. These were then categorised into six types: self-referred; referred by a family member/friend; a GP service; a hospital; a third sector organisation; or another kind of organisation. From this, two kinds of information could be ascertained: how many service users were referred to the ICP pilot by an organisation/individual in each category; and how many *different* organisations successfully referred someone to the ICP pilot, both in total and within each category.

The second collection of data, which is titled '*Referrals by ICP service deliverers to other organisations*', relates to referrals for service users, by ICP service providers, onto other services, sites, or community resources. For this, the types of referral were divided into eight categories. The first four, 'medical care/support', 'mental health', 'Assisting independent living' and 'citizens advice, housing advice or finance', directly reflected the subheadings noted above. In addition to this, four further categories were created. The first, social/activity groups, was added as research has shown that 'health and well-being programmes are beneficial because of the *social interaction* that they engender' (Wigfield et al 2015, p12). Secondly, 'exercise groups' were used as a category due to research showing that attending them can reduce health and social care costs by delaying the onset

of hip fractures (Davis and Ritters 2009), and by reducing premature deaths (Watt and Blair 2009). Thirdly, 'care and respite services' were counted as a high number of this referral type existed, and they are relevant to the appropriate use of statutory services. Finally, an 'other' category includes referrals that were unclear in their nature (eg 'Voluntary Centre Drop In' or 'Screwfix Direct'), related to post death services (eg Co-operative Funeral Care), were related to alarm systems installation (eg Age UK personal alarms), or are for reducing unwanted attention (eg telephone preference service).

As above, two types of data could be gleaned from this, albeit of a similar but not identical nature. These types of information are, firstly, on the total number of referrals/different organisations referred to, and secondly the total number of service users being referred to at least one organisation in each category. Three technical issues should also be noted. Firstly, the count includes referrals to other Age UK services, and referrals to separate departments within the same larger organisation, such as different departments within Sheffield City Council. Secondly, all organisations were only placed in one category despite the potential crossover of some. These were placed according to their primary status; for instance, though a gardening club would likely involve some exercise, it was designated an 'activity' group rather than an 'exercise group', as that is its foremost purpose (a full list of each organisation and in what category they were placed in is available in the Age UK reports database). Thirdly, all referrals were included in the count, though they were not all taken up by the service users, as the option to utilise a referral is an important facilitation of choice and independence, even if it was not eventually actioned upon.

Questionnaire

ICP service users were/are being asked to answer the same questionnaire at three stages of the programme: immediately prior to its commencement; immediately following its completion; and two months after their ICP service had completed. As with the referrals data, we extracted all of the people on the programme who were listed as completed on the 17th February 2016, a total of 78 people. For each time-point, any customer ID which did not have a questionnaire recorded at each of the time-points in the comparison, or which had invalid responses, was disregarded.

The areas identified as particularly relevant to the ICP: physical health; mental health;

independence and control; and finances, were afforded several questions each. The answers to these then combined to create composite scores, and shown as a mean score between one and five. In addition to this, three questions on 'social relationships', one on 'leisure and activities' and one on 'quality of life' are considered in this report (although other questions were asked that were not for this research). All the questions consist of a series of 'Likert-scale' style questions, in which people rate a statement on a scale of five potential answers from 'strongly disagree' to 'strongly agree', with 'neither agree or disagree' in the middle. A mixture of 'positive' and 'negative' statements were used, which in coding meant that for a 'positive' statement, selecting 'strongly disagree' was accorded a score of one and 'strongly agree' five. Conversely, for a 'negative' statement, 'strongly disagree' equated to a score of five, and 'strongly agree' one. The 'mental health' section, however, differed slightly as it utilised the seven item version of the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS), an increasingly widely utilised statistical measure of people's self-reported mental health. In this, statements are still rated according to a five code scale, however the answers range from 'none of the time' to 'all of the time', with 'some of the time' as the middle answer coded as three. A copy of the questionnaire is included in the appendix.

To analyse the statistical significance in any difference between time-points, a linear mixed model analysis was carried out in R (a statistical data computer programme), with customer ID as a random intercept. In other words, this model tests whether the difference can be accounted for by Age UK Sheffield's input (as best as we can measure with this service delivery model), rather than this difference occurring through random chance, and allows for the fact that people start with different baselines. Statistical significance was calculated according to the composite score means. The composite score means were then divided by the number of questions in the section in order to create the mean score between one and five shown. This was done for ease of reading, as each section had a different number of questions creating the composite scores. Finally, it is worth noting that, as there are only four degrees of freedom, and that it is highly improbable respondents will change their answers from 'strongly disagree' to 'strongly agree', relatively small numerical changes in the mean scores across the time-points represent a genuine change.

