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MEASURING WELL-BEING OUTCOMES IN OLDER PEOPLE RECEIVING HELP FROM THE AGE UK 'TOGETHER FOR HEALTH' INITIATIVE: A SOCIAL RETURN ON INVESTMENT ANALYSIS

Final Report

July 2016

Version 2.0

Anne-Marie Bagnall, Gary Raine, Karina Kinsella, Kris Southby, Chris Spoor, Jane South, Gianfranco Giuntoli

The Centre for Health Promotion Research,

Institute for Health and Wellbeing

Leeds Beckett University

Calverley Street

Leeds LS1 3HE

Contact: a.bagnall@leedsbeckett.ac.uk / 0113 812 4333

www.leedsbeckett.ac.uk

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Acknowledgements

This project was commissioned by Age UK Support Services (Yorkshire & Humber) to evaluate the ‘Together for Health’ project. We would like to thank Joanne Volpe and Richard Hindley, and all the Age UK staff and clients for their contributions to the evaluation.

We would also like to thank Humaira Akter, Frances Darby, Steven Markham, Leonie O’Dwyer and Sarah Asquith, who carried out interviews with Age UK clients and staff, and undertook transcription.

This report should be cited as: Bagnall AM, Raine G, Kinsella K, Southby K, Spoor C, South J, Giuntoli G (2016) Measuring well-being outcomes in older people receiving help from the Age UK ‘Together for Health’ initiative: A Social Return on Investment Analysis. Final Report. Leeds: Leeds Beckett University.

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Summary of key findings

- By the end of January 2016, data was received on 667 clients who had taken part in Together for Health, with 19,526 hours spent with Age UK workers.
- A range of interventions were offered to clients as part of T4H, including shopping, cleaning, befriending, taking to social events, helping with medication, reassurance, dog walking, post-hospital-discharge checks.
- Clients were signposted to a range of other services, including other care agencies, dementia groups, community transport, health trainers, lunch clubs, social services, befriending services, housing support, bereavement counselling.
- Statistically significant improvement were seen in all 8 domains of LEAF (n=420) at 6 week follow-up:
    - Small effect sizes for “feeling valued”, “feeling safe”, “control and choice” and “managing finances”;
    - Medium effect sizes for “emotional wellbeing”, “managing daily living”, “managing physical health” and “social networks”.
- At 12 weeks, the statistically significant improvement remained in all 8 domains of LEAF:
    - Small effect sizes for “feeling safe”, “control” and choice”, “feeling valued” and “managing finances”;
    - Medium effect sizes for “physical health”, “emotional wellbeing”, “managing daily living”;
    - Large effect size for “social networks”.
- The number of LEAF domains showing statistically significant improvement in Barnsley and Bradford increased from 6 weeks to 12 weeks follow-up. This suggests that the intervention needs to be sustained beyond 6 weeks.
- Gender differences were noted; while statistically significant improvements were seen in all 8 domains of LEAF for women, men did not see statistically significant improvements in the domains of “feeling valued” and “control and choice”. This suggests that although men benefit from Together for Health, they may receive further benefit from more targeted interventions.
- Responses to the loneliness questionnaire (n=177) showed a small, statistically significant decrease in loneliness scores from referral to discharge.
- Responses to the resilience questionnaire (n=174) showed no statistically significant change between referral and discharge.
- Health service use data, comparing clients’ use of hospital services 12 months before referral to (up to) 12 months following referral, indicated:
    - No change in inpatient stays or A&E visits;
    - Increase in outpatient visits (which may just reflect the reasons why clients were initially referred into Together for Health e.g. following a hospital stay)
- Qualitative interviews with clients and staff reported many key themes, including:
        - Support and confidence building
        - Friendly service
        - Trust

- Social benefits
- Financial benefits
- Practical benefits
- Range and flexibility of service
- "Client led approach"
- Collaborative working
- Benefits to family members
- Benefits to Age UK (organisation and staff)
- Wider benefits (community, health and social services)
- Implementation and evaluation issues

- Together for Health achieved its objectives of reducing social isolation and loneliness.
- SROI analysis found that for every £1 invested in Together for Health, the social return on investment is at least £4.84

1. Introduction

Recent estimates place the number of people aged over 65 who are often or always lonely at over one million (Local Government Association, 2012). Acute loneliness has been consistently estimated to affect around 10-13 per cent of the population of older people (Local Government Association, 2012). Cattan (2000) found that 12 per cent of people aged 65 or more years “feel trapped in their own homes”; 10 per cent felt “acutely isolated”; and two per cent had gone for a whole week without speaking to family, friends or relatives. A recent report from the Office of National Statistics found that in England and Wales, more than half of all people aged 75 and over live alone (ONS, 2010), and Victor et al. (2000) reported that 17% of older people in the UK are in contact with family, friends and neighbours less than once a week and 11% are in contact less than once a month. A study by Beaumont (2013) reported that loneliness is more prevalent in women than men, in those aged 52 or over who have been widowed, and in those aged 52 or over who report poor health.

Loneliness and social isolation are two related but distinct concepts. Cattan (2000; 2005) differentiate between social isolation, which refers to the number of contacts and interactions older person have with their wider social network, and emotional isolation or loneliness, which is defined as the subjective feeling of lack or loss of companionship (e.g. loss of a partner or children relocating). So, it is possible for individuals to be lonely, but not isolated, or isolated, but not lonely.

There is strong evidence that social isolation and loneliness have major negative effects on health and wellbeing (Cattan et al., 2005). Overall, the influence of social relationships on the risk of death are comparable to those for smoking and alcohol consumption and exceed the influence of physical activity and obesity (Holt-Lunstad et al., 2010). Loneliness is also an important risk factor for depression (Adams et al.,2004). The negative effects of depression in older adults are well established, including 'increased functional disability, increased suicide risk, recurrent and co-morbid psychiatric illness (in particular substance abuse), increased cognitive impairment, and increased morbidity and mortality from other medical conditions' (Adams et al., 2004).

As a result of these health impacts, loneliness and social isolation can increase the pressure on a wide range of council and health services, from adult social care to increased attendances at GP surgeries (Local Government Association, 2012). Taking action to address loneliness and social isolation can reduce the need for health and care services in the future, which is particularly important in a context of a rapid increase in the number of older people (de Groot et al., 2004) and of severe financial challenges for councils in delivering statutory services.

Overall, loneliness and social isolation are amenable to a number of effective interventions, which can be low cost, particularly when they involve voluntary effort. Nevertheless, older people are not a homogeneous group. For example, men and women age differently. In general, lonely men are best engaged through specific activities related to long-standing interests, such as sport, gardening etc., and respond less well to loosely defined social gatherings, which are of more interest to women (Local Government Association, 2012). An evaluation of the ”Men in Sheds” pilot programme found that it reduced isolation and contributed to the mental wellbeing of older men through social contact and meaningful activity (Milligan et al. 2012). There are also differences across diverse ethnic groups (Giuntoli & Cattan, 2012). Consequently, evaluating interventions aimed at reducing social isolation and loneliness entails well-developed approaches that are able to address the variety of needs, expectations, and backgrounds that characterise older people. This is particularly the case for the measurement of change in relation to loneliness, which entails going beyond

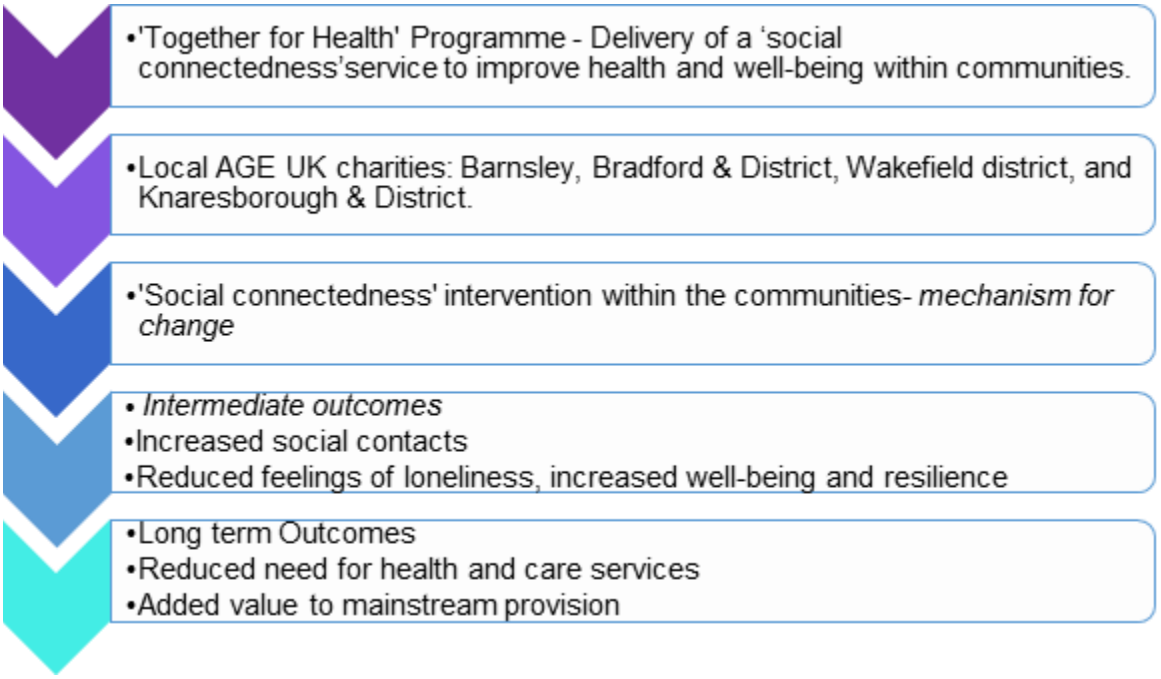
assessing efforts to maintain the number, or frequency, of social connections to investigating people's evaluations of the quality of their relationships (Adams et al., 2004).

Between 2013 and 2016, Age UK Yorkshire & Humber implemented a 3 year project called 'Together for Health' that aimed to deliver a new 'social connectedness' service to reduce levels of loneliness and isolation amongst vulnerable older people and improve their health and wellbeing. This project set out to work with health service professionals in secondary care, A&E professionals, geriatricians and surgical wards to 'prescribe' the 'Together for Health' service to older people who presented with health needs impacted by their social needs as assessed through measurable risk factors of loneliness. The project involved four local Age UK charities in Yorkshire: Barnsley, Bradford & District, Wakefield district, and Age UK Knaresborough & District.

2. Methods

We used a realistic evaluation methodology, using the Theory of Change (TOC) approach to provide a framework for the evaluation. The advantage of using a TOC approach is that it helps make explicit the links between programme goals and the achievement of outcomes in the four districts in which the programme is implemented (Green & South, 2006). It was also used to help the evaluation team map the confounders which may interfere with the data collected (which is a process called 'attribution' in SROI), such as for example significant life events, death of a spouse, a neighbour moving etc.

Figure 1: Theory of Change linking delivery of the 'Together for Health' service, 'social connectedness' and health and social impacts.



2.1 Evaluation objectives:

Formative evaluation

1. To identify and involve all the relevant stakeholders that may be affected by the 'Together for Health' project through the life of the evaluation: the project beneficiaries, the Age UK charities, the volunteers, and the health service professionals involved in prescribing 'Together for Health'.

2. To identify the ways in which each relevant stakeholder contributes to the delivery of 'Together for Health' and explore older people's care pathways.

3. To identify relevant indicators to measure the impact of 'Together for Health' on the physical and mental health, wellbeing and resilience of the project beneficiaries.

Summative evaluation

4. To measure the achievements of 'Together for Health' on the following outcomes across the four delivery areas (Barnsley, Bradford & District, Wakefield district, and Knaresborough & District):

    - Reduction in preventable hospital readmissions.
    - Improved social networks among older people, leading to improved emotional wellbeing.
    - Reduced levels of loneliness and social isolation.
    - Increased longer-term independence.
    - Improved service integration between primary, secondary and social care services.

5. An analysis of return on investment.

6. A cost benefit analysis/social return on investment which provides information on both the value for money of providing the service and the opportunity cost of not carrying out the 'Together for Health' service.

2.2 Data collection:

Data collection methods included:

- *Engaging stakeholders*: A short first phase of three months, in which we liaised with the key stakeholders and ran a two day workshop to introduce the SROI methodology and involve the stakeholders to think about the various changes or outcomes experienced by the project beneficiaries as a result of the 'Together for Health' services. This first phase primarily addressed evaluation objectives 1 to 3.

- Life Essentials Assessment Framework (LEAF) questionnaires administered to all Age UK clients at baseline, 6 weeks and 12 weeks. The LEAF questionnaires are a validated tool developed by Age UK Wakefield District (Giuntoli et al. 2013; Bagnall et al., 2014), that is also an essential part of the intervention. See Appendix A.

- Loneliness and resilience questionnaires administered at baseline and 12 weeks with a sample of Age UK clients. This questionnaire comprised the 6 item Brief Resilience Scale (Smith et al. 2008) and the 3 item UCLA Loneliness Scale (version 3) (Russell 1996). See Appendix B.

- Interviews with:
    - Age UK Yorkshire & Humber
    - The local Age UKs
    - A sample of Age UK clients
    - Health and social care professionals

Age UK staff were contacted directly by the University research team. Age UK clients were contacted via the Age UK staff who had been working with them in the first instance. Informed consent was obtained (see Appendix C and D for copies of consent forms and participant information leaflet) prior to interviews being carried out at Age UK premises or in the clients' own homes with Age UK staff present. See Appendix E for interview schedules

2.3 Data analysis:

Qualitative data: The interviews with stakeholders and clients were transcribed and the data were analysed by two researchers using thematic analysis methods (Braun & Clarke, 2006). Transcriptions and quotations were anonymised. Key cross cutting themes were described and reported using direct quotations from the participants' interviews to illustrate them.

Quantitative data: Data were collected from Age UK clients using the following instruments:

- A validated LEAF questionnaire administered at referral, 6 weeks and 12 weeks.
- A modified questionnaire based loosely on LEAF which was used by 3 out of the 4 areas and administered at referral, 6 weeks and 12 weeks.
- Resilience questionnaire administered at referral and 12 weeks (Brief Resilience questionnaire).
- Loneliness questionnaire administered at referral and 12 weeks (UCLA Loneliness Scale version 3).

Data were analysed using the statistical software package SPSS.

