‘STAYING WELL IN CALDERDALE’ PROGRAMME EVALUATION: FINAL REPORT: JULY 2016

UNIVERSITY OF LINCOLN

Dr Karen Windle, Reader in Health, Healthy Ageing Research Group (HARG), School of Health and Social Care, University of Lincoln.

Thomas George, Research Assistant, HARG, School of Health and Social Care, University of Lincoln

Rebecca Porter, (previously) Research Assistant, School of Health and Social Care, University of Lincoln.

Professor Steve McKay, Distinguished Professor in Social Research, School of Social and Political Sciences, University of Lincoln.

Dr Martin Culliney, (previously) Research Fellow, School of Social and Political Sciences, University of Lincoln.

Dr Janet Walker, Principal Lecturer and Deputy Head of School, HARG, School of Health and Social Care, University of Lincoln.

Jolien Vos, Graduate Research Assistant, HARG, School of Health and Social Care, University of Lincoln.

Nadya Essam, Independent Consultant and Visiting Research Fellow, Brocas Arvensis and University of Lincoln.

Heather Saunders, School of Health and Social Care, University of Lincoln.

ACKNOWLEDGEMENTS

This evaluation could not have taken place without the support of a wide range of senior managers, operational staff and the older people themselves. We would like to thank the 'Staying Well' Steering Group, in particular the Chair, Caron Walker and project manager, Julie Hosty. The 'Staying Well workers and 'hub' leads were enormously helpful to the research team. They provided timely data, supported older people in completion of the research tools and were prepared to be interviewed at three time points. The success in reaching the number of older people that we did was solely due to the 'Staying Well' and NST workers supporting older people to complete the research tool. Each hub was also prepared to carry out a process mapping exercise and the research team were very grateful for the refreshments! Finally, we would like to thank the older people themselves for completing the structured questionnaire at two time points. This was not an easy questionnaire, although we tried to make it as simple as possible. The data this provided has been invaluable, demonstrating some of what was wanted and needed; as well as the differences the 'Staying Well' programme made.

Thank you.

The evaluation team.

HOW SHOULD I CITE THIS REPORT?

You are free to quote from this report and use the quantitative findings. Please do ensure that if you do use information from this report you reference it appropriately. You should cite this report in text as (Windle et al., 2016). The report can then be referenced as follows:

Windle, K., George, T., Porter, R., McKay, S., Culliney, M., Walker, J., Vos, J., Essam, N., Saunders, H. (2016) *'Staying Well in Calderdale' Programme Evaluation: Final Report*. Lincoln, University of Lincoln. ISBN 978-1-86050-250-7.

EXECUTIVE SUMMARY

What is the 'Staying Well' Programme?

- **Five reasons were given as to why the 'Staying Well' programme was developed and implemented**:
    - To reduce social isolation and loneliness
    - To reduce less appropriate health and social care use
    - As a response to 'grass roots' pressures
    - To strengthen initiatives that could support early intervention and prevention
    - To improve community capacity and cohesion.
- **Four 'Staying Well' project workers were employed** and located in four locality area hubs, working closely with their Neighbourhood Scheme Team colleagues:
    - Elland and District
    - Hebden Bridge
    - Halifax Opportunities Trust
    - North Halifax.
- The **'Staying Well' workers were tasked with two activities**:
    - To proactively identify and support older people who were lonely and isolated;
    - To strengthen and support community cohesion and partnership.
- **'Staying Well' workers carried out a number of face-to-face 'holistic' and 'asset-based' visits** with older people to emerge their needs, wants and wishes.
- **Workers facilitated attendance at a range of community and local activities** through attending alongside the older people.
- **Each Staying Well 'hub' applied a devolved budget to undertake micro-commissioning;** building community capacity through strengthening existing local provision as well as developing new and innovative activities.
- **One primary and four secondary objectives were identified**. The primary objective of the programme was to reduce social isolation and loneliness. The secondary outcomes incorporated: improving individual well-being, reducing inappropriate primary care use; strengthening cohesive communities and intersectoral working.

What did the 'Staying Well Programme' do?