Semi-structured Interviews

In order to add real life context to compliment the statistical data, three in depth interviews were conducted. These were with a service user, a different service user's primary carer/blood relative, and an ICP service provider. The interviewees were sampled using a form of opportunity sampling, in that Age UK Sheffield's management contacted ICP service providers to request whether they and/or any of the service users they work with would agree to be interviewed. Interviewees were given an information sheet, and asked to sign a consent form, of which a copy is held by both the research team and the interviewee. All participants are anonymised in this report, and are not a part of the cohort of 78 in the referral and questionnaire data.

The service user was interviewed in their home, and the service user's relative in the home of the service user they cared for, both in the presence of an Age UK Sheffield staff member they knew in order to facilitate access (although the service user's relative was interviewed in another room to the Age UK Sheffield staff member). These interviews were not audio recorded as it was considered to be a potentially off-putting factor in gaining consent, in addition to which appropriate surroundings for recording could not be guaranteed. Instead, a series of notes were made by the researcher. However, the ILC was interviewed in a private setting where recording was possible, and therefore employed.

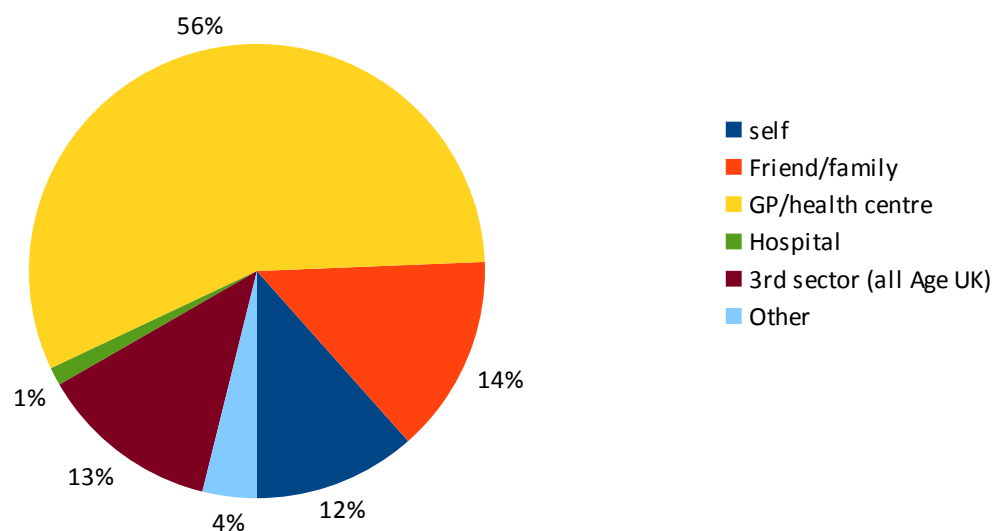
In the interviews, a narrative approach was taken, so that interviewees could give detailed examples of what influence the ICP has. An open style of questioning was taken to ensure that what the interviewee felt was important could be discussed (see Mason 2002). However, some structure was utilised in order to ensure service users' physical health, mental health, independence and control, and finances were discussed. A copy of the interview schedule is included in the appendix, however it should be noted that this was not prescriptively followed in the interviews, nor does it constitute the entirety of the questions asked.

3. Referrals

Referrals to the ICP

Figure 1 shows where referrals to the ICP came from, according to the type of organisation/individual. In this, we can see that over half of the referrals for our cohort were from GPs/medical centres, which in turn came from a total of 19 different GP surgeries/medical centres across Sheffield. Also, 58 of the 78 service users (74%) were referred by an organisation of any kind, including a total of 25 different organisations amongst those 58 referrals. Further to this, it is unknown where self and friend/family referrals learn of the ICP, which may constitute several more unknown organisations promoting the ICP. Overall, then, the variety of different referral origins suggests there is a good level of partnership across local services.

Figure 1



It is also noteworthy that a recent report on 'fit for the future', a project that was run by Age UK national across numerous British cities/towns (though not Sheffield) with local Age UK partners. The programme aimed to improve the health of older people through better diets and links with exercise groups, and the evaluation recorded that stakeholders felt more needed to be done to ensure 'joined up' health and voluntary sector services (Wigfield et al 2015). Most notably, this was primarily in relation to GP services that were supportive of

the programme, but did not see it as something they were involved in promoting. In light of this and given that 56% of the total number of referrals to the ICP originated from a GP service, including 19 different surgeries/medical centres, this therefore constitutes a notable success in facilitating 'joined up' health and voluntary sector services in the ICP.