LEAF data

95% confidence intervals of the mean change in ratings over time were calculated. Paired (related samples) t-tests were also used to assess whether there was a statistically significant difference in the mean rating for the 8 individual domains (listed below). Each domain was scored on a scale ranging from 1-10.

- Managing daily living
- Managing finances
- Managing physical health to still make the most of life
- Having one's say in decisions - control and choice
- Feeling safe
- Social networks and social life
- Feeling valued by others
- Happiness - emotional wellbeing

A confidence interval provides an indication of the range within which the true effect is likely to be. The width of a confidence interval is affected by the size of the sample, with smaller samples tending to have larger confidence intervals than bigger ones. A confidence interval of a mean difference that does not pass through 0 is indicative of a statistically significant change. For all inferential tests a p value of 0.05 was taken to be statistically significant.

Cohen's D was calculated to determine the size of the change between time points. D values of 0.2, 0.5 and =>0.8 were considered small, medium and large effects, but these cut offs should be considered a broad guide rather than a rigid standard.

Only Knaresborough & District collected all data using just the LEAF questionnaire. Barnsley, Bradford & Wakefield all collected data using LEAF & the alternate questionnaire

Data collected using the alternate questionnaire

This questionnaire covered 6 domains (listed below), with an extra question addressing life satisfaction. Scoring ranged from 1-4 for the individual domains and 0-10 for life satisfaction.

1. Managing daily living
2. Managing health
3. Social contact
4. Enjoyment
5. Safety & security
6. Independence

Once again, 95% confidence intervals of the mean change in ratings over time were calculated and paired t-tests used to assess whether there was a statistically significant difference in the mean rating for the individual domains.

Resilience: Responses to the 6 items of the Brief Resilience Questionnaire were assigned a score from 1 to 5. Items 2, 4 & 6 were negatively worded and required reverse coding. For all statements the least positive option scored the lowest and the most positive the highest. The scores from each of the 6 items were added together to give a total for resilience. The maximum possible score was 30 and the minimum was 6 - the higher the score the great the level of resilience.

Loneliness: Responses to the 3 items of the UCLA Loneliness Scale (v3) were scored from 1 to 4, with the least positive option scoring the highest. An overall total score for loneliness was then calculated for each client. The maximum possible score was 12 and the minimum was 3 - the higher the score the great the level of loneliness.

SROI analysis: An SROI analysis is undertaken in six steps, which follow seven principles (see Table 1). The first two steps of the SROI analysis are achieved through the workshops and the first interviews with a sample of service users. The third step, 'evidencing outcomes', is achieved through the use of the LEAF questionnaire, routinely collected data, client interviews, and the two additional questionnaires on resilience and loneliness. Financial values were given using direct methods (see Social E-valuator, 2008) for data for which there is a market traded 'price', for example hospitalization, visits to GPs, etc[1]. For data for which there is no market traded 'prices', such as for example loneliness and emotional well-being, financial proxies were created using established approaches (see for example, New Economics Foundation, 2012; Social Value Lab, 2011, http://www.globalvaluexchange.org/).

Table 1. Stages and principles in an SROI analysis

Stage of an SROI analysis	SROI principles
1. Establishing scope and identifying stakeholders	☐ Involve stakeholders ☐ Understand what changes ☐ Value what matters ☐ Include only what's material ☐ Avoid over-claiming ☐ Be transparent ☐ Verify the result
2. Mapping outcomes	
3. Evidencing outcomes and giving them a value value	
4. Establishing impact	
5. Calculating the SROI	
6. Reporting, using and embedding	

The fourth step, 'establishing impact', entails creating a cost benefit model that includes:

[1] http://www.pssru.ac.uk/project-pages/unit-costs/2015/index.php

- The cost (in the marketplace) of all the investments made by the funding stakeholders summed together. Such investments can consist of money, time or people, e.g. advice, volunteers, and in kind donations, e.g. free rent, free inventory, etc.

- The opportunity costs related to 'Together for health': What would happen to the project beneficiaries if they did not join it and gain the ability to live independently in the community? What social and health services would they require to be assisted? These would be calculated using direct methods as mentioned above.

- Deadweight (what would have happened anyway) and attribution (An assessment of how much the outcome in question was caused by 'Together for Health' as opposed to the contribution of other organisations or people).

- Benefit period and drop-off rate (how long the outcomes last and when they diminish).

The fifth step, 'calculating the SROI', entails comparing the social values calculated in the third step against the investment value calculated in the fourth step to create a SROI ratio.

Finally, as part of a sensitivity analysis, a number of key assumptions that would sit within the chosen socio-economic model would be varied to understand their relative contribution.

3. Findings

3.1 Stakeholder workshops

Two workshops were held in September 2013 and a total of 17 participants attended. These consisted of Age UK regional managers and CEOs, Age UK staff and the Leeds Beckett University research team. The workshops covered the format of the evaluation and the stages of a SROI, followed by group work to map out the range of stakeholders potentially affected by and outputs, outcomes and impacts produced by Together for Health, and a map of the "client pathway" to identify which outcomes might occur at which time points (Figure 1).

3.1.1 List of potential stakeholders identified:

- Older people; carers; families; partners;
- Private care companies;
- Residential care;
- GPs; OTs; District Nurse; Health visitor; incontinence nurse; Physiotherapist; CPN; Falls practitioner;
- Social workers; community workers;
- Commissioners: social services; clinical services;
- Other VCS organisations e.g. Alzheimer's;
- Dial; Vision; Carer's society; Age Action Alliance; UKAFA;
- Campaign to end loneliness etc.;
- DWP; LA; CCG; NHS; DoH; Public Health;
- Wider community resources; neighbours;
- Age UK local/ paid for services;
- Age UK Volunteers; Age UK staff;
- Age UK regional/ national company; trustees;
- Leeds Beckett University;
- Hospitals; consultants;
- Transport services.

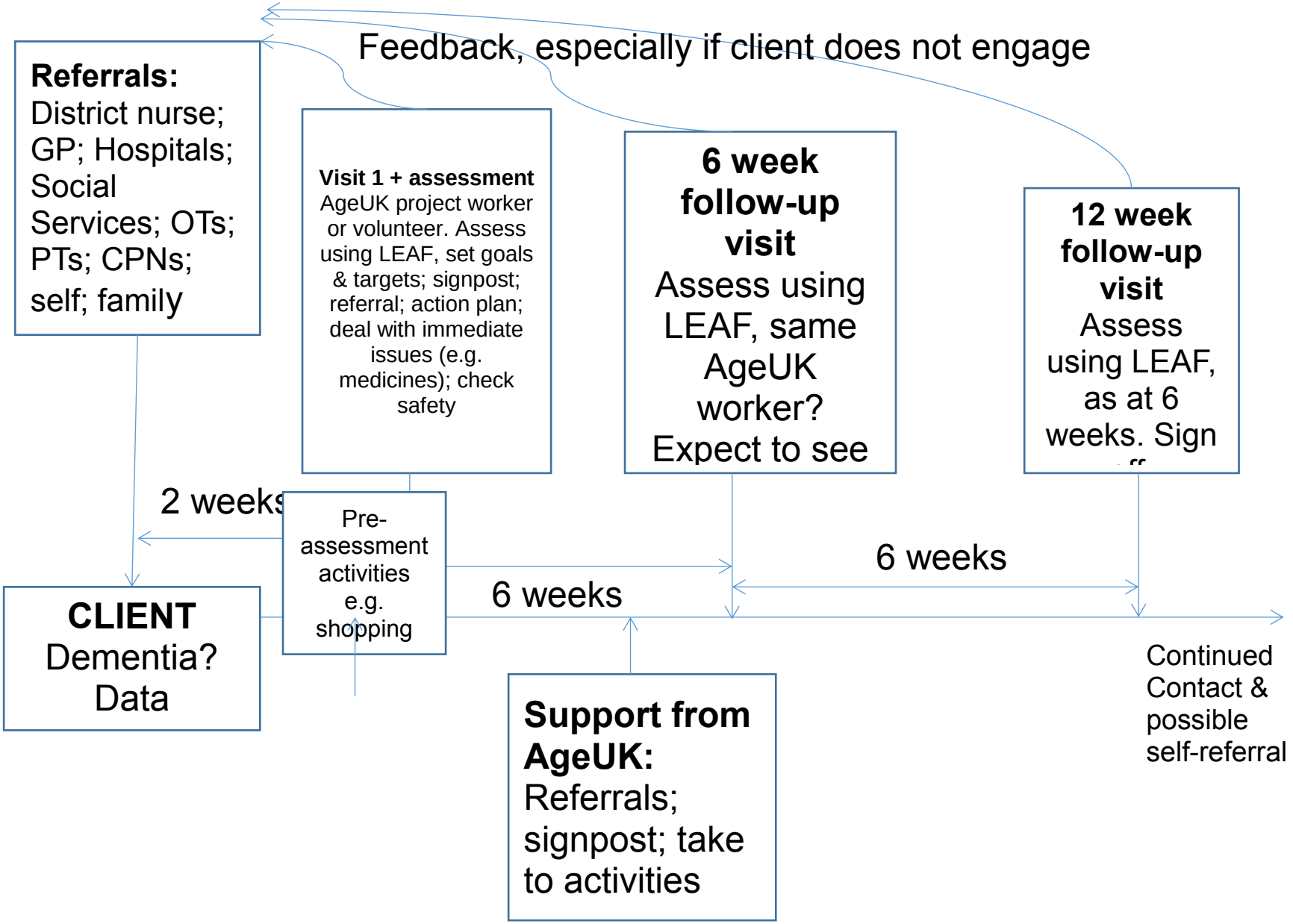
3.1.2 Outputs, Outcomes and Impacts identified

Outputs are defined as tangible, practical, immediate and intended results produced through sound management of the agreed inputs. Outcomes are defined as the likely or achieved short-term effects of an intervention's total set of outputs. Outcomes can be seen as the actual use of the outputs. Impacts are defined as the long-term effects in the lives of people and their natural environment. The following potential outputs, outcomes and impacts were identified at the stakeholder workshops:

Table 2: Outputs, outcomes and impacts identified by stakeholders

Outputs	Outcomes	Impacts
- Number of referrals (where from/ source); Willing to be involved?; - Number of visits and assessment; - Action plan and goal setting; - Signposting; - Referral to social activity; - Referral to other agencies; - Attendance at activities run by Age UK; - Attendance at other activities; - Number of volunteers involved; - Number of social contacts; - Number of GP visits; - Number of unplanned hospital visits; - Improved financial management; - Referral to handyman service/ jobs.	- Increased confidence – to socialize & general engagement; - Increased control and choice; - Voices being heard in relation to health; - Increased confidence to go out; - Improved social relationships; - Increased wellbeing; - More money to socialize; - Feeling safe – make home safer e.g. key safe; - Change in number of GP visits; - Reduction in number of unplanned hospital visits; - Change in number of visits to A&E.	- Better use of health resources, better relationships with health professionals; - Better quality of life; - Being able to self-manage their “condition”; - Reduced social isolation; - Reduction in feelings of loneliness; - Improved resilience; - More independence and confidence; - Improved feelings of safety/ reduced fear of crime.

Figure 2 Client pathway



3.2 Monitoring data

By the end of January 2016, 667 clients provided data, or consented to provide data as part of “Together for Health”: 236 clients from Knaresborough & District, 114 from Barnsley, 231 from Bradford and 86 from Wakefield. Just over two third (69%, n=457) were females with just under one third (31%, n=210) being male.

Due to the way data was recorded, age is presented separately for clients who used the validated LEAF questionnaire and for those who used the alternative LEAF questionnaire:

Validated LEAF, age (n=394) The mean age of clients was 79.5 years (SD = 10.2), with the oldest individual aged 100 years and the youngest 39 years. Three quarters were 75 years or older (75%) and 57% were at least 80 years old. The mean age of females (80 years) was slightly higher than mean age of males (78 years).

Alternate LEAF questionnaire (n=246) The mean age of clients was 80 years (SD = 8.67), with the oldest individual aged 101 years and the youngest 53 years. Three quarters were 75 years or older (76%) and 59% were at least 80 years old. There was little difference in the mean age of females (81 years) & males (80 years).

The total number of documented hours that Age UK workers spent with clients as part of Together for Health was 19,526.

A range of interventions were offered to clients as part of Together for Health. These included shopping, cleaning, befriending, taking to social events, helping with medication, dog walking, bathing, reassurance, post-discharge (from hospital) checks.

Clients were also signposted to a range of services, including other care agencies, dementia groups, community transport, health trainers, lunch clubs, social services, befriending services, housing support, bereavement counselling.

3.3 Questionnaire data

Results will be reported separately for data collected using the validated LEAF & the alternate (non-validated) LEAF questionnaire.

3.3.1 Overall findings

For clarity, the number of responses on which analyses were calculated is provided (n =). In some cases, percentages may not add up to exactly 100% due to rounding.

3.3.1.1 Validated LEAF questionnaire

In total 420 clients provided referral data to at least 1 of the items using the validated LEAF questionnaire

Town (n=420) Out of the 420 clients, 56% were based in Knaresborough & District (n=236), 25% in Barnsley (n=106), 15% in Bradford (n=64) and 3% in Wakefield (n=14).

Responses to the 8 leaf questions

Change from referral to 6 weeks

Table 3 presents the average change in ratings from referral to 6 weeks. It can be seen that there was statistically significant improvement ($p<0.001$) over this period for all domains. The size of the improvement was:

- Small for ‘Feeling valued’ (d=0.20), ‘Control and choice’ (d=0.31), ‘Feeling safe’ (d=0.36) and ‘Managing finances’ (d=0.46)
- Medium for ‘Emotional wellbeing’ (d=0.63), ‘Managing daily living’ (d=0.66); ‘Managing physical health’ (d=0.68) & ‘Social networks’ (d=0.70).

Additional analysis revealed that amongst females there was a statistically significant difference in average change for all of the domains. Amongst males, there was a statistically significant difference in average change for all of the domains except ‘Control and choice’ (p=0.06) & ‘Feeling valued’ (p=0.409).