- **A total of 779 users were referred to the programme** across the time frame of the evaluation (November 2014 – April 2016). Over a third were referred from statutory services (38%), under half self-referred or were referred by family members (42%), with a further fifth (20%) referred through voluntary organisations.
- The **mean age** of those individuals referred or self-referred to the programme **was 69**.
- **Just under half the total sample were recorded to have one long-term condition** (48%) with **over a third (38%) reporting two or more long-term conditions.**
- **Over a third of the sample (37%) were identified as living with some form of cognitive impairment or learning disability.**
- **The number of home visits with older people impacted on the likely service take-up.** If no home visit was undertaken, just over a fifth of individuals accessed a particular

'Staying Well in Calderdale' Final Evaluation Report. July 2016: ISBN 978-1-86050-250-7.

activity or intervention. In comparison almost half of those users that received one home visit took up some form of activity.

- **Younger individuals were less likely to attend group social activities or day opportunities** and far more likely to be referred onto other services, take up volunteering opportunities or receive mental health support.
- The main facilitator in driving the programme forward was the **close working relationships in and between the 'hubs'.**

What did the 'Staying Well' programme achieve?

Improved outcomes for older people

- The programme was **effective in ensuring appropriate inclusion;** 55% of users were drawn from the most deprived areas.
- **Those who live in areas of higher deprivation reported a lower quality of life, health-related quality of life, a greater number of long-term conditions and higher levels of loneliness and social isolation when compared with their less deprived peers.**
- **Over three-quarters of the sample that completed the user questionnaire before and after the programme reported at least one long-term condition** (85%); over half reporting two or more long-term conditions (57%) with almost a third (29%) reporting three or more long-term conditions.
- **Over a quarter of users reported** that they were living with mental health problems (27%).
- At base-line almost **two-thirds of the sample (64%) identified themselves as lonely or very lonely.**
- **Overall, the mean 'score' of loneliness fell;** users reported feeling less lonely than before the start of the programme**.**
- **Three of the four hubs were successful in reducing loneliness.**
- Users **aged under 55** reported an **improvement in their health related quality of life by almost a fifth (18%).**
- Users **aged 59 and under** reported **an improvement in their health-related quality of life of over two-thirds (70%).**
- Users that accessed the Elland and District 'Staying Well' programme reported a (significant) **10% improvement in their health state.**
- **Loneliness did not seem to be a factor in seeing a GP.** Those with a higher number of long-term conditions were 1.4 times as likely to attend two or more appointments. Those with better health were, not surprisingly, 84% less likely to attend two or more GP appointments.

Improved intersectoral working

- **Relationships and partnerships** across the health, social and third sector environment were perceived as **improving or improved**.
- The **'Staying Well' steering group** was perceived as having made **appropriate and strong links.**
- Relationships between the **hubs and wider health and community provision had improved**.

Connected and cohesive communities

- The 'Staying Well' programme was **effective in developing and strengthening cohesive or connected communities.**
- This was done in three ways: 1) through micro-commissioning existing and nascent community-led projects; 2) identifying and supporting existing community projects enabling each to know of the other and work together and; 3) involving community organisers and organisations on each hub 'Steering Group'.

Cost-effective?

- The 'Staying Well' programme has yet to achieve full cost effectiveness owing to the short-time frame that the programme has been in operation. In particular, the changes in outcomes (health-related quality of life) were measured across a scant four months.
- It is argued that **improvements of the necessary magnitude to ensure cost-effectiveness are possible** as such positive changes in health-related quality of life were seen for the younger age groups (those aged under 59).
- The 'Staying Well' programme would **easily have cleared any thresholds for cost-effectiveness if the findings for the younger users had been replicated** for those older participants.

What now for the 'Staying Well' programme?

- **The 'Staying Well' programme as a 'brand' is well-recognised** and accessed across the different localities.
- **Project workers were successful in identifying lonely and socially isolated individuals;** providing efficient, effective and long-term support to users.
- Accompanied visits alongside users **ensured individuals could 'test out' a range of activities and opportunities.**
- **The micro-commissioning exercise was particularly effective.**
- **Positive changes were found across a number of outcomes**: loneliness, health status, intersectoral working and community cohesion.
- **Indicators are in the right 'direction of travel'**.
- **It is recommended that the programme is continued.**

'Staying Well in Calderdale' Final Evaluation Report. July 2016: ISBN 978-1-86050-250-7.