Referrals by ICP service deliverers to other organisations

In our cohort, a total of 724 referrals to other organisations were recorded by ICP staff, constituting an arithmetic average of 9.24 referrals onwards for each service user. Amongst these 724, there were 265 different organisations/departments within organisations referred to, 253 of which were not Age UK services. Figure 2, then, relates to the number of different organisations that have been referred to within each category. From this, we can see that ILCs are aware of a variety of relevant places to refer service users, as well a large number of them, with particularly high numbers of different 'medical care/support' organisations and 'social/activity clubs' utilised by ICP staff. The only lower numbers of different organisations are for 'mental health' referrals, for which 14 is still a

Figure 2		
A Table showing the number of different organisations ICP service users were referred to according to the type of organisation		
<i>Referral type</i>	<i>Number of different referrals of this type</i>	<i>As a % of the total number of different organisations</i>
Medical care/support (eg dentists, health condition support groups)	54	20%
Mental health (eg loneliness helplines, therapists)	14	5%
Assisting independent living (eg meal delivery, home adaptations)	33	13%
Citizens advice, housing advice or finance (eg debt advice, housing officers)	36	14%
Social/activity clubs (eg lunch clubs, gardening groups)	58	22%
Exercise groups (eg chair-aerobics, exercise focused singing)	2	1%
Care and respite services (eg befriending services, long term social care)	36	14%
Other	32	12%
Total number of different referrals	265	100%

notable number of different places to refer people to in a cohort of 78 people, and 'exercise groups', for which a low number may be due to the fact that the social/activity groups, though not specifically for the purpose of exercise, nevertheless include varying degrees of it.

With regard to the number of service users that were referred to at least one organisation within each category, figure 3 shows that almost all of our cohort (92%) experienced at least one referral, and that a particularly high number (73%) were referred to some kind of physical health focused organisation. As a result of this, long term NHS savings are likely due to the general support they provide as well as the early identification of ailments, although no attempt at calculating this has been made due to the small nature of this research and the intrinsic difficulty of such calculations (Taylor 2004). The percentages of 'mental health' and 'exercise group' referrals are also noteworthy (though they only for 5%

Figure 3		
A table showing how many service users were referred to at least one organisation within each referral category		
<i>Referral type</i>	<i>Number of services users with at least one referral of this type</i>	<i>Percentage of services users with at least one referral of this type</i>
Medical care/support (eg dentists, health condition support groups)	57	73%
Mental health (eg loneliness helplines, therapists)	18	23%
Assisting independent living (eg meal delivery, home adaptations)	55	71%
Citizens advice, housing advice or finance (eg debt advice, housing officers)	35	45%
Social/activity based clubs (eg lunch clubs, gardening groups)	36	46%
Exercise (eg chair-aerobics, exercise focused singing)	13	17%
Care and respite services (eg befriending services, long term social care)	42	54%
Other	42	54%
Service users with at least one referral of any kind	72	92%
All service users	78	100%

and 1% respectively of the different organisations referred to); with 23% and 17% of the cohort referred to an organisation of this nature, implying Age UK Sheffield's ILCs are making good use of the services that are available even if there are less of them.

Furthermore, all of the interviewees offered considerable support for the conclusion that the above numbers represent high levels of service integration. Indeed, the service user interviewed described their ILC as a '*walking information database*', and the service user's relative stated that they '*didn't know just how much help there was out there*'. The interviews also demonstrated the person centred nature of the referring. For instance, the service user's relative described how, when their relative was referred to a lunch club, it did not stop there; the ILC then arranged for a volunteer to assist her to the club, as well as for transport, the combination of which they felt helped the service user to actually start attending (which they still do). On the other hand, the other service user described how what would seem a relatively uninvolved referral, which would be described as '*moneysupermarket.com*' in the database, actually involved the two of them looking around the website at length, and resulted in savings on their bills.

4. Physical Health

Figure 4 shows that there was an overall improvement in health reported by our cohort. This is statistically significant when comparing both day one to the follow up, or completion to the follow up, though not when comparing day one to completion. However, though the significant increases come after completion of the project, it is reasonable to

Figure 4						
A table showing the average (mean) 'health' answer code of ICP service users at each stage of the ICP pilot (derived from 4 questions)						
	<i>Day 1</i>	<i>Completion</i>	<i>Follow Up</i>	<i>Difference in score</i>	<i>Completed questionnaires count</i>	<i>Statistical significance <0.05</i>
Day 1 vs. Completion	2.32	2.43		0.11	47	0.1399
Day 1 vs. Follow Up	2.15		2.67	0.52	15	0.0020
Completion vs. Follow Up		2.19	2.63	0.44	16	0.0038

suggest that this is still evidence of the efficacy of the ICP for two reasons. Firstly, health improvements as a result of changed or new habits/activities are rarely immediate, therefore it is reasonable to hypothesise that a shorter term improvement is less likely to show.