Table 4 shows the number of clients whose ratings increased, decreased or remained the same from referral to 6 weeks. For 4 items of LEAF, the majority of clients had an improved rating at 6 weeks. The proportion of individuals who improved was similar for ‘Managing physical health’ (60%); ‘Social networks’ (60%); ‘Managing daily living’ (59%) & Emotional wellbeing (56%). For 3 items of LEAF, the majority of clients had no overall change in rating. These were ‘Control and choice’ (56%); ‘Feeling valued’ (53%) & ‘Managing finances’ (51%). The proportion of clients who had no overall change in rating for ‘Feeling safe’ (43%) was similar to the percentage who improved from referral to 6 weeks (44%).

Table 3: Mean change from referral to 6 weeks

	Mean rating score at referral (SD)	Mean rating score at 6 weeks (SD)	Mean change (SD)	95% confidence interval	Statistically significant change	
1) Managing daily living (n=238)	4.98 (2.16)	6.33 (1.98)	1.35 (2.04)	1.088-1.61	✓	t=10.18,df=237, p<0.001
2) Managing finances (n=144)	6.31 (2.65)	7.10 (2.46)	0.79 (1.71)	0.502-1.067	✓	t=5.493,df=143, p<0.001
3) Managing physical health (n=224)	4.37 (1.78)	5.52 (1.85)	1.16 (1.69)	0.934-1.379	✓	t=10.235, df=223, p<0.001
4) Control and choice (n=123)	5.85 (2.30)	6.37 (2.17)	0.52 (1.67)	0.222-.819	✓	t=3.453, df=122, p=0.001
5) Feeling safe (n=136)	6.46 (2.06)	7.15 (1.77)	0.70 (1.93)	0.371-1.026	✓	t=4.213, df=135, p<0.001
6) Social networks (n=168)	4.52 (2.06)	5.90 (2.15)	1.38 (1.98)	1.079-1.683	✓	t=9.034, df=167, p<0.001
7) Feeling valued (n=119)	5.01 (2.49)	5.33 (2.38)	0.32 (1.61)	0.028-.611	✓	t=2.171, df=118, p=0.032
8) Emotional wellbeing (n=198)	4.62 (2.07)	5.77 (2.04)	1.15 (1.82)	0.892-1.401	✓	t=8.89, df=197,p<0.001

Table 4: Number of clients with increases, decreases or no change in scores at 6 weeks

	Number of clients with an improved rating at 6 weeks	Number of clients with no change in rating at 6 weeks	Number of clients with a lower rating at 6 weeks
1) Managing daily living (n=238)	141/238	81/238	16/238
2) Managing finances (n=144)	60/144	74/144	10/144
3) Managing physical health (n=224)	135/224	67/224	22/224
4) Control and choice (n=123)	42/123	69/123	12/123
5) Feeling safe (n=136)	58/136	60/136	18/136
6) Social networks (n=168)	100/168	58/168	10/168
7) Feeling valued (n=119)	40/119	63/119	16/119
8) Emotional wellbeing (n=198)	110/198	69/198	19/198

3.3.1.2 Alternate LEAF questionnaire

Data were collected using the alternate LEAF questionnaire from 3 areas: Barnsley, Bradford & Wakefield. In total, 247 clients provided referral data to at least 1 of the items using the alternate LEAF questionnaire.

Town (n=247) Out of the 247 clients, 68% were based in Bradford (n=167), 29% in Wakefield (n=72) & 3% in Barnsley (n=8).

Change from referral to 6 weeks

Table 5 presents the average change in ratings from referral to 6 weeks. It can be seen that there was statistically significant improvement over this period for 'Social contact' & 'Enjoyment', as well for 'Life satisfaction'. Improvement in both 'Social contact' & 'Enjoyment' was small (d=0.28 & d=0.21), and medium for 'Life satisfaction' (d=0.68).

Further analysis revealed statistically significant improvement in 'Social contact'; 'Enjoyment' & 'Life Satisfaction' for both males & females. No other item showed significant change for either sex.

Table 6 shows the number of clients whose ratings increased, decreased or remained the same from referral to 6 weeks. A majority of clients had an improved rating for 'Life satisfaction' (51%), but for all other items, most individuals showed no change.

Table 5: Mean change from referral to 6 weeks

	Mean rating score at referral (SD)	Mean rating score at 6 weeks (SD)	Mean change (SD)	95% confidence interval	Statistically significant change	
Managing daily living (n=188)	2.53 (0.80)	2.57 (0.81)	0.04 (0.40)	-0.10-0.106	✗	t=1.623,df=187, p=0.106
Managing your health (n=187)	2.57 (0.84)	2.62 (0.80)	0.05 (0.46)	-0.018-0.114	✗	t=1.445,df=186, p=0.150
Social contact (n=188)	2.56 (0.85)	2.71 (0.84)	0.15 (0.54)	0.072-0.226	✓	t=3.806, df=187, p<0.001
Enjoyment (n=190)	2.25 (0.78)	2.35 (0.80)	0.1 (0.47)	0.027-0.162	✓	t=2.760, df=189, p=0.006
Safety & Security (n=189)	3.09 (0.70)	3.11 (0.72)	0.02 (0.39)	-0.034-0.076	✗	t=0.755, df=188, p=0.451
Independence (n=187)	3.02 (0.91)	3.04 (0.87)	0.02 (0.37)	-0.026-0.79	✗	t=1, df=186, p=0.319
Life satisfaction (n=188)	5.66 (2.14)	6.46 (2.02)	0.80 (1.17)	0.635-0.971	✓	t=9.418, df=187, p<0.001

Table 6: Number of clients with increases, decreases or no change in scores at 6 weeks

	Number of clients with an improved rating at 6 weeks	Number of clients with no change in rating at 6 weeks	Number of clients with a lower rating at 6 weeks
Managing daily living (n=188)	18/188	163/188	7/188
Managing your health (n=187)	19/187	160/187	8/187
Social contact (n=188)	33/188	148/188	7/188
Enjoyment (n=190)	24/190	158/190	8/190
Safety & Security (n=189)	9/189	176/189	4/189
Independence (n=187)	9/187	174/187	4/187
Life satisfaction (n=185)	96/185	85/185	7/185

3.3.2 Change from referral to 6 weeks - by area

3.3.2.1 Validated LEAF questionnaire

Analyses were conducted to examine ratings change from referral to 6 weeks for Barnsley, Bradford & Knaresborough & District separately, and the results are showed in Table 7. Wakefield was excluded from the analyses due to the low number of clients from which LEAF data were collected using the validated questionnaire. It can be seen that there was statistically significant improvement for the domain of 'Social networks' in all 3 areas. Furthermore, in both Barnsley & Knaresborough & District, significant improvement was also found for: 'Managing finances'; 'Control & choice' & 'Emotional wellbeing'. Ratings for the

remaining 3 domains of 'Managing physical health'; 'Feeling safe' & 'Feeling valued' also improved significantly in Knaresborough & District. The size of the improvements in Knaresborough & District were large (d>0.8), except for 'Managing finance' (d=0.73) & 'Control & choice' (d=0.52) which were medium sized improvements. The size of improvement for 'Social networks' in Barnsley & Bradford was medium. All other improvements in Barnsley were small (d<0.45).

Table 7: Change in ratings from referral to 6 weeks, by area

	Barnsley		Bradford		Knaresborough & District	
	Mean change (Referral-6W)	Statistically significant change	Mean change (Referral-6W)	Statistically significant change	Mean change (Referral-6W)	Statistically significant change
1) Managing daily living	0.47 (SD=1.97) (n=66)	✘ (p=0.057)	0.12 (SD=0.82) (n=26)	✘ (p=0.478)	1.94 (SD=2) (n=144)	✓ (p<0.001)
2) Managing finances	0.52 (SD=1.50) (n=68)	✓ (p=0.06)	0.26 (SD=1.32) (n=27)	✘ (p=0.316)	1.45 (SD=2) (n=47)	✓ (p<0.001)
3) Managing physical health	0.39 (SD=1.77) (n=66)	✘ (P=0.075)	0.14 (SD=0.88) (n=29)	✘ (p=0.403)	1.81 (SD=1.5) (n=127)	✓ (p<0.001)
4) Control and choice	0.58 (SD=1.84) (n=67)	✓ (p=0.012)	-0.26 (SD=1.16) (n=27)	✘ (p=0.257)	1 (SD=1.94) (n=27)	✓ (p<0.001)
5) Feeling safe	0.19 (SD=2.0) (n=67)	✘ (p=0.432)	0.14 (SD=0.59) (n=28)	✘ (p=0.212)	1.92 (SD=1.94) (n=39)	✓ (p<0.001)
6) Social networks	1.0 (SD=2.06) (n=63)	✓ (p<0.001)	0.81 (SD=1.33) (n=31)	✓ (P=0.002)	1.94 (SD=2.03) (n=72)	✓ (p<0.001)
7) Feeling valued	0.1 (SD=1.58) (n=61)	✘ (P=0.628)	-0.30 (SD=1.49) (n=23)	✘ (p=0.338)	1.15 (SD=1.46) (n=34)	✓ (p<0.001)
8) Emotional wellbeing	0.88 (SD=2.23) (n=69)	✓ (P=0.02)	0.2 (SD=0.76) (n=25)	✘ (p=0.203)	1.56 (SD=1.57) (n=103)	✓ (p<0.001)

3.3.2.2 Alternate LEAF questionnaire

Analyses were conducted to examine ratings change from referral to 6 weeks for Bradford & Wakefield, and the results are showed in Table 8. Barnsley was excluded from the analyses due to the low number of clients from which data were collected using the alternate questionnaire. It can be seen that there was statistically significant improvement for the domains of 'social contact'; 'Enjoyment' & 'Life satisfaction' in both areas. Furthermore, in Wakefield significant improvement was also found for: 'Managing daily living' and 'Managing your health'. There was no significant change in ratings for 'Safety & security' or 'Independence' in either area. Medium sized improvements were identified in both areas for 'Life satisfaction' (d=0.72), with all other significant changes being small. (d<0.4).

Table 8: Change in ratings from referral to 6 weeks, by area

	Bradford		Wakefield	
	mean change (Referral-6W)	Statistically significant change	mean change (Referral-6W)	Statistically significant Change
Managing daily living	0.01 (SD=0.28) (n=139)	✘ (p=0.764)	0.21 SD=0.59) (n=44)	✓ (p=0.027)
Managing your health	0 (SD=0.40) (n=138)	✘ (p=1.0)	0.21 (SD=0.55) (n=44)	✓ (p=0.018)
Social contact	0.12 (SD=0.38) (n=139)	✓ (p=0.001)	0.27 (SD=0.76) (n=44)	✓ (p=0.022)
Enjoyment	0.071 (SD=0.33) (n=141)	✓ (p=0.012)	0.21 (SD=0.63) (n=44)	✓ (p=0.037)
Safety & Security	0.01 (SD=0.17) (n=140)	✘ (p=0.319)	0.068 (SD=0.66) (n=44)	✘ (p=0.498)
Independence	0.01 (SD=0.26) (n=139)	✘ (p=0.740)	0.136 (SD=0.51) (n=44)	✘ (p=0.083)
Life satisfaction	0.74 (SD=1.03) (n=140)	✓ (p<0.001)	1.05 (SD=1.45) (n=44)	✓ (p<0.001)

3.3.3 Change from referral to 12 weeks

3.3.3.1 Validated LEAF questionnaire

Table 9 details the average change in ratings from referral to 12 weeks. Analysis revealed there to be statistically significant improvement over this period for all 8 of the LEAF domains

The size of the improvement was:

- Small for ‘Feeling safe’ (d=0.37), ‘Control and choice’ (d=0.38), ‘Feeling valued’ (d=0.47), and ‘Managing finances’ (d=0.49)
- Medium for ‘Physical health’ (d=0.64), ‘Emotional wellbeing’ (d=0.69), ‘Managing daily living’ (d=0.70).
- Large for ‘Social networks’ (d=0.84).

Additional analysis revealed that amongst females there was a statistically significant difference in average change for all of the domains. Amongst males, there was a statistically significant difference in average change for all of the domains except ‘Feeling safe’ (p=0.06).

Table 10 shows the number of clients whose ratings increased, decreased or remained the same from referral to 12 weeks. For 4 items of LEAF, the majority of clients had an improved rating at 12 weeks, with two thirds (67%) of individuals showing an improvement for ‘Social networks’. The proportion who improved was similar for ‘Managing daily living’ (60%), ‘Emotional wellbeing’ (60%) & ‘Managing physical health’ (59%). In addition, half of the clients showed improvement for ‘Managing finances’ (50%), and the largest proportion of individuals had an improved rating for ‘Control and choice’ (44%). For 2 items of LEAF, the

largest proportion of clients had no overall change in rating. These were: 'Feeling Safe' (48%) & 'Feeling valued' (45%).

Table 9: Mean change from referral to 12 weeks

	Mean rating score at referral (SD)	Mean rating score at 12 weeks (SD)	Mean change (SD)	95% confidence interval	Statistically significant change	
1) Managing daily living (n=122)	5.02 (2.30)	6.99 (2.08)	1.97 (2.80)	1.473-2.478	✓	t=7.783 df=121 p<0.001
2) Managing finances (n=88)	6.10 (2.72)	7.02 (2.51)	0.92 (1.86)	0.525-1.316	✓	t=4.631 df=87 p<0.001
3) Managing physical health (n=112)	4.29 (1.89)	5.85 (1.96)	1.56 (2.45)	1.10-2.016	✓	t=6.740 df=111 p<0.001
4) Control and choice (n=79)	5.81 (2.28)	6.57 (2.19)	0.76 (1.98)	0.317-1.202	✓	t=3.417 df=78 p=0.001
5) Feeling safe (n=85)	6.41 (2.09)	7.29 (1.82)	0.88 (2.35)	0.375-1.390	✓	t=3.458 df=84 p=0.001
6) Social networks (n=117)	4.44 (2.14)	6.41 (2.13)	1.97 (2.35)	1.543-2.405	✓	t=9.071 df=116 p<0.001
7) Feeling valued (n=83)	5.04 (2.65)	5.96 (2.32)	0.93 (1.98)	0.495-1.360	✓	t=4.268 df=82 p<0.001
8) Emotional wellbeing (n=95)	4.45 (2.27)	6.09 (2.12)	1.64 (2.37)	1.160-2.124	✓	t=6.767 df=94 p<0.001

Table 10: Number of clients with increases, decreases or no change in scores at 12 weeks

	Number of clients with an improved rating at 12 weeks	Number of clients with no change in score at 12 weeks	Number of clients with a lower rating at 12 weeks
1) Managing daily living (n=122)	73/122	39/122	10/122
2) Managing finances (n=88)	44/88	35/88	9/88
3) Managing physical health (n=112)	66/112	34/112	12/112
4) Control and choice (n=79)	35/79	32/79	12/79
5) Feeling safe (n=85)	35/85	41/85	9/85
6) Social networks (n=117)	78/117	32/117	7/117
7) Feeling valued (n=83)	35/83	37/83	11/83
8) Emotional wellbeing (n=95)	57/95	29/95	9/95

3.3.3.2 Alternate LEAF questionnaire

It was not possible to examine change over this period owing to low numbers with data for the second time point.