TABLE OF CONTENTS

Acknowledgements 2
How should I cite this report? 2
EXECUTIVE SUMMARY 3
Introduction 7
Methods 8
SECTION ONE: Rationale, aims, objectives, structures and processes of the 'Staying Well' programme. 10
Perceived rationale 10
Perceived objectives 11
Structure of the support provided 12
Activity in supporting the user. 16
Working alongside the user: demographics 16
Working alongside the user: activity around placement 20
Working alongside the user: placement 23
Development of local provision: Micro-commissioning 26
Barriers and facilitators to the delivery of the programme 30
SECTION TWO: Achieving the project aims 33
Improving user outcomes: loneliness, social isolation, quality of life, health-related quality of life and changes in demands on primary care. 33
Introduction 33
Demographics: deprivation, age, sex, ethnicity, marital status, accommodation. 34
Long-term conditions 39
Changes in loneliness 42
Changes in risk of social isolation 44
Changes in health-related quality of life 46
Changes in self-reported health status 51
Changes in the visual analogue scale (vas) 53
Changes in overall quality of life 54
Changes in service use 56
Improved intersectoral working 60
Connected and cohesive communities 63
SECTION THREE: Cost-effectiveness 65
SECTION FOUR: Conclusion 67
References 70

INTRODUCTION

The 'Staying Well Programme' was set up across Calderdale Metropolitan Borough Council in November 2014. The programme incorporates three aims: a reduction in loneliness and social isolation for older people; an increase in community capacity and improved intersectoral working. The programme put in place four 'Staying Well' (SW) workers sited in four new 'hubs', the locality areas of: Elland and District, Halifax Opportunities Trust, Hebden Bridge and North Halifax. The SW workers were tasked with identifying lonely and isolated older people and signposting them to appropriate community services. As part of this role, SW workers would also map and identify gaps in existing community provision. Working alongside their Neighbourhood Team Scheme (NSTs) colleagues, the older people themselves and the wider community; the SW workers would support the development of range of interventions that would mitigate loneliness and social isolation (e.g., cultural activities, befriending schemes, cinema courses). In addition, the 'Staying Well' programme commissioned 'North Bank Forum' to put in place volunteer social prescribers in five pilot GP practices.

To explore the effectiveness and cost-effectiveness of the 'Staying Well Programme', Calderdale Metropolitan Borough Council, their health and third sector partners, requested an evaluation of the programme. Specialists from the University of Lincoln were awarded the tender following a competitive process.

This report details the effectiveness of the 'Staying Well in Calderdale' programme against their three key objectives. We first provide an outline of our methods and then detail how strategic and operational staff perceived the rationale and objectives behind the programme. Whilst there are numerous research reports that demonstrate the long-term health effects of social isolation and loneliness on e.g., blood pressure, heart disease and stroke (Valtorta et al., 2016; Windle, 2014; Windle et al., 2011; Hawkley et al., 2010; Holt-Lunstead et al., 2010), there are far fewer that illustrate how loneliness and/ or social isolation should be tackled. In consequence, we provide a 'picture' of the structures and processes of the 'Staying Well' programme. In addition, we analyse the anonymised user records to assess the overarching activity, identifying the type of individual referred to the programme (either formally or self-referred), how the 'Staying Well' workers emerged their needs and wants and the type (and extent) of community activities and services participants were able to access. In this same section, we discuss the mechanisms that were used to develop and enhance local interventions, outlining the overarching barriers and facilitators to the programme.

In the second section, we report the findings of the project aims; reducing individual social isolation and loneliness, improving individual well-being, improving intersectoral partnership and supporting the move toward cohesive and connected communities. In our penultimate section we explore if the 'Staying Well' programme achieved cost-effectiveness or, at full implementation would be cost-effective in terms of 'quality adjusted life years'. It should be noted that the activity carried out by North Bank Forum (volunteer social prescribers) is not included in the evaluation. The processual and structural challenges of this part of the programme resulted in little activity and few referrals. Finally, we bring all this analysis together, providing a brief conclusion.

METHODS

The research methods applied to capture effectiveness and cost-effectiveness are provided below. Where relevant, further details are provided as to areas of enquiry and the numbers of participants A multi-method approach was taken that included: 83 interviews with strategic and operational staff over three time points; secondary data analysis of 779 anonymised user records; four process mapping exercises involving 17 operational staff; 378 self-completion questionnaires and; financial records completed by the central 'programme' manager and four hubs.