Secondly, Office of National Statistics data (2011) for Yorkshire and the Humber show that 10.7% of people aged 55-64 report bad/very bad health, and 67.2% good/very good health. Amongst people aged 65 and over, however, the amount of people reporting bad/very bad health increases by 6% to 16.7%, and those reporting good/very good health decreases drastically by 21.1% to 46.1%. As our cohort are all within these two age groups, then, it would be reasonable to hypothesise that a control group should show a *decrease* in reported health scores over each time-point, as the wider population of the county implies that self-reported health scores are decreasing at these ages. That there is actually an *increase* in scores for our cohort, then, adds further support for the notion that the ICP has a beneficial effect on the health of its service users.

From the interviews, three distinct ways in which the ICP has assisted service users to improve their health were noted. Firstly, the service user's relative told us that they now

possessed what they described as a '*stretching sheet*', which was used to do a daily stretching routine that will aid mobility and reduce the likeliness of falls. This had been recommended by a physiotherapist, whom their ILC had referred them to. As well as being an example of how referral to a physical health care/support organisation may improve a service users health, this also shows demonstrates significant potential for long term financial savings; the cost of living in a care home has been estimated as £37,388 per year (Personal Social Services Research Unit 2011), and the cost of hospitalisation and hip fracture as £3,577 (NHS reference costs 2011), both of which have had their likeliness of happening reduced as a result of the referral to a physiotherapist, and the subsequent use of the stretching sheet.

Secondly, all the interviewees at some point commented on how the ICP assists people to be, as the service user put it, '*generally more active*', which in turn improves their health. For the service user interviewed, this was through membership of the Age UK club, and day trips to a place of interest that were occasionally arranged. For the service user whose relative was interviewed, this was through lunch clubs and taxi trips to see friends. Finally, the ILC interviewed mentioned a large number of places they had facilitated service users access to, ranging from lunch clubs to a wheelchair hang-gliding organisation. The fact that the interviewees felt the exercise gained from attendance at these groups was beneficial to their physical health, then, supports the above consideration that a low number of exercise group referrals may be a result of the benefits of other groups negating a need for them.

The final area in this section to consider is nutrition. Though the service user and the service user's relative both felt that they had always had a good diet, the ILC noted that there were times when other service users they had been referred to were not drinking enough water, or were not eating enough. Through their assistance, though, they felt that they had reduced these service users potential for contracting a urinary tract infection (which can be caused by inadequate water consumption), reduced the likeliness of them falling (as dehydration and poor nutrition can both cause dizziness), and improved general nutrition through the use of '*build up drinks*' (which contain all the nutrition a person needs for someone having difficulties eating enough).

5. Mental Health

In figure 5, we can see a statistically significant increase in our cohort's WEBWMS score from day one of the service to completion, as well as between day one and the follow up. Furthermore, although the increase from completion to follow up is not statistically significant, it should be noted that measures of statistical significance are affected by the completed questionnaires count. As the ICP pilot returns more completed questionnaires,

Figure 5						
A table showing the average (mean) 'WEMWBS' answer of ICP service users at each stage of the pilot (derived from 7 questions)						
	<i>Day 1</i>	<i>Completion</i>	<i>Follow Up</i>	<i>Difference in scores</i>	<i>Completed questionnaires count</i>	<i>Statistical significance <0.05</i>
Day 1 vs. Completion	2.99	3.17		0.18	49	0.0036
Day 1 vs. Follow Up	2.87		3.27	0.4	17	0.0424
Completion vs. Follow Up		3.09	3.29	0.2	16	0.1218

then, should the increases in score remain similar, the significance levels will improve. Overall, it can be concluded that the data so far suggest a real improvement in the mental health of ICP service users.

For both the service user and service user's relative, this was considered a very important area where the ICP had been beneficial. Indeed, as the service user's relative said, *'I used to ring (them) and (they would) say 'Lord, take me now!'. But now, things are so much better'*. For them, the reason the ICP had improved their relative's mental health was a result of better opportunities for socialising, originating from three avenues. Firstly, there was the lunch club noted in the referrals section. Secondly, their ILC had arranged a taxi account for them, which enabled them to use the taxi to visit friends who prior to the ICP they had not seen for 'ages'. Finally, the ILC had introduced them to another service user who lived nearby, and who they had become good friends with. It is also worth noting that, although this was considered important by the service user's relative, the introduction to another service user would not show up in the referrals database. Additionally, none of these three ways in which it was felt their mental health benefited would constitute a

'mental health' referral.