3.3.4 Change from referral to 12 weeks - by area

3.3.4.1 Validated LEAF questionnaire

Analyses were conducted to examine ratings change from referral to 12 weeks for Barnsley, Bradford & Knaresborough & District, and the results are showed in Table 11. Wakefield was excluded from the analyses due to the low number of clients from which data were collected using the validated LEAF. It can be seen that there was statistically significant improvement for the domain of 'Social networks' & 'Managing finances' in all 3 areas. Furthermore, in both Barnsley & Knaresborough & District, significant improvement was also found for: 'Managing daily living'; 'Managing physical health'; 'Control & choice'; 'Feeling value' & Emotional wellbeing. Ratings for 'Feeling safe' also improved significantly in Bradford & Knaresborough & District. All improvements in Knaresborough & District were large, (d>0.8) except for 'Managing finances' which was medium sized (d=0.75). Improvements in Barnsley were large for 'Social networks' (d=0.87), medium sized for 'Emotional wellbeing' (d=0.56) and small (d<0.5) for the other domains with significant change. In Bradford, improvements were medium sized for 'Social networks' (d=0.55) & 'Managing finances' (d=0.5) & small for 'Feeling Safe' (d=0.33).

Table 11: Change in ratings from referral to 12 weeks, by area

	Barnsley		Bradford		Knaresborough & District	
	mean change (Referral-12W)	Statistically significant change	mean change (Referral-12W)	Statistically significant change	mean change (Referral-12W)	Statistically significant change
1) Managing daily living	1 (SD=2.17) (n=43)	✓ (p=0.004)	0.35 (SD=1.06) (n=26)	✗ (p=0.107)	3.53 (SD=2.97) (n=53)	✓ (p<0.001)
2) Managing finances	0.77 (SD=1.93) (n=44)	✓ (p=0.011)	0.93 (SD=1.86) (n=28)	✓ (p=0.0140	1.31 (SD=1.74) (n=16)	✓ (p=0.009)
3) Managing physical health	0.72 (SD=2.20) (n=43)	✓ (p=0.037)	0.27 (SD=1.08) (n=28)	✗ (p=0.199)	3.32 (SD=2.38) (n=41)	✓ (p<0.001)
4) Control and choice	1.09 (SD=2.51) (n=44)	✓ (p=0.006)	0 (SD=0.4) (n=26)	✗ (p=1.0)	1.33 (SD=0.87) (n=9)	✓ (p=0.002)
5) Feeling safe	0.60 (SD=2.75) (n=42)	✗ (p=0.168)	0.15 (SD=0.46) (n=27)	✓ (p=0.103)	2.88 (SD=2.13) (n=16)	✓ (p<0.001)
6) Social networks	1.57 (SD=1.80) (n=42)	✓ (p<0.001)	0.87 (SD=1.59) (n=30)	✓ (p=0.006)	3.09 (SD=2.77) (n=45)	✓ (p<0.001)
7) Feeling valued	0.81 (SD=2.11) (n=41)	✓ (p=0.019)	0 (SD=0.31) (n=22)	✗ (p=1.0)	2.20 (SD=2.17) (n=20)	✓ (p<0.001)
8) Emotional wellbeing	1.42 (SD=2.53) (n=45)	✓ (p<0.001)	0.43 (SD=1.08) (n=21)	✗ (p=0.83)	2.86 (SD=2.28) (n=29)	✓ (p<0.001)

3.3.4.2 Alternate LEAF questionnaire

It was not possible to examine change over this period owing to low numbers with data for the second time point.

3.3.5 Resilience & loneliness data

Referral and discharge scores for resilience and/or loneliness were available for 188 clients: Of these:

- 128 (68%) were from Bradford
- 28 (15%) were from Barnsley
- 22 (12%) were Knaresborough & District
- 10 (5%) were from Wakefield.

Resilience

A resilience score was calculated for 174 clients.

The average resilience score at referral was 18.67 (SD=4.58). The highest score was 30 and the lowest was 6. At discharge the average score was 18.91 (SD=4.46), with the highest score being 30 and the lowest 6.

Whilst the average resilience score was higher at discharge than at referral, this change (+0.24) (SD=1.66) was not statistically significant (t=1.924, df=173, p=0.056).

Out of the 174 clients:

- 34 (20%) had an improvement in resilience score from referral to discharge
- 16 (9%) had a decrease in score
- 124 (77%) had no overall change.

Loneliness

A loneliness score was calculated for 177 clients

The average loneliness score at referral was 7.67 (SD=2.26). The highest score was 12 and the lowest was 3. At discharge the average score was 7.53 (SD=2.24), with the highest score being 12 and the lowest 3.

The percentage of people who were lonely (*i.e.* answering “sometimes” or “always” to each of the three loneliness questions) was as follows:

Q1 How often do you feel that you lack companionship? 62.7% on referral; 57.5% on discharge

Q2 How often do you feel left out? 60.1% on referral; 57.0% on discharge

Q3 How often do you feel isolated from others? 60.8% on referral; 56.5% on discharge

The average change in loneliness score was -0.14 (SD=0.90) and the 95% confidence interval was -0.275 to -0.08, which indicates a significant decrease in levels of loneliness ($p<0.05$).

A paired t-test also suggested there was a small statistically significant decrease in loneliness from referral to discharge (t=2.08, df=176, p=0.039) (d=0.2).

Out of the 177 clients:

- 27 (15%) had a decrease in loneliness score from referral to discharge
- 12 (7%) had an increase in loneliness score
- 138 (78%) had no overall change.

3.4 Health Service Use data

Data on the number of inpatient stays, Accident & Emergency department visits & Outpatient's appointments were analysed for 275 individuals who participated in the Together for Health intervention. This comprised 68 clients from Barnsley, 29 from Bradford, 59 from Knaresborough & District & 119 from Wakefield. Data were collected for the period of 1 year prior to referral dates & up to 1 year after. A full year's post intervention data were not available for all clients. The numbers of individuals who did not have a full year's data were as follows:

- Inpatient stays = 35
- A & E visits = 35
- Outpatient visits = 50

A breakdown of the results is provided in Table 12.

There was no significant change in the average number of inpatient stays (average change from pre-post intervention +0.13, sd=2.02, t=0.982, df=274, p=0.327).

There was no significant change in the average number of A & E visits (average change from pre-post intervention +0.16, sd=1.50, t=1.80, df=274, p=0.072.

Analysis revealed that the average number of outpatient visits post intervention (2.77, sd=4.97) was significantly higher than at pre intervention (1.74, sd=3.67) (average change=1.03, sd=4.70, t=3.648, df=274,p<0.001). The size of the increase was small (d=0.22).

Table 12: Change in hospital service use (pre-post)

	Mean change from (pre-post)	Statistically significant change	
Number of inpatient stays	+0.13 (SD=2.02) (n=275)	✘	t=0.982,df=274, p=0.327
Number of A&E visits	+0.16 (SD=1.50) (n=275)	✘	t=1.80,df=274, p=0.072
Number of outpatient visits	+1.03 (SD=4.70) (n=275)	✓	t=3.648, df=274,p<0.001

3.5 Qualitative data

A total of 17 interviews were conducted with Age UK management and staff and 23 with Age UK clients across four regions (Barnsley, Bradford, Knaresborough & District and Wakefield). The following analysis reports on prominent themes identified from the interview data.

Table 13: Qualitative interview participants

	Age UK management	Age UK staff	Clients	Total
Barnsley	2	4	5	**11**
Bradford	3	2	5	**10**
Knaresborough & District Knaresborough	2	1	6	**9**
Wakefield	1	2	7	**10**
Total	**8**	**9**	**23**	**40**

3.5.1 Delivery of Together for Health in the four areas:

Barnsley

In Barnsley, the Together for Health funding allowed the Age UK to double the staff time. The original idea was that there would be one main referral partner – the rehabilitation and reablement service, but it became clear that it wasn't generating sufficient referrals for the service, so in year 2 a project worker was appointed and a lot of work was done to raise awareness with other referral partners, such as the council, GP practices, and the hospital. They also changed the internal referral pathways, so there was a single referral route into the Visiting and befriending service and into Together for Health, so that clients could be referred to the most suitable service for their needs. The service was seen to work well and obtained additional funding from the CCG to continue the work until a larger social prescribing initiative begins. It was felt that being part of a larger initiative and having positive findings in the interim evaluation report contributed to this success.

Bradford

In Bradford, the project got off to a slow start with very few referrals, but this prompted Age UK outreach workers and managers to network more with GP surgeries, hospitals and social services as part of Together for Health. The funding associated with the project allowed the outreach workers to spend more time with clients and to visit more clients. Clients were now being referred through the hospital, social workers and GPs.

Knaresborough & District

In Knaresborough & District, it was originally planned to divide the Together for Health funding between 4 areas, but this was found to be problematic, so the project focused on

Knaresborough, as the model there was to work with clients for the long term. Most clients were referred via GPs or hospitals (the majority from hospitals), but there were some self-referrals and some family referrals.

Wakefield

In Wakefield, the decision was made to base the Together for Health service within the hospital, part of the reasoning being to build relationships with health and social care professionals, and partly to focus on a client group who are known to be isolated. The Age UK workers were physically based in the hospital and attend in-reach meetings with the consultant, the lead older people's nurse, occupational therapists and social workers.

3.5.2 Client interview themes:

Referral into the service

Clients were referred to Age UK through a variety of routes. Some were referred through the healthcare system; the GP/hospital service or Social Services. Others self-referred or were referred into the service by concerned family members.

> *"They actually referred me on to Age UK because I said I've lost a lot of my confidence and I needed motivating to get out of the house because otherwise you become a bit of a hermit, a recluse, and I didn't want that to happen."* (Client)

Support and confidence building

Many clients stated that they were keen to remain independent but admitted that they needed support around certain aspects of their lives:

> "*I want to be independent for as long as possible*." (Client)

Clients were overwhelmingly positive about the practical and emotional support provided by Age UK. Some expressed that they needed initial encouragement to access support. This included encouragement to attend groups or events, or to fulfil tasks outside of the home such as going shopping. Clients explained that having an Age UK worker who would come to their house and accompany them to appointments/activities helped to build their confidence. One client indicated that when people are reluctant to attend activities being encouraged/accompanied by an Age UK worker can help to empower people:

> *"We want more people like [*name of Age UK worker*] to go and drag them out, yeah then they'll come on their own next week. It's true that, I did*." (Client)

Other clients emphasised that the support not only helped them to feel more confident but less stressed or worried.

> *"They supported me with nearly everything really, you know what I mean. Now I mean I feel more settled. I wasn't before; I was a nervous and everything."* (Client)

Some clients who had been referred to Age UK by hospital services explained that the support they received helped them with their recovery and settling back into the community:

> "[Name of Age UK Worker] *put me on the road to recovery I suppose, pulling myself together and snapping out of it."* (Client)

One client was surprised at the type of support Age UK can offer and described the service as a 'life line'.

> *"I mean I think she's at full capacity really with me having the shopping and helping out. I'm quite happy with it, especially the shopping aspect. I didn't expect that, I didn't know anybody would do that. That is fantastic for me, it's a life line for me, it really is. I couldn't do without her really at the moment."* (Client)

This opinion was echoed by another client who spoke about the enjoyment clients get from attending a craft activity run by Age UK.

> *"If they took them away, they'll all feel the same you know, it's ridiculous to think isn't it that they depend, all these old women depend on this few hours that you're giving. But it's true."(*Client)

Friendly service

A key theme that resonated throughout the data was that clients were extremely satisfied with the 'friendly' and 'informal' service provided. Age UK workers were praised for being kind, patient and approachable. In addition they were described as friendly and always willing to make time to 'have a natter'. It was highlighted that the informal chats were a key benefit to the clients with many of them stating that they felt like Age UK workers were 'more like friends'.

> *"She was lovely [name of Age UK worker] she'd do anything for you. You could talk to her, she was becoming more like a friend […] she used to have a cup of coffee and a little chat and that made all the difference you know."* (Client)

Trust

Clients highlighted the importance of being able to trust someone who is coming into their homes. They attributed the building up of trust and relationships to the friendly nature of the Age UK workers. One client had a cleaner through his involvement with Age UK, who visited his house on a regular basis. He expressed that it is important to have a cleaner he can trust in his house and for this to happen there needs to be continuity of Age UK workers.

> *"She knows what to do, she's knows where things are… And I wouldn't like it to have different ones come, she's settled down and I like the lady that does it, we get on very well and she does a good job."* (Client)

A member of the client's family felt that she gained 'peace of mind' as she also trusted the worker and felt confident that her elderly family member was receiving a trustworthy and reliable service:

> "*And can I say from our point of view as well because we don't live local so we like to know who's coming to the house and we like to meet them and, y'know we all need to be happy."* (Client)

Social benefits

Clients felt that having someone to talk to was a huge benefit of the service. They described enjoying the company of the Age UK workers. Some clients expressed that they can become isolated when living alone and Age UK staff provided an important source of support.

> *"With [Age UK worker] you seem to have more of a friend. I'd recommend them to anybody, honest to God I would […] It's just having a friend to come in you know. She used to phone "I'll be with you Thursday" and she's be here. We used to sit and chat. I would recommend them to anybody."* (Client)

Some clients indicated that before receiving support from Age UK, they had been 'feeling low' and 'stuck in the house watching telly'.

> *"We got stuck in a rut you see, we never get out anywhere but since Age UK come to our house we've been getting out a lot more and meeting more people […] we've been happy since we started coming."* (Client)

For some clients, engaging with Age UK connected them back into the community and made them more away of other services and activities that were available locally.