Method	Areas of enquiry	Type and number of participants
Early implementation semi-structured interviews	• Job role and role within 'Staying Well' programme. • Type and extent of partnerships prior to the 'Staying Well' programme. • Rationale and objectives underpinning the 'Staying Well' programme. • Barriers and facilitators to implementation. • Likely programme outcomes. • Project development and sustainability.	**Total number of interviews = 38.** • Programme management/ Steering group staff (n=22) • 'Staying Well' and NST staff (n=16)
Process maps	• Perceived aims and objectives • Role of participants in achieving aims and objectives • Type of individuals being supported • Structures and processes of the work • Barriers and facilitators to implementation	• Elland and District 'Hub'; including SW and NST (n=4) • Halifax Opportunity 'Hub' ; including SW and NST(n=6) • Hebden Bridge Hub (n=2); including SW worker and hub lead • North Halifax Hub; including SW and NST (n=5)
Structured questionnaires (base-line and four month follow-up)	• Participant assets (e.g., strengths, preferred activities, volunteering activities). • Quality of life (Bowling, 2002). • Social Isolation (Lubben social network scale). • Loneliness Scale (de Jong Gieveld and Kamphuis, 1985). • Health-related quality of life (EQ-5D3L). • Individual service use (Beecham and Knapp, 1992). • Demographics (e.g., marital status, accommodation, work/ retirement, benefit receipt, ethnicity, sexuality, faith).	Total number of returns to date **= BL 369 / FU 189 (51.2%).** • Elland and District (n = 99/ 43) • Halifax Opportunities Trust (n = 95/ 57) • Hebden Bridge (n = 123/ 65) • North Halifax Trust (n = 52/ 24)
Cost data	• Total budget • Direct expenditure on staff (management and operational staff) • Additional resources necessary for set-up (e.g., IT, workforce training, marketing, financial administration) • Additional finance to implement SW project (e.g., on-going marketing, development of projects)	Cost data returned from: • Overall SW programme management • Elland and District • Halifax Opportunities Trust • Hebden Bridge • North Halifax Trust
Pre-collected project data	• Numbers of individuals • Demographics (e.g., gender, age, ethnicity) • Referral route • Activity (e.g., type(s) of provision offered • Length of case • Case-loads	**Anonymised user records received (n = 779):** • Elland and District • Halifax Opportunities Trust • Hebden Bridge • North Halifax Trust

Method	Areas of enquiry	Type and number of participants
Interim set-up interviews	• Activities undertaken • Projects developed • Improvements in partnerships	**Total number of interviews = 12**
Final interviews	• 'Staying Well' progress over the timeframe • Suggested changes to structures and processes • Further funded projects • Project outcomes (improved quality of life, community cohesion, supported older people, impact on health and social care economy, impact of statutory services) • Your Experience (impact on your professional role, impact of December flooding on 'Staying Well') • Community partnership (improved partnership, culture change/ raised awareness, partnership with health and social care) • Project development and sustainability (grant streams, effectiveness and cost – effectiveness, concerns) • Impact to date (value of 'Staying Well', development of community capacity, impact on primary and community service use)	**Total number of interviews = 33**. • Programme management/ Steering group staff (n = 17) • Hub Staff; including SW workers and NST staff (n = 16)

SECTION ONE: RATIONALE, AIMS, OBJECTIVES, STRUCTURES AND PROCESSES OF THE STAYING WELL PROGRAMME.

PERCEIVED RATIONALE

From the interviews, participants suggested five reasons as to why the 'Staying Well' programme was implemented: a reduction in social isolation or loneliness; a reduction in less appropriate health and social care use; a response to 'grass roots' pressures; to strengthen initiatives that could support early intervention and prevention; and to improve capacity across third sector organisations.

The majority identified, not surprisingly, that a core driver behind the programme was the recognition that social isolation and loneliness was not being effectively addressed across Calderdale. It was stated by some participants that there was a 'moral imperative' to community inclusion; ensuring that individuals were valued and felt a sense of 'belonging'. This identification of a 'moral imperative' extended the discussion of the rationale behind the programme to incorporate community cohesion. Participants argued that whilst the programme would identify and support individuals, a further task would be to support communities to develop and implement activities that could '*keep people linked and fit and well throughout their life'.*

Alongside such discussions, most participants detailed their understanding of the health and social care consequences of loneliness or social isolation (e.g., greater use of services, poorer quality of life and health). As such, for the majority of those interviewed, the perceived **primary rationale** of the 'Staying Well' programme was to reduce less appropriate use of primary or social care service use; *'if people have good mental and physical health then they won't use GPs or other services to the same extent'*.

It was recognised by many that early intervention and prevention was the only way that chronic social isolation and loneliness could be mitigated; participants stating that such conditions could easily lead to crisis. Putting in support at the early stages, building cohesive programmes of care, would ensure that the programme could also contribute to the overarching focus of the Calderdale health and social care environment; well-being, prevention and early intervention.