The other service user commented on two further ways their experience of being on the ICP improved their mental health. Firstly, they stated that *'it's easier to talk to a professional than someone you know sometimes'* – in other words, as their ILC was someone there to help them, with whom they had no previous social relationship, this helped them to be more open about their mental health needs. Secondly, they also noted that that their ILC offered *'encouragement'*, *'motivation'*, and even *'a little push'*, all of which helped them to go out on trips, to a social club, and to an art therapy group the ILC had referred them to.

6. Independence and Control

Figure 7 shows that there were increases across all time points in self-reported measures of independence and control, albeit not statistically significant. However, four factors should be noted in relation to these results. Firstly, there were, again, a small number of completed questionnaires, particularly regarding the follow ups, therefore as mentioned

Figure 7						
A table showing the average (mean) 'independence and control' answer of ICP service users at each stage of the pilot (derived from 2 questions)						
	<i>Day 1</i>	<i>Completion</i>	<i>Follow Up</i>	<i>Difference in score</i>	<i>Completed questionnaires count</i>	<i>Statistical significance <0.05</i>
Day 1 vs. Completion	3.74	3.92		0.16	47	0.1632
Day 1 vs. Follow Up	3.7		3.94	0.24	15	0.4822
Completion vs. Follow Up		3.69	3.82	0.13	16	0.5226

earlier the increases may become statistically significant as more questionnaires are completed. Secondly, the actual increases in mean scores are not drastically less than the above data, nor are the completed questionnaire counts. The reason these results are statistically insignificant, then, is that these scores are based on just two survey questions (rather than four and seven questions as in the above sections), which again means that more responses will improve the statistical significance if the mean scores remain similar.

The other two points regard potential reasons respondents are unlikely to show increases in their reported scores, given that the statements being rated are 'I can please myself what I do' and 'I have a lot of control over the important things in my life'. Firstly, 71% of the cohort referred to an organisation designed to promote independent living, many of which were organisations assisting mobility (eg wheelchair provision organisations, home adaptations), therefore it is likely that many respondents have experienced a reduction in mobility. Finally, all ICP service users possess at least two long term health condition, further exacerbating the unlikelihood of drastically improved responses to these statements. Overall, then, given these factors, the fact that there is still some improvement in scores along the time-points constitutes some evidence of success in the aim to facilitate greater

independence and control for service users.

In the interviews, neither the service user nor the service user's relative focused directly on this area. However, the service user's relative did comment that '*I don't know if (the service user) would still be living here (at home) if it wasn't for the ILC*'. In other words, were it not for the ICP, they believed that the service user may be living in residential care. Though it is impossible to definitively know how likely this was, if it had been the case, this may represent a notable prevention of loss of independence and control, as well as a large financial saving in terms of the £37,388 per year noted above as the estimated cost of residential care. Similarly, a preventative measure to avoid a future loss of independence was also noted by the other service user, in that they had a ramp built on their doorstep in case they required a wheelchair in the future.

The ILC, however, focused far more on independence as a concept. Indeed, they listed many examples of objects, adaptations and organisations that aimed to maintain independence and control for the people they supported, including (but not limited to) walking sticks, wet rooms, home library services, community transport services, 'Just can't wait' cards and RADAR keys. They also discussed how they are sometimes '*challenging people's (low) aspirations and expectations of what being older involves, and the fact that they can do things despite their condition*'. In practice, they felt that this meant they '*not only help people manage (their health condition) better, we can help people to come to a new understanding of what they can do*'.

Overall, the focus in this narrative was on preventing or limiting a future loss of independence and control. This supports the notion that the ICP has a beneficial effect on independence, however it is important to note that these preventative measures will not show an increase in scores on the survey, as no *current* aspect of independence has actually been improved. The focus on preventing/limiting the future loss of independence, then, provides an important additional insight to this area of the research, which given the cost of residential or domiciliary care, and the poor health that may result from reduced levels of activity, one which could also constitute real savings in the social care sector and/or NHS.

7. Service Users' Finances

As figure 8 shows, there is a statistically significant improvement in the reported finances of service users from day one to completion, a reasonably large (albeit not statistically significant) increase from day one to follow up, and no change between completion and follow up. However, as financial assistance is given during the course of the ICP, in most cases the benefit of that assistance would be expected between day one and completion. That there are only increases in score when comparing day one to either time-point, then, further implies support for the notion that the ICP has a beneficial effect on service users' finances, rather than it being a result of chance.