> *"It's brought us out, you know what I mean […] and mixing, and we like mixing with people." (*Client)

Group activities were enjoyed by some clients. The food and atmosphere along with an opportunity to socialise with other people was appreciated.

> ***"****Well its good company. It spends the day (laughs)…I get a decent meal… and the atmosphere is good. And I meet people too, that's what… that sums it up as far as I'm concerned. I can't take part in all the activities they have there, but that doesn't matter a bit."* (Client)

Financial benefits

Many clients described getting help with financial issues such as bills, benefits and pensions. Many stated that before they received support from Age UK they were unaware of the benefits they were entitled too. Others described not feeling confident enough to fill in forms on their own.

> *"I just contacted them and said can you come and see me and discuss what if any benefits I may be entitled to apart from the standard OAP, Old Age Pension, national pension. And then they came to me and discussed with me, had a chat, a long interview and then they went off and they actually helped with all the form-filling and everything."* (Client)

Several clients explained that Age UK workers had helped them to apply for the appropriate benefits which resulted in some clients receiving more money:

> *"So before I had a good living, plus savings, and now I could just about manage on what I got on my pension. And that's where this good lady came in, luckily, and got me I think it was another £85 or something per week on that."* (Client)

Practical benefits

A range of practical support was received from Age UK. In some instances this came through referrals from Age UK to the Social Services. Clients discussed many different forms of practical help, this included adjustments to houses to help avoid slips and falls (hand rails, perching stools, ramps), walking aids, and warm clothing.

> *"Well I got my attendance allowance for it and I got various aids through my GP like the wheelchair and walking frame and sticks and a rail near the front door to get down the steps, one near the back door."* (Client)

Other practical help was offered such as accompanying clients to appointments and workers helping to administer medication in the form of organise prescription/medication packets for clients with poor eyesight.

"They help me with my tablets, I can do it on my own, but it's nice because some of them are so tiny and with not having good eyesight, it's nice to have them put in my hand." (Client)

Help with cleaning the home and transport to activities was also offered in some areas:

"Transport was provided, so that it was brilliant. And it was, it was absolutely brilliant. I really benefitted from that. And meeting people." (Client)

Range and flexibility of the service

The different localities provided slightly varying services, however the main services discussed were; befriending, cleaning, transport, shopping, walk from home, help with administering medication. Clients were happy with the range of services provided and the commitment of the staff;

"I think what's nice for us is we can get more help when we need it can't we? So you could go to the lunch club another day or we could, the cleaner comes for two hours at the moment on one day, so we could always change that, to two days for an hour, y'know so… If you get to a point that you can't get out quite so easily we can get more help coming in can't we?" (Client)

When clients were asked about potential improvements to the service most stated that they were satisfied. One client suggested that he would like to attend some evening activities such as a film club or a supper club. Clients expressed that they enjoy and value the service and want it to continue.

3.5.4 Stakeholder interview themes:

Aim of Together for Health

Age UK staff understood the aim of the service to be combating isolation and loneliness amongst *people* aged fifty plus who could be attending the GP or hospital administration *"quite a lot"*. As such, Together for Health supports clients to access services they may need and explore alternative options for maintaining their independence in the community. Together for Health intends to reduce inappropriate use of medical services, including A&E departments and GPs.

"The project is focused on looking at people who are coming on a regular basis either to GPs or in to A&E departments or through services, and it's looking at the needs of that person really and whether there is an overuse of medical resource due to social issue rather than a medical problem" (Manager)

Together for Health was thought to have some unique aspects; drawing together health and social care and the voluntary sector, attempting to reduce the use of health recourses through reducing loneliness, highlighting the value of the role of the voluntary community sector, working across more than one Age UK. This was felt to differentiate Together for Health from other Age UK projects. At an operational level, Together for Health provides "*the one-to-one support, regular contact with that person*".

Staff felt Together for Health complemented the work and ethics of Age UK. Loneliness and isolation is an issue "*that has always been sort of at the top of the agenda for us*" (Manager). The assessment process of Together for Health was thought to feed into other services each Age UK provides. Where Together for Health has been successful, staff had made an effort

to connect into their existing services, such as 'home from hospital' and social contract schemes.

> *"There's certainly links between this project and other projects. It, like I said, it already kind of directly links in with the social contact scheme, but certainly others, you know, because I'll, I'll see clients in the hospital and make either signposting or referral to, to other projects within Age UK, so it might be things like benefit rights, and things like that"* (Staff).

A 'client led' approach

Together for Health is delivered in a 'client led' way. This involves service users being at the *centre* of the process, setting their own goals and making decisions about what they want to do. Treating service users as individuals and respecting their specific needs was felt to be "*part of the DNA of Age UK"* (Manager). The role of Together for Health staff is to support service users in the decision making process, to find out what their interests are and to help them action their goals, including finding appropriate services. An important skill of Together for Health staff was felt to be not pre-judging what a service user wants or needs:

> *"Sometimes family, or social workers that think 'oh this person must be really lonely' or whatever, but if they are content in their own home, watching the soaps or whatever, then who are we to you know decide otherwise"* (Manager).

Reflecting Age UK's overall person-centred approach, staff administering Together for Health aim to provide consistent, on-going support to service users. Even where service users might be initially quite negative about Together for Health, staff always leave them some information about the service:

> *"Quite often … will say 'no' initially because they don't know what things are about, they're not sure about it, so we will take the time to give them time to think about things and you know, and we'll revisit that]. And I think that is fairly unique"* (Manager).

As part of the person-centred approach, Age UK staff administering Together for Health also endeavoured to develop a personal or 'befriending' rapport with service users. Developing such relationships between service users and staff was felt to have assisted during the different stages of the Together for Health process, in that service users might be more willing to complete an assessment.

Providing person-centred support to service users can be difficult, however. For a variety of reasons service users can be reluctant to engage with Together for Health. Service users may have had negative experiences in the past, while others "*just want to get home*" (Manager) and not be asked questions. The content of discussions in the Together for Health process might also be quite personal and service users may be reluctant to divulge information if "*they've got the rest of the group's eyes on them*" (Staff). A person-centred approach may also be time consuming, particularly if meetings take place in a service users home because "*they like to chat a bit longer…we may be there for 2, 3 hours*" (Staff).

Collaborative working

Together for Health was thought of as a way of promoting more collaborative working between individual Age UKs in Yorkshire and Humberside – particularly within theKnaresborough area– with statutory health service providers and with other voluntary sector organisations.

> *"From a strategic level I think we need to ensure…commissioners can see that we are good at what we do and that we can work very well with health and social care and if, you know, if they think of us as a partner, … that'll be you know sort of a real win-win situation so that we can develop that, continue to develop that integrated care approach and they can see us as a valuable player"* (Manager)

There were reported to have been some successes at working with statutory health services. Wakefield Age UK, for example, was reported to have been successful working on the 'in reach' ward at Pinderfields hospital. A manager described how they now have a presence with the local hospital and "*work closely with the ward staff and doctors there and the social workers*". Staff attend morning multi-disciplinary meetings from which they have a list of in-reach clients in hospital to work with.

Other Age UKs have been less successful, however. For example, staff suggested they have had conversations "*about how we can work together*" with statutory services but "*nothing has come of it*". The lack of cooperation is a "*frustration*" (staff). It has been "*quite surprising how little some of the Age UKs are actually connected to the health and social care system*" (manager). Broader changes to the health service and local authorities have meant building relationships has been difficult. A staff member reflected on the large number of voluntary sector organisations trying to work with statutory services and the negative impact this might have:

> *"It perhaps has been difficult in some respects because there are so many groups were all doing the same thing, we're all along to the integrated care meetings or the multi-disciplinary team meetings…there is a very diverse voluntary sector here in Bradford, huge amount of organisations and it doesn't seem to be somebody who is co-ordinating it all". (Staff)*

Where Age UKs have been successful in collaborating with other third sector organisations it has been a case of trying to "*support one another*" when organisations are trying to do a specific piece of work. A manager described how they were trying to build a database of activities in the local area, which "*linked [them] into other groups and activities and organisations*".

Delivery

The delivery of the project varied within the four localities. Some staff members expressed that it was hard to engage GPs in the service and highlighted a need for further promotion and awareness raising of the service and among other agencies.

> *"I found it hard initially getting the GPs engaged which I have done in other projects and other jobs and I know it's hard. I've worked with GPs, worked in surgeries so it's really hard. I think if we can get through the NHS system and start at the top and come down, you know making more people aware of we're doing this to keep your referrals down, whether it's a GP or in the hospital. If we had more connections…*" (Staff)

One staff member who delivered the service in the community suggested that delivering the service from a hospital ward could increase referrals through 'having a presence on the ward' and help to inform families about the support available.

> *"We can tell them all that information, they can see our faces you know, we're not going to come into your home and change your life – we're there from the beginning.*

The family can meet us. On the discharge maybe we could give a little pack on the discharge so the family know about us." (Staff)

One of the localities based on a hospital ward stated this did help with engaging clients and building relationships with health professionals who could refer clients to the service.

"*Instead of waiting for the hospital to contact us because they've got our information there it's actually physically being there and having that presence and building up those relationships with those teams […] I think we've had to get on and work with professionals in the hospital so from a strategic point of view we've had to – for me I've had to build those relationships which has been good."* (Staff)

In addition to building relationships with health professionals some workers were invited to attend training with health professionals and Social Services which provided workers with a greater understanding and insight of how services work and enabled them to be more informed about the advice and support that exists for their clients. It was suggested that this helped increase referrals to the Age UK service and other relevant services;

*"We've learned a bit by going to integrated meetings with the health professions, which we didn't do before […] we want to work more with health professions, we have been out to doctor's surgeries […] we've also been invited now through this to sit with the social services for two days next."(*Staff)

" But because we got in touch with the GP, that then in turn has prompted them to get in touch with the community mental health team" (Staff)

One staff member felt that while it was difficult to engage professionals from statutory services, older people might feel more comfortable talking with someone from a voluntary organisation;

"And also some people don't like statutory services and they will talk to people from Age UK, but they won't speak to someone from health and adult services… and there's a big difference from there I think." (Staff)

Volunteers: A secondary goal of Together for Health was to recruit and train volunteers. However, the number of volunteers involved in Together for Health was lower than intended. Whilst some Age UK didn't use volunteers at all, other Age UK's chose to redeploy existing volunteers rather than training new ones. In general, Age UKs chose to deploy their limited resources "*getting the numbers of older people rather than the volunteers to support them"* (Manager).

"We don't currently have any resources to train the volunteers and the amount of referrals we receive is too small" (Staff)

It was felt that without the initial referrals there was no need for the volunteers. From a strategic point of view, involving volunteers is a key element in "*developing [Together for Health] in a more sustainable way"* (Manager). In the first instance this may require "*a bit more funding into it to possibly get more staff involved [in order to get] more volunteers involved"* (Staff).

Staff turnover: There was reported to be a high degree of turnover of staff involved in the project, although the staff turnover was not due to the project. This included staff leaving Age UK for a variety of reasons who "*weren't going to be around to continue [Together for Health]"* (Staff), staff who have had to "*step in…and work across a number of projects"*

(Staff), managers who "*inherited"* Together for Health from predecessors, and students completing their work placements and leaving the project. In some instances, high staff turnover was felt to have had a detrimental effect on the implementation of Together for Health.

Experience and knowledge

Age UK workers expressed great enjoyment from their work and brought a wealth of experience and knowledge to the role. Many of them had previous experience of doing outreach work and working with the client group.

Support offered

Staff described the support as person-centred that addressed social rather than medical needs. The person-centred goal planning approach was used with clients to enable confidence building and help them to keep their independence where possible.

> *"Say if it's daily living and they can't manage to get on to a bus to go to the shops, then we'll put things in place so the team will go out and physically go with them on the bus until they have built enough confidence to be able to manage for themselves. So it's those small steps that we work with that individual to get back into that social - or to hopefully to where they were before if we can manage to."* (Staff)

Staff explained that the for clients who are leaving hospital, the service helps to rehabilitate and connect them back to the community whilst ensuring they have the right things in place to be able to live independently and well.

> *"So physically they may have had the rehabilitation but they've never had enough of the confidence building and so they end up too scared to go actually. Now if this project has stopped those people ending up housebound, I think that's a great success."* (Staff)

The LEAF questionnaire was described as "*a very important tool…to ascertain the needs and wants and the wishes*" of service users (Manager).

> *"We had one gentleman we worked with who wanted to get out a bit more so we put an intervention into place and it really helped him – it really worked…it is a great way of signposting people and its very holistic and looks at the whole person in general"* (Staff).

Benefits to clients

Staff listed many ways that clients benefitted from the service. Age UK workers were able to help with many social and practical issues (these are similar to the benefits previously discussed in the client findings). They commented that the service helps people to remain independent and focus on the positives in their lives. One staff member stated that although they might only see a client for a few months they have a 'big responsibility' in that client's life and they are highly trusted.

> *"You need to keep it active for as long as possible and you need to keep people independent for as long as possible. So that's the benefit because it gives people a focus on what's right in their life other than everything that's wrong in their life*." (Staff)

> *The day to day social contact, seeing someone every morning, having a chat… like [name of Age UK worker] goes in and she does the cleaning for the gentleman,*

y'know it's that personal interaction, personal friendship/relationship that is probably what they would classify as just as important or perhaps we think is important." (Staff)

Benefits to family members: relieves worry and provides peace of mind

Staff members suggested that having support from a recognised organisation that supports older people can help to relieve worries for families. They explained that many family members live far away or do not have enough time to devote to taking care of their elderly relatives and this can cause stress and worry. One worker stated this was particularly important if an older person was in hospital and their family members were unable to visit, Age UK staff could go to the hospital to check on the older person and then telephone their family members.

> *"Their families benefit because in some cases it might relieve a bit of pressure, it'll certainly relieve the worries that families tend to have. You know if you've got a relative in these sorts of situations, you worry so even if you're not so hands on with that relative, it gives them a bit of peace of mind. And in some cases, I don't hear so much about this but we may well be relieving some of the family members of some of the things that they might be trying to do but they're not really probably equipped to do that themselves. So there's a benefit there as well for sure."* (Staff)

In addition one worker suggested that the service can act as a 'bridging role' between elderly people and their families if their relationships have become difficult:

> "*There is this notion that you're meant to look after your parents and, that your parents can be very difficult and treat their children as if they don't know what they're doing and everything and it can be very difficult with that emotional load on top."* (Staff)

Benefits to Age UK(s): Implementing Together for Health was felt to have raised the profile of Age UK and been "*been beneficial in terms of getting our name out there*" (Manager). Together for Health was also seen as a pilot project for testing out whether working more closely with statutory health services was a "*long term…possible direction for the charity*" (Manager), and "*an opportunity to…[gain] some robust evidence*" about the value of the voluntary sector working alongside statutory healthcare providers in supporting elderly people.