It was evident from our initial interviews that participants perceived that the 'Staying Well' programme was something that would be welcomed by older people. However, few thought that the older people themselves were demanding such support; *'I don't think there is any overall pressure for the community to deliver it, rather I think it is a programme that is service-led'.* Indeed, some respondents argued that such a service-led focus excluded the very communities and individuals that were tasked in further developing and embedding provision: *'the community did not get consulted with before 'Staying Well' was set up and I question whether service users had a voice in its design'.* Few participants were able to state the rationale behind the selection of the four different 'hubs' (or community areas), although they perceived such selection may have ensured that different geographies and socio-economic aspects were incorporated.

Nevertheless, the central role of community organisations was welcomed and participants argued that the final rationale behind the programme was to develop and strengthen third sector and voluntary capacity; building innovative and bespoke community-led activities.

PERCEIVED OBJECTIVES

There was a general consistency and coherence across participants when discussing the perceived objectives of the programme, most reflecting the rationale behind its development. One primary and four secondary objectives were identified, ranging from user focused (e.g.., reduction in loneliness) to system outcomes (e.g., improvement in partnerships).

The majority of respondents identified 'reduction of social isolation and loneliness' as the primary objective of the 'Staying well programme. Such an overarching objective was perceived as supporting a number of secondary outcomes. The first of these was individual well-being; *'Being able to live longer, happier, healthier and more independent lives will increase overall well-being'.* Nevertheless, it was also recognised that such increased health or well-being *should* enable a further secondary outcome of reducing pressures on the health and social care environment that '*otherwise would be above and beyond their capacity'.*

The third secondary outcome was the recognition that social isolation and loneliness needed to be tackled at both the individual and community level, incorporating the development and support of the wider community to become resilient communities; *'neighbours need to become more neighbourly'*. However, participants also raised concern that beyond the ability to micro-fund community organisations (see below for further discussion) there had been little discussion of any activities or actions that could be undertaken to deliver this particular objective. Some respondents questioned the definitions of 'resilient communities' and 'community capacity' finding it difficult to grasp the concept. Many participants argued that the only starting point to strengthen and support communities would be solely dependent on the hub organisations leading community activities; they were unable to perceive that the local authority could enhance social interaction.

A further two secondary objectives identified were necessarily linked; improving partnerships and 'breaking down barriers' between organisations. Some respondents illustrated that partnerships have been a little 'muddy' and there was some concern that the term 'partnership' had been somewhat devalued by its over use. One respondent stated that the term partnership had become ubiquitous, resulting in a meaningless 'hash-tag', *'#partnership working'*. They stated that to achieve partnership there needed to be an understanding that *'collaborative working'* and *'building relationships'* first had to be undertaken. It was suggested by participants that historically, partnerships between the third sector, GPs and Public Health had been poor, leading to little effective communication between these organisations. Participants were excited about the possibility of the 'Staying Well' programme as a 'vehicle' to improve relationships with GPs. Whilst there was some scepticism that they could be fully drawn into the programme, establishing trusted relationships; it was felt that any improvement in contacts between the 'hubs' and GPs

could result in a real benefit to communities and organisations. Participants also highlighted that robust partnerships should also be enabled and developed between the different 'hubs', housing associations, the local authority and CCG. There was recognition that if the hubs were to be *'quick and slick at sharing things that work'*, then inter-sectoral working necessarily had to be incorporated as a secondary objective.

STRUCTURE OF THE SUPPORT PROVIDED

The overall funded project detailed how the 'Staying Well' programme would be structured. The programme would be managed by a single project manager who would be supported by a multidisciplinary Steering Group with representatives from across the health, social and third sector care environment. Four 'Staying Well' workers would be employed by Calderdale MBC, managed by the project manager, placed into the existing Neighbourhood Scheme Teams (NST) and sited in four 'hubs' across Calderdale: Elland and District, Hebden Bridge, Halifax Opportunities Trust and North Halifax. These 'hubs' were located within each of the 'locality areas' and differed across the programme. For example, the 'Staying Well worker in the 'Park Ward hub' was located in Halifax Opportunities Trust ensuring access to a range of support: a Chief Executive, Operations Manager, two outreach workers who also took on roles such as 'Tutor' or 'Community Organiser', a Project Coordinator as well as the 'Staying Well Project Worker'. Similarly, the Hebden Bridge 'Staying Well' worker was located in the heart of Hebden; working out of the Town Hall. In contrast, the Elland and District 'Staying Well' worker necessarily developed a 'virtual' hub supported by the Elland and District Partnership. It was only in March 2015 (five months after the start of the programme) that North Halifax stepped in as the 'Anchor Organisation'; providing appropriate and effective support to the Elland and District Staying Well Worker. Placing the 'Staying Well' workers within the existing NSTs ensured appropriate support and knowledge could be shared. The NSTs have been working to support and place vulnerable and isolated individuals into community activities over the last four years. Their innovative way of working, one-to-one and accompanied visits with the user to community services, was mirrored by the 'Staying Well' workers.