Figure 8						
A table showing the average (mean) 'finances' answer of ICP service users at each stage of the pilot (derived from 3 statements)						
	<i>Day 1</i>	<i>Completion</i>	<i>Follow Up</i>	<i>Difference in score</i>	<i>Completed questionnaires count</i>	<i>Statistical significance <0.05</i>
Day 1 vs. Completion	3.63	3.84		0.21	47	0.0198
Day 1 vs. Follow Up	3.44		3.87	0.43	15	0.1773
Completion vs. Follow Up		3.83	3.83	0	16	1.0000

The interviewees identified three ways in which the ICP assisted with finances, the first of which can be summarised as assisting with the organisation and appropriate challenging of bill payments. In regard to this, the service user's relative described how their ILC noticed that the gas and electric bills had been calculated according to estimates for several years, estimates that were higher than their actual usage, resulting in a large reimbursement from the billing company. Furthermore, as noted in the referrals section, the service user described how reviewing comparison websites had resulted in a financial saving for them.

The other two types of benefit were noted by the ILC only. The first of these can be described as financial safeguarding, and though they said this type of safeguarding was relatively rare, they relayed one example where a service user had informed them that they had given someone large amounts of money in dubious circumstances, which they then reported to the appropriate safeguarding professionals (the details were omitted by the ILC to ensure anonymity). The final type of financial assistance they gave was via help

with benefit claims. In regard to this, they felt they helped to not only assist with the logistical problems of claiming, but in some instances with overcoming the stigma of claiming benefits.

8. Social Connections and Quality of Life

Social Relationships

Figure 9 shows that there was a significant increase in social relationships between day one and completion, but significant decreases when considering the follow up. It should be noted, though, that this decrease emerges primarily from the fact that two of the 16 follow up respondents were large 'outliers'; in this case, two people reported very large decreases, when the rest reported little change in their scores.

Figure 9						
A table showing the average (mean) social relationships question answer of ICP service users at each stage of the pilot (derived from 3 questions)						
	<i>Day 1</i>	<i>Completion</i>	<i>Follow Up</i>	<i>Difference in score</i>	<i>Completed questionnaires count</i>	<i>Statistical significance <0.05</i>
Day 1 vs. Completion	3.37	3.64		0.27	47	0.0110
Day 1 vs. Follow Up	3.29		2.69	-0.60	15	0.0310
Completion vs. Follow Up		3.63	2.63	-1.00	16	0.0000

The possible reasons for this are conjectural, but four possibilities can be identified. Firstly, a relative or friend could have passed away, or moved to a less accessible location. Secondly, a group they attended could have ceased to run, and they were unable to find a suitable replacement (although the 'leisure and activities' data in figure 10 suggest this is not the case, as it does not show a corresponding decrease in scores). Thirdly, unavoidable issues such as a deterioration in health, a recent fall, or even a change in the weather could have resulted in spending less time in the company of others. Finally, following completion of the ICP, service users no longer have a social relationship with their ILC, which for some people may itself constitute a noticeable drop in their social relationships.

Both the interviewees suggested the ICP had led to increased opportunities for social relationships, and indeed the service user's relative felt that this was the key reason their relative was much happier. Furthermore, the referral data showed large numbers of referrals to organisations that should facilitate the formation of social relationships. Finally, as these scores result from just two outliers, the fact that there is a significant increase in

relationship scores during the ICP, and that the data regarding emotional well-being are positive, the importance of this decrease in scores should not be overstated. More research, then, would be required to accurately ascertain the cause of this result, and whether its cause is something that the ICP, or any service, could or should affect. First and foremost, however, time for more questionnaires to be returned should be allowed to see if the relationship does indeed continue in this manner.

Leisure and Activities

Figure 10 shows an insignificant increase from day one to completion, a large though still insignificant increase from day one to the follow up, and a very small and statistically insignificant decrease from completion to the follow up. In this section, then, as there is only a single question, it would seem that more questionnaires need to be returned until the data can be considered statistically significant. However, the interviews and referral data both support the notion that service users are able to access more leisure and activities groups as a result of the ICP. Overall, then, though the questionnaire data are inconclusive alone, in conjunction with the other data it is reasonable to suggest that the ICP is facilitating better opportunities for leisure and activities.

Figure 10						
A table showing the average (mean) leisure and activities question answer of ICP service users at each stage of the pilot (derived from 1 question)						
	<i>Day 1</i>	<i>Completion</i>	<i>Follow Up</i>	<i>Difference in score</i>	<i>Completed questionnaires count</i>	<i>Statistical significance <0.05</i>
Day 1 vs. Completion	2.96	3.17		0.21	47	0.2492
Day 1 vs. Follow Up	2.80		3.53	0.73	15	0.0682
Completion vs. Follow Up		3.31	3.25	-0.06	16	0.8425

Quality of Life

As figure 11 shows, only day one to the follow up shows a real change in mean score, and none of the time-point comparisons are statistically significant. Until more questionnaires are returned, then, this adds little insight to that which has already been discussed.