At an operational level, Together for Health was felt to have served to "*integrate [Age UK] into health and social care teams*" (Director). Together for Health has also enabled Age UK to be more involved with other service providers and engendered a "*greater awareness of other things that are around*" (Director).

> *"Meeting people who are involved at working with older people across the district and indeed working with other age groups across the district, … you're broadening, you know, your network"* (Staff).

Benefits for staff: Age UK staff reported benefits to themselves from being involved in Together for Health, in terms of feeling good about themselves for helping people, and increased awareness of social isolation and other issues affecting older people:

> *"when you know you have helped somebody, things like that you get a good feeling"* (Manager)

Age UK staff also reported professional benefits in terms of learning new skills in response to the challenges of implementing the project, and using the assessment tools. It also in some cases improved staff members' knowledge of other local services:

"It has been quite challenging in terms of implementing the project to get going, so…so sort of professionally you know I've learnt quite a lot and developed quite a number of new skills I would say" (Director)

"it's certainly helped us with our services, kind of with our knowledge or what we do and what other charities in the local area and health services do to signpost…kind of helped us with our knowledge, knowing what there is and signposting them" (Staff).

Benefits to the community: There was a general feeling among the directors and Age UK staff that the project would have benefits for the wider community, in terms of increasing awareness, building resilience, and allowing community members to contribute by becoming volunteers:

"one of the objectives is to get volunteers through the Age UKs involved so there is […] a benefit to the community" (Director)

"building more resilient communities…increasing you know people's, making people more aware of their local community – what is happening in their local community; people feeling more a part of that community, feeling they've got a contribution to make as well" (Manager)

Wider benefits: preventative work

Several workers commented that due to cuts Social Services are very limited in what they can deliver and therefore refer to other agencies. It was suggested that the Age UK service can work with elderly people before they reach a crisis situation, potentially relieving referrals to Social Services;

"Social Services who are completely over stretched at the moment. We're getting a lot more referrals from them, they're wanting a lot more interventions from us because they are completely stretched and they're only dealing with crisis often at the moment. So we are getting in and doing that preventative work if you like before it gets to crisis situation." (Staff)

However, it was acknowledged that the service would need to be funded for longer to have a noticeable impact on the health care system;

"The number of admissions and attendances that they're dealing with are huge, and the pressures they're under are enormous. So our bit of it, yes it is contributing but I doubt very much that anyone in the hospitals would necessarily notice the change or indeed in the council. If it was scaled up that might be different." (Staff)

Some workers suggested that the benefits from the service can impact upon the wider community as older people can reconnect and contribute to the community.

"It means that you know communities are better off when people are more active, they're more engaged you know, it's got to be better for communities and societies as a whole hasn't it." (Staff)

"Contributing to the economy aren't they as well. So obviously we do a benefits check on a lot of people that we see so maximising income so that they can get out and they can spend more. There's that impact as well." (Staff)

Cost savings and other benefits for the health care system

A key theme to emerge was the potential savings to the health care system. Workers explained that having a community intervention that offers social support can help older people to self-help and prevent the use of the health care system to meet social needs.

> *"The benefits for the Health Service are that because of our intervention it could have a reduced need to use healthcare services because they've got that community support, they've got our support so they're probably not using as much resource from the Health Service because of what we've been able to put in place. They're self-managing more, they're not going back to their GP more because they're not socially isolated and getting depressed, they're actually managing to get out and not getting to that point where they're actually going to the GP because of depression and it's not always a medical need. It's more about a social need but they don't know where else to go."* (Manager)

Lack of resource and funding

Staff reported that the administration tasks were very time consuming. It was suggested that if the project is to be extended then it would be useful to have dedicated administrators as this would allow other workers to focus on outreach and engagement work. Lack of resource and short term funding was highlighted as a reoccurring source of concern. Staff expressed concerns around developing skills and expertise to deliver valuable work in the community that would stop when the short-term funding came to an end, leaving older people with a lack of support. In addition it was highlighted that it was difficult for staff who were working in short-term posts.

> *I think they need to be pumping more money into it if I'm being perfectly honest with you because it seems to me like a project that's been delivered on limited resources and limited funds. But services like this could serve, save the health service a lot of money. The fact that we've got limited resources restricts us from doing a lot more."* (Staff)

Implementation and evaluation issues

It was suggested that the LEAF assessment should be delivered over a period longer than 12 weeks. One stakeholder suggested that using a 12 week approach could be detrimental for older people who require support over a longer period.

> *"This runs a risk in my opinion, the 12 week approach, the minute the staff pulls away that's it they're going to fall back straight."* (Staff)

Stakeholders stated that relationships with clients need to be built before the LEAF assessment can be done. It was noted that the scoring system involved was not practical for clients with dementia or mental health issues;

> "Y*ou think you've set this plan up and then at your next visit there's something else will come out of the woodwork so it's not all straightforward as it looks initially. So then you have to start work on that, whether it's an anxiety problem or a health issue."* (Staff)

It was noted that the loneliness and resilience questionnaire was difficult to implement. One stakeholder commented that the phrasing of the questions could be perceived as focusing on negative aspects of an older person's life:

The loneliness questionnaires – they've been a little bit difficult because asking somebody about being lonely it makes them feel even worse. So we had a few problems with those questions as well. That's been quite tricky." (Staff)

3.6 SROI analysis

Valuation

Table 14 summarises the investments made by Age UK into Together for Health, and the benefits demonstrated by the evaluation, and their costs or the value attributed.

Staff time has been valued at £11 per hour, based on a presumed average annual salary of £25000, using an online wage calculator: http://wageindicator.co.uk/main/pay/hourly-pay-converter

Other costs to Age UK from delivering interventions such as case management were estimated form one site only (Knaresborough) at a total extra cost of £3600 (for 227 clients =£15.25 per client, extrapolated to all 667 clients total additional cost = £10,175).

Hospital use cost was based on PSSRU (2015) Unit costs of health and social care[2]. The cost for outpatient attendance was taken as the weighted average of all outpatient attendances at £112.

Financial proxies for social values were found using the global value exchange tool http://www.globalvaluexchange.org although we could not find proxies for all the domains of LEAF, we did find some, for Managing finances, feeling safe, social networks and social life, and loneliness.

[2] http://www.pssru.ac.uk/project-pages/unit-costs/2015/index.php

Table 14 Costs and benefits attributed to Together for Health

Input	Unit cost	Total cost	Benefit	Number with improvement	Unit value	Total value
19,526 hours spent by AgeUK staff with clients	£11 per hour	£214,786	Hospital service use	+1.03 outpatient visits per patient	112	-76,945
Interventions	varies	£10,175	Managing daily living (LEAF)	141/238	?	?
			Managing finances (LEAF)	60/144	£59 per course per participant[3]	3540
			Managing physical health (LEAF)	135/224	£240 per person[4]	32,400
			Control & choice (LEAF)	42/123	£12,310 per person per year[5]	517,020
			Feeling safe (LEAF)	58/136	£3976 per person[6]	230,608
			Social networks & social life (LEAF)	100/168	£15 per household per year[7]	1500
			Feeling valued by others (LEAF)	40/119	£124.80[8]	4992
			Emotional wellbeing (LEAF)	110/198	£38,800[9]	4,268,000
			Loneliness (UCLA v3)	27/177	£15666 per person per year[10]	422,982
			Resilience (BRS)	0		
SUM		**224961**				**10,885,139**

If the total cost of the investment into Together for Health is estimated at £224,961 and the total social value (minus the cost of additional outpatient visits) is £10,885,139, then the

[3] Value for "Personal budgeting and money management course costs" taken from www.matrec.org.uk
[4] Value for annual gym membership
[5] Value for "feeling of being in control of life" http://www.hact.org.uk/value-calculator
[6] Taken from "anxiety about being a victim of crime (change in) for people aged over 50 living outside London but in UK from http://www.globalvaluexchange.org/valuations
[7] Value for "social club membership" taken from Social Return on Investment (SROI) Analysis of the Organisation Workshop www.marshfarmoutreach.org.uk/PDF%27s/Appendix%202%20-%20SROI%20forecast.pdf
[8] Average value of a donation to charity (taken from Carrick 2011)
[9] Value for "relief from depression and anxiety (adult) taken from http://www.hact.org.uk/value-calculator
[10] Value for "interaction with neighbours" taken from http://www.pssru.ac.uk/project-pages/unit-costs/2015/index.php

SROI = 48.39. **This means for every £1 invested in Together for Health, the social return on investment is £48.39.**

Duration and drop off

Before the calculation can be finalised a decision has to be made as to how long the changes produced by Together for Health will last. Some outcomes may last longer than others and may also be dependent on whether the activity is continuing or not. We think that benefits related to reductions in loneliness and improvements in emotional wellbeing and social networks are likely to continue, at least until the older person experiences another episode of ill health or hospitalisation. Outcomes which may continue to have a value in future years cannot be expected to maintain the same level of value, so we assume that the value will reduce or "drop off" each year. Annual rate of attendance at A&E in England in 2013/14 in people aged 70-79 years is around 347 per 1,000 population (34.7%), going up to 574 per 1,000 population (57.4%) in people aged 80-89 years and 831 per 1,000 population (83.1%) in people aged 90 years and over (Baker, 2015). We can therefore make a conservative estimate of a drop off in value of 57.4% per year, which assumes that all social benefits would cease once a person had another emergency hospitalisation.

Deadweight

A reduction for deadweight reflects the fact that a proportion of an outcome might have happened without any intervention. However, due to the population group being selected or referred on the basis of being frail and/ or socially isolated, it is probably more likely that most domains of LEAF would get worse rather than better without any intervention. The English Longitudinal Study of Ageing (ELSA) found a small but consistent deterioration in affective wellbeing between 2002-3 and 2010-11 (Steptoe et al. 2012) using CASP-19 which was also used to validate the LEAF scale (Bagnall et al. 2014), so we can assume a similar reduction would be seen on the LEAF domain scores without the intervention having taken place. Therefore no adjustment has been attempted for deadweight.

Attribution

Attribution takes account of external factors, or the contribution of others, that may have played a part in the changes that are identified. From qualitative interviews with Age UK staff, it was clear that many regarded that activities they undertook as part of Together for Heath as very similar to those they would have undertaken anyway as Age UK. The difference lay in the extra funding associated with Together for Health, enabling extra staff time to be spent with referred clients, and in an increased level of referrals being sought and given. Attribution is therefore difficult to calculate, but a conservative estimate could attribute 50% of the benefits to the Together for Health intervention, over and above what would be achieved by Age UK without that intervention.

Displacement

Displacement applies when one outcome is achieved but at the expense of another, or another stakeholder is adversely affected. In relation to Together for Health, the most

obvious source of displacement could have arisen as a result of Age UK staff being diverted from other Age UK interventions. However it is difficult to calculate the effect of this.

There is another issue, in that the outcome domains (e.g. of LEAF) are unlikely to be independent of one another, and the original outcomes for the source values are also unlikely to be independent of one another. Also, of course, the source outcomes for values are not completely the same as the measured outcomes in this study. Therefore a ten fold reduction in the social return on investment estimate has been included in the sensitivity analysis, due to this overlap.

Sensitivity analysis

As the previous sections indicate, estimates of this kind are inevitably subject to uncertainty. While we have followed established SROI approaches and made adjustments for duration of effect, deadweight loss, the extent to which the intervention may have displaced other valuable activities, further adjusting for the issues above by halving the original outcome value estimated still gives a social return of £24.19 for each £1 invested. However, even if an extreme assumption is made attributing only 1/10th of the estimated value to the intervention, the SROI would suggest that each pound invested would generate an additional social value in return of £4.84. Whilst that is a good return, the true value generated is likely to be higher. However, this should be balanced against the higher likelihood of emergency readmission to hospital in this age group (57.4% per year), after which point the benefits gained would be lost and the holistic assessment process would need to begin again.

Revised Assumptions	**Social Return**
Attribution across all outcomes is halved	£24.19
Social return on investment is reduced ten-fold due to uncertainty and overlap	£4.84

4. Discussion

Summary of key findings

- By the end of January 2016, data was received on 667 clients who had taken part in Together for Health, with 19,526 hours spent with Age UK workers.
- A range of interventions were offered to clients as part of T4H, including shopping, cleaning, befriending, taking to social events, helping with medication, reassurance, dog walking, post-hospital-discharge checks.
- Clients were signposted to a range of other services, including other care agencies, dementia groups, community transport, health trainers, lunch clubs, social services, befriending services, housing support, bereavement counselling.
- Statistically significant improvement were seen in all 8 domains of LEAF (n=420) at 6 week follow-up:
    - Small effect sizes for “feeling valued”, “feeling safe”, “control and choice” and “managing finances”;
    - Medium effect sizes for “emotional wellbeing”, “managing daily living”, “managing physical health” and “social networks”.
- At 12 weeks, the statistically significant improvement remained in all 8 domains of LEAF:
    - Small effect sizes for “feeling safe”, “control” and choice”, “feeling valued” and “managing finances”;
    - Medium effect sizes for “physical health”, “emotional wellbeing”, “managing daily living”;
    - Large effect size for “social networks”.
- The number of LEAF domains showing statistically significant improvement in Barnsley and Bradford increased from 6 weeks to 12 weeks follow-up. This suggests that the intervention needs to be sustained beyond 6 weeks.
- Gender differences were noted; while statistically significant improvements were seen in all 8 domains of LEAF for women, men did not see statistically significant improvements in the domains of “feeling valued” and “control and choice”. This suggests that although men benefit from Together for Health, they may receive further benefit from more targeted interventions.
- Responses to the loneliness questionnaire (n=177) showed a small, statistically significant decrease in loneliness scores from referral to discharge.
- Responses to the resilience questionnaire (n=174) showed no statistically significant change between referral and discharge.
- Health service use data, comparing clients’ use of hospital services 12 months before referral to (up to) 12 months following referral, indicated:
    - No change in inpatient stays or A&E visits;
    - Increase in outpatient visits (driven by data from Wakefield, where clients were recruited from the hospital so might be expected to have follow-up visits).