Figure 11

A table showing the average (mean) quality of life question answer of ICP service users at each stage of the pilot (derived from 1 question)

	<i>Day 1</i>	<i>Completion</i>	<i>Follow Up</i>	<i>Difference in score</i>	<i>Completed questionnaires count</i>	<i>Statistical significance <0.05</i>
Day 1 vs. Completion	3.09	3.17		0.09	47	0.6876
Day 1 vs. Follow Up	3.07		3.53	0.47	15	0.3181
Completion vs. Follow Up		3.31	3.25	-0.06	16	0.8400

9. Conclusion

The ICP had three main aims. The first of these was promoting integration with, and the appropriate use of, community resources and statutory services. In regard to this, four notable areas of success were noted in the report: the high numbers of GPs reporting people to the service; the large numbers of referrals made to other services; the wide variety of referral types that were utilised by ICP service deliverers; and the supportive and person centred manner in which the referrals were conducted (as told by the interviewees).

The second facet of the aim of ICP was to deliver a service that improved the physical and mental health of service users, and promote their independence. Though the relatively low number of completed questionnaires limited the possibility of the data being statistically significant, the data that do exist provided positive results, and were statistically significant in regard to important aspects of physical health, mental health, and service users' finances. The interviews also suggested the ICP had helped with service users' physical and mental health, and showed how, in real life contexts, this was being achieved. Furthermore, they also suggested that an important aspect of the ICP was through the employment of preventative measures, particularly in regard to maintaining independence, which would have no positive effect to record on the surveys, but which could result in important benefits for service users. Overall, then, at this interim stage of the pilot, the combination of survey and interview data suggests the ICP has been successful in this second facet.

Finally, the service aimed to support financial stability in Sheffield's health and social care sectors. As previously noted, calculating the exact financial difference of what *has* happened to what *might have* happened had the ICP not been piloted is intrinsically difficult and imprecise, therefore has not been attempted given the minimal resources available for this research. Nevertheless, potential savings were identified through the ICP assisting service users to continue living in their own home, to avoid hospitalisation via improved mobility or nutrition, to link with appropriate health services that can assist them to effectively maintain their health conditions, and to attend groups involving a degree of

exercise. Most notable, though, is the general success found throughout the research in terms of improving service users' physical health, mental health, independence and control, and finances. In other words, that service users are reporting that they feel healthier and happier is not just a success in itself, it is also evidence that they are less likely to be hospitalised or require additional health and/or social care.

Overall, it can be concluded from this research that the aims of the ICP are indeed being fulfilled, albeit with varying levels of confidence, across different aspects of the service. For greater confidence in these conclusions, three recommendations are proposed. Firstly, simply re-consult the survey data at a later date when more questionnaires have been completed. Secondly, effective ways in which to calculate the costs of not having been on the ICP, either financial or human, would assist in calculating the financial stability of the project, though again the difficulty of doing this effectively should be noted. Finally, more interviews/case studies may be useful for learning why people have answered in the manner in which they have, as well as for identifying how prevalent the preventative measures that would not translate into an increased score on the survey are. Similarly, a redesigned survey could consider the preventative aspect of support. In general though, despite these recommendations, the current data offer real evidence of the efficacy of the project. As almost all aspects of this research suggest that the aims of the ICP are being fulfilled, then, it can reasonably be concluded that the ICP is indeed a positive and worthwhile project that facilitates genuine benefit for all parties involved in it.

References:

Bartley, M. (2004) *Health Inequality: An Introduction to Theories, Concepts and Methods*, Cambridge, Polity Press.

Davis, H. and Ritters, K. (2009) *Linkage plus national evaluation: End of project report*, DWP, London.

Mason, J. (2002) *Qualitative researching*, 2nd edition, London, Sage.

NHS reference costs for 2010/11. Available from:

<https://www.gov.uk/government/publications/2010-11-reference-costs-publication>

Office of National Statistics (2011), *Age by general health by sex by country of birth (bespoke list) - EW and London Boroughs*. Available from:

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/adhocs/005321ct05632011censusagebygeneralhealthbysexbycountryofbirthbespokeelistewandlondonboroughs>

Taylor, A., Cable, N., Faulkner, G., Hillsdon, M., Narici, M., & Van Der Bij, A. (2004) 'Physical activity and older adults: a review of health benefits and the effectiveness of interventions', *Journal of Sports Sciences*, 22 (8), pp 703-725.

Personal Social Services Research Unit (2011) *Personal Social Services Research Unit: Unit costs of health and social care*. Available from: <http://www.pssru.ac.uk/>

Watt, P. and Blair, I. (2009) *The business case for linkage plus*, Crown Copyright, Norwich.

Wigfield, A., Kispeter, E., Alden, S., Turner, R. and Clarke, T. (2015) *Age UK's fit for the future Project: Evaluation Report*, Centre for International Research on Care, Labour and Equalities, University of Leeds.

Appendix I: Survey

Health and Wellbeing Questionnaire

We are asking you to complete this questionnaire at the beginning and at the end of your support from us. It will help show us how things have changed for you. We are asking everyone to complete these forms and they will help us understand what we do well and what improvements can be made. They will also help us with future funding bids to enable us to carry on the service.

Below are some statements about a number of different areas of your life. Please tick the box that best describes your experience of each over the last 2 weeks. There are no right or wrong answers and it is best to answer the questions quickly with your first thoughts.

		Strongly agree (1)	Agree (2)	Neither agree or disagree (3)	Disagree (4)	Strongly disagree (5)
	Health					
1	I have a lot of physical energy					
2	Pain affects my wellbeing					
3	I am healthy enough to have my independence					
4	I am healthy enough to get out and about					
	Social relationships					
5	My family, friends or neighbours would help me if needed					
6	I would like more companionship or contact					
7	I'd like more people to enjoy life with					
	Independence and control over life					
8	I can please myself what I do					
9	I have a lot of control over the important things in my life					
	Home and neighbourhood					
10	I feel safe where I live					
	Financial circumstances					
11	I have enough money to pay my household bills					
12	I am struggling to manage my money and make ends meet					
13	The cost of things compared to my pension/ income restricts my life					

		Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
	Leisure and activities					
14	I have social or leisure activities/hobbies that I enjoy doing					

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

		Very good	Good	Alright	Bad	Very bad
15	My quality of life as a whole is					

Wellbeing

		None of the time	Rarely	Some of the time	Often	All of the time
16	I have been feeling optimistic about the future					
17	I have been feeling useful					
18	I've been relaxed					
19	I've been dealing with problems well					
20	I've been thinking clearly					
21	I've been feeling close to other people					
22	I have been able to make up my own mind about things					

If you look after someone else such as your partner, relative, neighbour, friend please answer the following questions.

		Never	Some of the time	A lot of the time	Always
23	I feel I get the help and information I need				
24	Caring stops me doing what I want to do				
25	I am mentally exhausted by caring				
26	I am physically exhausted by caring				

27	I can manage most situations with the person I care for				
28	I enjoy being a carer				

Medical Services

Think back over the past 3 months. During this time how many times have you needed the support of health services by;

29	Calling for an ambulance	Going to A&E	Going in to hospital	Going into your GP surgery	Calling your GP out to your home

PAMs Questionnaire for Health Customers

Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by ticking the box. Your questions should be what is true for you and not just what you think others want you to say.

		Disagree strongly	Disagree	Agree	Agree strongly	N/A
1	I am the person who is responsible for taking care of my health					
2	Taking an active role in my own health care is the most important things that affects my health					
3	I am confident I can help prevent or reduce problems associated with my health					
4	I know what each of my prescribed medications do					
5	I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself					
6	I am confident that I can tell a doctor or nurse concerns I have even when he or she does not ask					
7	I am confident that I can carry out medical treatments I may need to do at home					
8	I understand my health problems and what causes them					
9	I know what treatments are available for my health problems					
10	I have been able to maintain lifestyle					

	changes, like healthy eating or exercising					
11	I know how to prevent problems with my health					
12	I am confident I can work out solutions when new problems arise with my health					
13	I am confident that I can maintain lifestyle changes, like healthy eating and exercising, even during times of stress					

Please answer this question at the end of the support you have had from Age UK Sheffield

How likely are you to recommend the Age UK service you have received to friends and family if they needed support? Please circle.

Extremely likely	Likely	Unlikely	Extremely unlikely	Neither	Don't know
-------------------------	---------------	-----------------	---------------------------	----------------	-------------------

Name _____

Date _____

Beginning

End

Follow up

Appendix II: Question schedule loosely utilised in the interviews

With service user/service user's relative questions

How has it been having (name of ICP worker) visit?

What kind of things have they done?

Has (name of ICP worker) helped you to find and go to any activity groups? Like a lunch club, gardening group, coffee morning, anything like that?

Has (name of ICP worker) helped you with eating healthily or getting exercise at all? It's OK if not!

Has (name of ICP worker) helped you with any financial issues?

ICP support worker questions

What are your immediate thoughts about the ICP? Delve!!!

What do you tend to do for people?

Do you do anything for people that may improve their health?

Do you do anything for people that may improve their emotional well being?

Do you do anything for people to promote independent living?

Do you do anything for people that may improve their finances?

Do you refer people to a lot of other groups?

When you refer people to other groups, how does that tend to go?