- Qualitative interviews with clients and staff reported many key themes, including:
    - Support and confidence building
    - Friendly service
    - Trust
    - Social benefits
    - Financial benefits
    - Practical benefits
    - Range and flexibility of service
    - "Client led approach"
    - Collaborative working
    - Benefits to family members
    - Benefits to Age UK (organisation and staff)
    - Wider benefits (community, health and social services)
    - Implementation and evaluation issues

- Together for Health achieved its objectives of reducing social isolation and loneliness.
- Social return on investment analysis found that for every £1 invested in Together for Health, the social return on investment is at least £4.84.

Findings from similar work

A research briefing from the Social Care Institute for Excellence (Windle et al, 2011) on prevention of social isolation and loneliness reported that people who used befriending and Community Navigator services were less lonely and socially isolated following the scheme. Together for Health has similarities to the Community Navigator interventions in that older people are helped to find appropriate support by individuals (often volunteers) acting as an interface between them and community and public services. The briefing recommends flexibility and adaptation of one to one and group services, tailoring them to users' preferences, which is what Together for Health aims to do.

Two systematic reviews have identified closed self-help or support groups as effective in reducing loneliness and social isolation (Cattan et al. 2005; Findlay 2003), particularly those that included social group activities (Savikko et al. 2010).

In terms of health service use, the SCIE research briefing (Windle et al. 2011) reported little evidence on this outcome, with only two studies of group-based interventions exploring before and after health service use. Both reported less health service use in the intervention group compared to the control group (Cohen et al. 2006; Pitkala et al. 2009), although in one of these studies self-reported GP visits rose in both groups following the intervention (Cohen et al. 2006). Our evaluation of Together for Health did not include a control group, so we are unable to say whether the increase in outpatient visits post-intervention was smaller than

would have been seen in a control group, but given that this increase was dominated by results from Wakefield area, where patients were recruited following a hospital stay, it is likely that the increase in outpatient visits was due to follow-up appointments, and would have been similar in both groups.

The SCIE briefing noted the importance of health and social care statutory services working alongside the voluntary sector to deliver effective interventions. They recommended that strong partnership arrangements need to be put in place between organisations at the planning stage to ensure developed services can be sustained (SCIE, 2011). A systematic review by Findlay (2003) recommended high quality approaches to the selection, training, and support of the facilitators or coordinators of interventions, and the involvement of older people in the planning, implementation and evaluation stages. The review also found that interventions have a greater chance of success if they use existing community resources and aim to build community capacity. Another systematic review (Cattan et al. 2005) on preventing social isolation and loneliness among older people concluded that educational and social activity group interventions that target specific groups can be effective.

In interviews, some Age UK staff described Together for Health as being similar to social prescribing. A recent review of social prescribing initiatives (Thomson et al. 2015) reported positive outcomes for participants, such as increases in self-esteem and confidence, sense of control and empowerment, improvements in psychological and mental wellbeing, and positive mood. The review also found that increasing social contact and support in local communities, as well as encouraging patients to become proactive in decisions about their own health, led to a reduction in reliance on health care services. This effect was seen particularly in 'marginalised groups' such as older adults at risk of social isolation. The most successful models involved the use of a 'link worker' or referral agent acting as a 'one stop shop' for referrers from health and social care.

Baseline loneliness levels in this study (i.e. combined numbers of people answering "some of the time" or "always" to each question) were 60-62% on referral. This is higher than the 40-50% levels found for the >70 year age groups in the English Longitudinal Study of Ageing (ELSA), which also used the 3 item UCLA loneliness scale.

A SROI analysis of the Craft Café programme - an intervention which had a similar aim to Together for Health in a similar population (to reduce social isolation and loneliness experienced by older people) found a social return on investment of £8.27 for every £1 invested (Social Value Lab, 2011). Benefits for older people included making new friends, improving social relationships, and reducing loneliness, more confidence and independence, a more positive outlook and better quality of life. Physical health benefits were also reported.

An evaluation of social return on investment for a programme of led health walks in Glasgow (Carrick 2013) found that every £1 invested would generate between £7 and £9 of benefits. Some of the positive changes identified were similar to those seen in our evaluation of Together for Health, such as having more social contacts, experiencing less social isolation, feeling safe and having improved self-esteem, personal satisfaction and a sense of worth. There were also benefits in terms of improved physical health and new skills, particularly for walk leaders.

Another evaluation of social return on investment for an allotment project working with adults with mental health problems and children at risk of social exclusion[11] found an overall social return on investment value of £1.94 for every £1 invested. Some of the benefits identified were similar to those produced or aimed for by Together for Health, such as making friends

[11] https://www.family-action.org.uk/content/uploads/2014/06/ESCAPE-SROI-Assured-Report.pdf

and developing social confidence, reducing anxiety and developing more personal resilience.

Limitations and strengths

The lack of a control group means that we cannot be sure whether the changes seen over time in the client group would have happened to the same extent without the Together for Health initiative. However, the large numbers of participants for whom baseline and follow-up questionnaires were available make this a robust evaluation.

'Teething' problems with implementation of the initiative led to a slow start and meant that we interviewed fewer clients than originally planned, although final client numbers were higher than we expected. However, the evaluation team were satisfied that data saturation was reached in terms of themes emerging from client interviews, so the number of clients interviewed was felt to be sufficient.

Another issue caused by the slow start was that the health service use data was not available for a large proportion of the participants and a significant number did not have a full 12 months follow-up in the data set. We were also unable to distinguish between planned and unplanned inpatient stays. This limits the usefulness of the health service use data. There was also a notable difference between health service use between Wakefield and the other three areas, which was probably due to differences in client characteristics. The Wakefield clients were recruited from the hospital and were therefore likely to be frailer and have more physical health problems than clients in the other three areas. They were also more likely to have routine follow-up appointments following hospital discharge. They also comprised the largest number of participants for whom we had health service use data, so the data set is dominated by their increased service use in the follow-up period. This increase was not seen in the other 3 areas.

SROI methods attempt to make systematic use of available data to produce the most valid possible estimates of the value of the social return on investment. These are interpreted alongside more direct quantitative and qualitative evidence. Ideally, a cost effectiveness analysis such as SROI would use values generated directly from the participant group who have been affected by the intervention, using established methods, such as stated preference and contingent valuation. However, as stated, we obtained values indirectly using publically available data. Given the methodological and statistical uncertainties that inevitably arise in using secondary data in this way, caution is required in interpreting specific figures. Our baseline estimate of £48.39 is derived using recommended SROI methods and should therefore be comparable with other studies using similar approaches. However our sensitivity analysis which reduced this using extreme values (£24.19 and £4.84) showed that even if only 1/10th of the estimated value is assumed, the Together for Health programme produces a strong return on investment.

5. Conclusion

Together for Health achieved its objectives of reducing social isolation and loneliness.

Older people who took part in the Together for Health initiative experienced improvements in all domains of the holistic LEAF assessment tool, with the largest effect size at final follow-up seen in the domain of 'social networks'. There was also a small but statistically significant decrease in loneliness scores.

Older people reported social, financial and practical benefits of the initiative, including increased confidence, and appreciated the range, flexibility and friendliness of the service.

Despite a small increase in outpatient visits following the service, the Social Return on Investment analysis found that for every £1 invested in Together for Health, the social return on investment is at least £4.84.

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Appendix A: LEAF questionnaire (validated version)

Wakefield District age UK

leaf

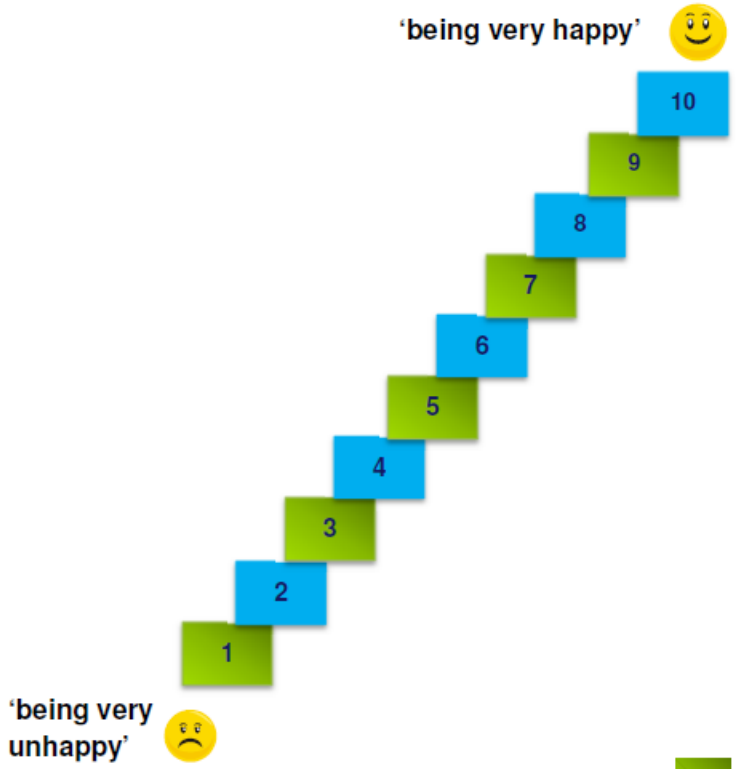
life essentials assessment framework

Questionnaire

Question 8 – Emotional Wellbeing

On a scale of 1-10, where 1 means '**being very unhappy**' and 10 means '**being very happy**'

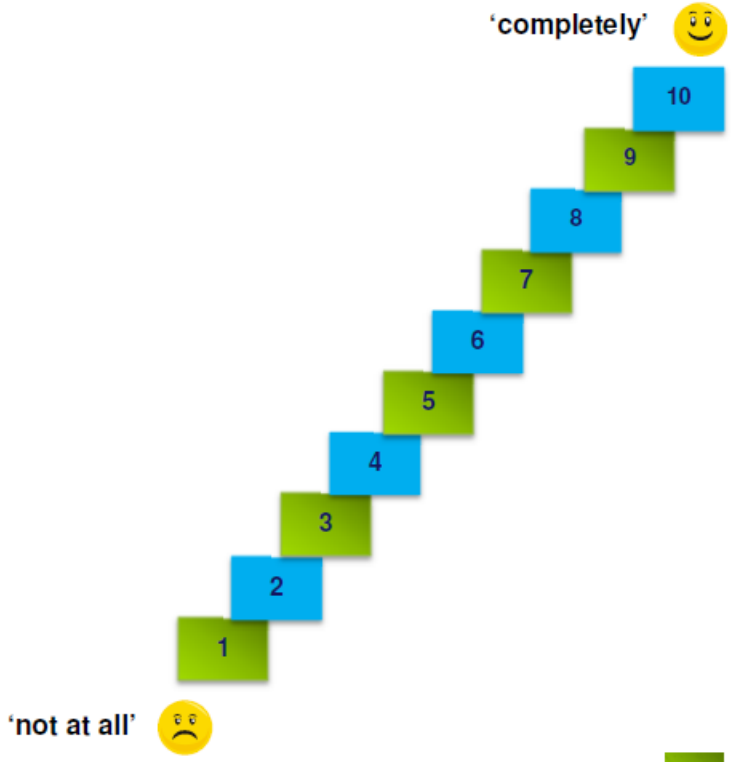
How happy do you feel nowadays?



Question 1 – Daily Living

On a scale of 1-10, where 1 means '**not at all**' and 10 means '**completely**'

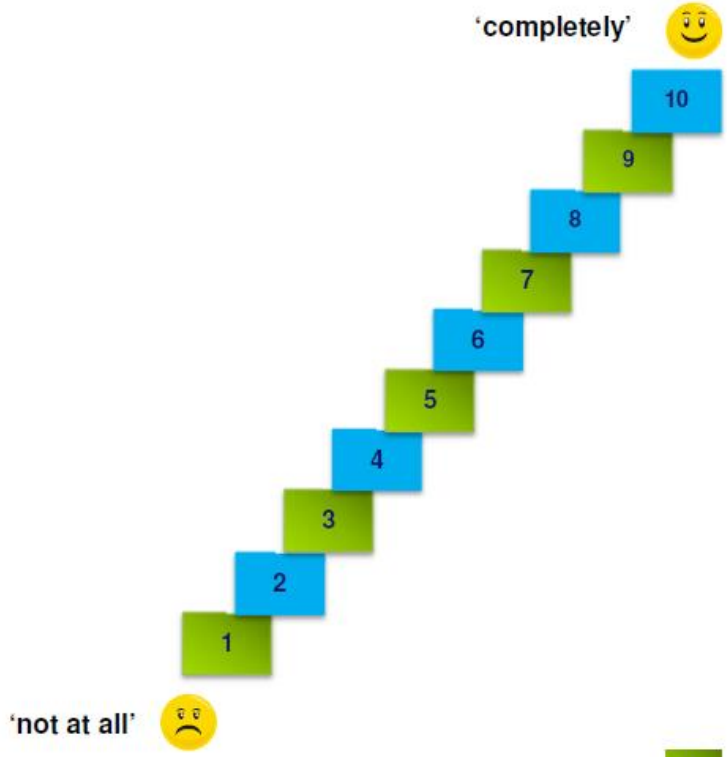
Over the last week, how well have you managed your daily living?
eg managing your personal care, preparing meals and carrying out household tasks, etc.



Question 2 – Finance

On a scale of 1-10, where 1 means '**not at all**' and 10 means '**completely**'

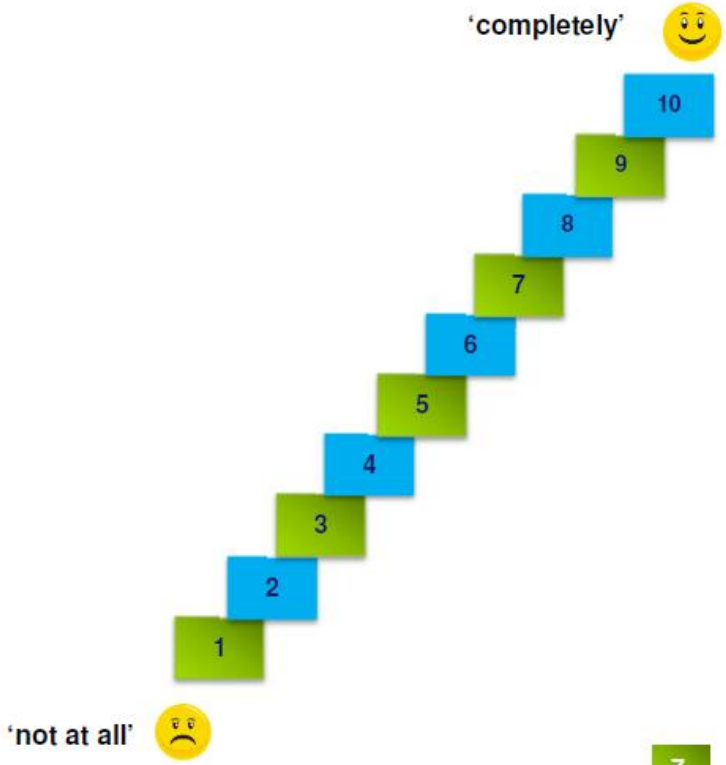
How well are you able to manage your financial affairs?
eg budgeting and managing your income, planning for the future, filling in forms, etc.



Question 7 – Contribution

On a scale of 1-10, where 1 means '**not at all**' and 10 means '**completely**'

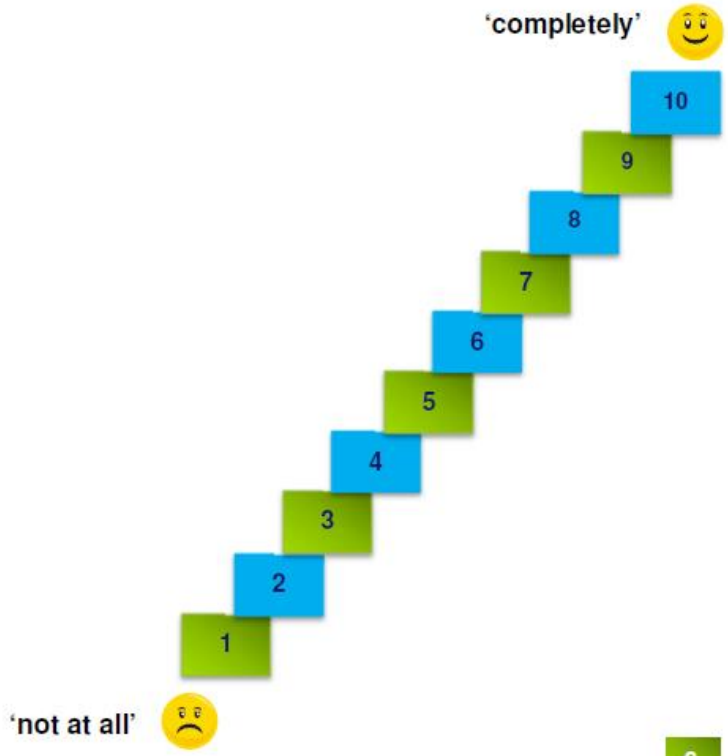
To what extent do you feel that what you do is valued by others?



Question 6 – Social Networks

On a scale of 1-10, where 1 means '**not at all**' and 10 means '**completely**'

How satisfied are you with your social life nowadays?
eg seeing family and friends and/or talking with them on the phone.



Question 3 – Physical Health

On a scale of 1-10, where 1 means '**completely dissatisfied**' and 10 means '**completely satisfied**'

How satisfied are you given your physical health nowadays, that you are able to make the most of your life?
eg do the things you like to do, take part in activities and take up opportunities.

Question 4 – Control and Choice

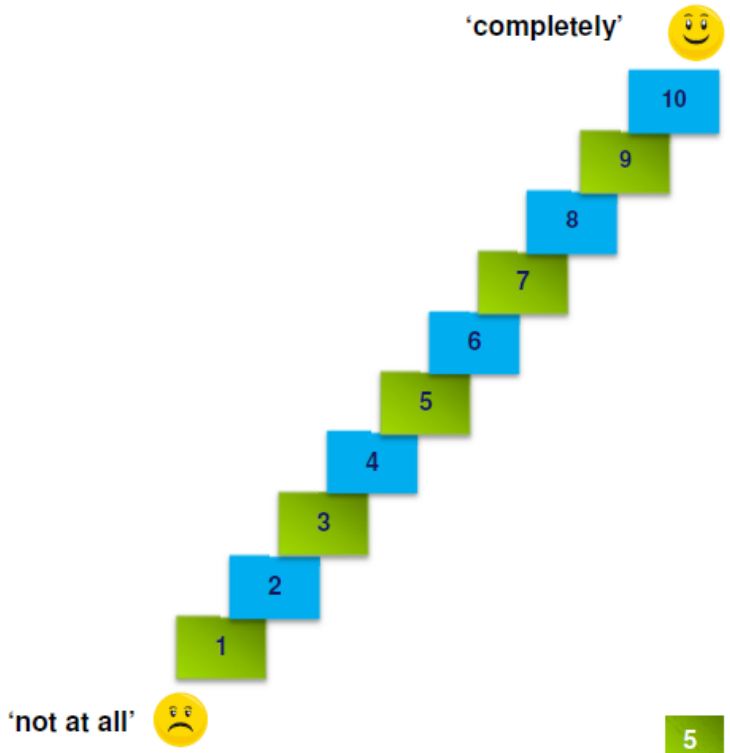
On a scale of 1-10, where 1 means '**completely dissatisfied**' and 10 means '**completely satisfied**'

How satisfied are you that you have a say in the decisions that affect you?
eg you have been fully involved in any decisions that affect your care and all the information you have received about your care has been clear and understandable.

Question 5 – Safety

On a scale of 1-10, where 1 means '**not at all**' and 10 means '**completely**'

How safe have you felt in the last week?
eg feeling that your home and neighbourhood are safe places for you to live and that you can receive assistance in an emergency.



Appendix B: Loneliness and resilience questionnaires

Resilience and Loneliness Questionnaire

Instructions
This booklet contains two questionnaires, one to measure **resilience** and one to measure **loneliness**, which have to be asked to clients after having administered the LEAF questionnaire. There are a total of 9 questions.

Please ask all the questions in the order in which they come in this booklet.

Data inputting
Please record the number next to the ticked box in the Excel spread sheet.

Please note that the numbers next to the boxes are not always in the same order. Please make

sure that you enter the number as it is shown next to the ticked box.

Patient Identifier

_____

Brief Resilience Questionnaire

Please read the words below to each client and show them the booklet to help them choose their answers from the list underneath each question:

"I am going to read to you a number of statements that describe how people sometimes feel. Please indicate how much you agree with each of the following statements using the five options provided: 'Strongly Disagree', 'Disagree', 'Undecided', 'Agree', 'Strongly Agree'"

Q1 I tend to bounce back quickly after hard times

Strongly agree ..... ❑5

Agree ..... ❑4

Undecided ..... ❑3

Disagree ..... ❑2

Strongly Disagree ..... ❑1

Q2 I have a hard time making it through stressful events

Strongly agree ..... ❑1
Agree ..... ❑2
Undecided ..... ❑3
Agree ..... ❑4
Strongly Disagree ..... ❑5

Q3 It does not take me long to recover from a stressful event

Strongly Agree ..... ❑5
Agree ..... ❑4
Undecided ..... ❑3
Disagree ..... ❑2
Strongly Disagree ..... ❑1

Q4 It is hard for me to snap back when something bad happens

Strongly Agree ..... ❑1
Agree ..... ❑2
Undecided ..... ❑3
Disagree ..... ❑4
Strongly Disagree ..... ❑5

Q5 I usually come through difficult times with little trouble

Strongly Agree ..... ❑5
Agree ..... ❑4
Undecided ..... ❑3
Disagree ..... ❑2
Strongly Disagree ..... ❑1

Q6 I tend to take a long time to get over set-backs in my life

Strongly Agree ..... ❑1
Agree ..... ❑2
Undecided ..... ❑3
Disagree ..... ❑4
Strongly Disagree ..... ❑5

UCLA Loneliness Scale (Version 3)

Please read the words below to each client and show them the booklet to help them choose their answer from the list underneath each question:

"I am going to read to you a number of statements that describe how people sometimes feel. Please indicate how often you feel the way described by each statement using the four options provided: 'Never', 'Rarely', 'Sometimes', 'Often'

Q1 How often do you feel that you lack companionship?

Never..... ❑1
Rarely..... ❑2
Sometimes..... ❑3
Always..... ❑4

Q2 How often do you feel left out?

Never..... ❑1
Rarely..... ❑2
Sometimes..... ❑3
Always..... ❑4

Q3 How often do you feel isolated from others?

Never..... ❑1
Rarely..... ❑2
Sometimes..... ❑3
Always..... ❑4

Thank you for taking the time to complete these questionnaires!

Appendix C Consent form for interviews

Age UK: Together for Health evaluation

CONSENT FORM

NAME:

I have read and understood the Participant Information Leaflet. All my questions about this study have been satisfactorily answered.	☐
I agree to take part in the above research study and I am willing to take part in an interview.	☐
I understand that my participation in this study is voluntary and that I am free to withdraw from the study at any time up until the point of analysis and this will not affect my involvement with the project.	☐
I know that all the information about me from the research must remain strictly private and confidential.	☐
I agree that the research results can be published. I understand that all personal identifying details will be excluded and that any quotations will be made anonymous.	☐

Data Protection Act

I agree to Leeds Metropolitan University recording and analysing this information. I understand that information will be used only for the purpose of this study and my consent is conditional upon the University complying with its duties and obligations under the Data Protection Act.	☐

……..……

……..

Signed Date

FOR COMPLETION BY RESEARCHER

I ……..……, a member of the Research Team working on the Together for Health study, confirm that I have informed the above named about this research project. I have given them the Information Sheet. To the best of my knowledge, they have understood and have given free and informed consent to become a participant in the research study.

Signed ……..…… Date ……

Appendix D Participant Information Sheet

Age UK: **Together for Health**

Participant Information Leaflet

Please read this leaflet carefully. Please ask if you do not understand or would like any more information.

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully, and discuss it with friends and family, and your AgeUK worker if you would like to. Please ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

Age UK Yorkshire & Humber is implementing a 3 year project called "Together for Health" that aims to deliver a new service to improve the health and wellbeing of older people, and reduce their risk of loneliness and isolation. Leeds Metropolitan University have been commissioned to carry out an evaluation of Together for Health, which explores the experiences and views of the people involved in it. We will be interviewing a number of people, including Age UK staff, health and social care professionals, volunteers and clients. We are interested in your views of the project and would like to invite you to take part in an interview.

Why have I been chosen?

You are being invited to take part in the study because you have been involved with the Together for Health service.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. Your relationship with the service or AgeUK will not be affected in any way whatsoever if you do or do not take part. In addition, if you change your mind about taking part afterwards, you can also withdraw what you have said up until the point at which we have started to analyse the findings. This is because it becomes very difficult to separate everything out from then onwards.

What will happen to me if I take part?

The study involves taking part in an individual interview. The interviews will follow a schedule and will be led by one of the research team. The researcher will be asking open questions about your project and you will have chance to discuss some of the issues. With your agreement we would like to tape record the conversation so that we can remember everything that is said. You have the right not to be recorded or stop the recording at any point.

The interview will normally take around 45 minutes and will be held at a convenient time and place for you.

What are the possible disadvantages and risks of taking part?

There should be no risk from taking part in this study. We hope that being interviewed does not raise any concerns with you, but if it does then please get in contact with any of the researchers on the team, our details are below, or speak to somebody you know at AgeUK.

If you have a concern about any aspect of this research you should ask to speak to the researchers who will do their best to answer your questions. If you remain unhappy and wish to speak to someone independent from the study, you can do this through Dr Diane Lowcock, Faculty of Health & Social Sciences (Tel: 0113 812 24409 or d.lowcock@leedsmet.ac.uk).

What are the possible benefits of taking part?

You will be making a valued contribution to the development of knowledge in this field of work but there are no personal benefits.

Will my taking part in this study be kept confidential?

All information which is collected about you and your views during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it. We store all information in a secure place in the University in accordance with the Data Protection Act. Only members of the research team will have access to the information.

What will happen to the results of the research study?

The results of the study will contribute to the development of Age UK's services. We hope that the research will eventually be published in articles and reports and presented at conferences. You will not be identified in any report or publication about the study.

Thank you for taking the time to read this information sheet. We look forward to meeting you very soon.

Contact us. The team members are:

Anne-Marie Bagnall
Reader, Centre for Health Promotion Research
Tel: 0113 812 4333
E-Mail: a.bagnall@leedsmet.ac.uk

Joanne Trigwell
Research Fellow, Centre for Health Promotion Reesearch
Tel: 0113 812 7679
E-Mail: j.trigwell@leedsmet.ac.uk

Gary Raine
Research Officer, Centre for Men's Health
Tel: 0113 812 9288
E-Mail: g.raine@leedsmet.ac.uk

Appendix E Interview schedules

Age UK Together for Health:

Interview schedule for people involved in delivering the project

1. Can you tell me about your involvement in the Together for Health project?

   Probe: extent of involvement/ knowledge

   Role in the project

   Why/ how involved (activities/ rationale for getting involved)?

2. What do you think the benefits are for you personally?

   Probe: training, skills, confidence?

3. What do you think the benefits are for clients who are involved?

4. What do you think the benefits are for the health service, other services and the wider community?

5. Does anyone else benefit from the project do you think?

6. Are there any drawbacks to being involved, for yourself or others?

7. How well do you think the project has gone so far? Is there anything you would like to see done differently?

8. How do you think the Project will develop in the future? Do you think it will continue (as it is or with changes)?

9. Anything further to add?

Thank you!

AgeUK Together for Health:

Interview schedule for clients

1. Can you tell me how you came to be involved with this project? (Probe: What happened immediately before? Who referred them? What happened after that?)
2. (if necessary) Can you tell me a little bit about the things that you needed help with?
3. How long/ when were you involved with this project?
4. Do you feel that you've benefited from being involved in the project? In what ways?
5. Have there been any drawbacks or negative aspects to being involved?
6. Has there been anything about being involved in this project that surprised you?
7. Can you tell me a little bit about your interaction with the person from AgeUK who comes to see you?
8. Is there anything that you would like to see done differently?
9. Have you been involved with any other similar services? How did this compare?
10. Anything further to add?