It was envisaged that the 'Staying Well' project worker would be tasked with two responsibilities. The first was to proactively identify and support older people who were lonely and social isolated. The second was to strengthen and support community capacity and development. This latter task would be supported by providing micro-funding to different community groups or local activity providers to set up a range of interventions that could mitigate and manage social isolation (e.g., group social activities and day opportunities).

As with many successful bids written for tender, the actual implementation was carried out by other individuals and this innovative and complex project necessarily developed over the timeframe. In the early interviews, questions and comments were raised over the structure and process of the programme: "*There was no clear instructions from the beginning or explanations about the different pathways that should be implemented and you feel that the CCG has just got some money and thought 'ah well, let's just do that'".* A number of challenges arose over the first year that required changes in the envisaged shape of the programme. These included, the overall management structure, the roles and

responsibilities of the different organisations and communication challenges and these are discussed further below (see, 'Barriers and facilitators to programme implementation').

However, despite this early confusion, robust structures and processes developed over the first year and were captured through four process mapping exercises; each involved staff from the four hubs. In identifying and supporting older people who may be lonely or socially isolated the 'Staying Well' workers carried out a range of activity (see Figure 1 and

Figure 2Figure 2 below as an example).

With all hubs, the process started with 'publicising' the 'Staying Well' programme. Two types of project 'publicity' were discussed: developing and circulation of passive 'branding' and 'publication materials and more proactive 'sign-up' events in the community. With regard to the former, it had initially been planned that such 'branding' and 'publicity' would be undertaken by the Calderdale MBC 'communications team'. However, on-going delays and lack of engagement resulted in some of the total monies of £10,000 for publication (e.g., flyers, printed 'shopping' bags, postcards, short information films) being devolved to each of the hubs.

All 'passive' publication material was circulated as widely as possible. For example, Hebden Bridge 'hub' developed a short film discussing loneliness and social isolation and highlighting the types of interventions that were available to individuals in the locality (https://vimeo.com/153090157). This short film was shown at the Hebden Bridge 'Picture House' on a regular basis ensuring the wider community could be informed of the work being done and how to access the project. Similarly, postcards and 'shopping bags' developed by North Halifax were taken to a variety of events along with 'sign-up' sheets to encourage older people who may feel lonely or socially isolated to come forward.

The 'proactive' sign-up events were wide ranging, encapsulating links to statutory and community organisations (e.g., police, adult social care, community health services, GPs, housing associations) as well as to individual older people themselves. Meetings were set up early in the programme process with colleagues from across the health and social care environment. As the project began to develop, some of the 'Staying Well' workers were invited to specific 'multidisciplinary team meetings', to identify those older people that might benefit from the 'Staying Well' programme. As will be seen (Figure 1), such activity generated referrals; over half of the sample (58%) referred from statutory or voluntary organisations: *'local groups know who I am, they want to work with me which is important and because of this, our referrals have increased'*.

In ensuring that older people themselves were aware of and could access the 'Staying Well' programme, each hub identified areas where it was likely that 'recruitment' and/ or 'identification' of lonely or socially isolated older people could be undertaken. For example, the 'Staying Well' project worker in Elland and District 'hub' obtained permission from the local supermarket to spend a number of days being available to, and discussing with, older people what support might be suitable and highlighting interventions that may be of interest. In addition, many of the 'Staying Well' project workers identified areas in their community with a high prevalence of older people and visited each house; knocking on the different doors to introduce themselves, the programme and leaving publicity material and

referral form with the householder. Such activity ensured that of the overall referrals to the 'Staying Well' programme, over 4 in 10 individuals were 'self or family' referred.

Figure 1: Summary process map detailing Staying Well worker activity (Hub 1).

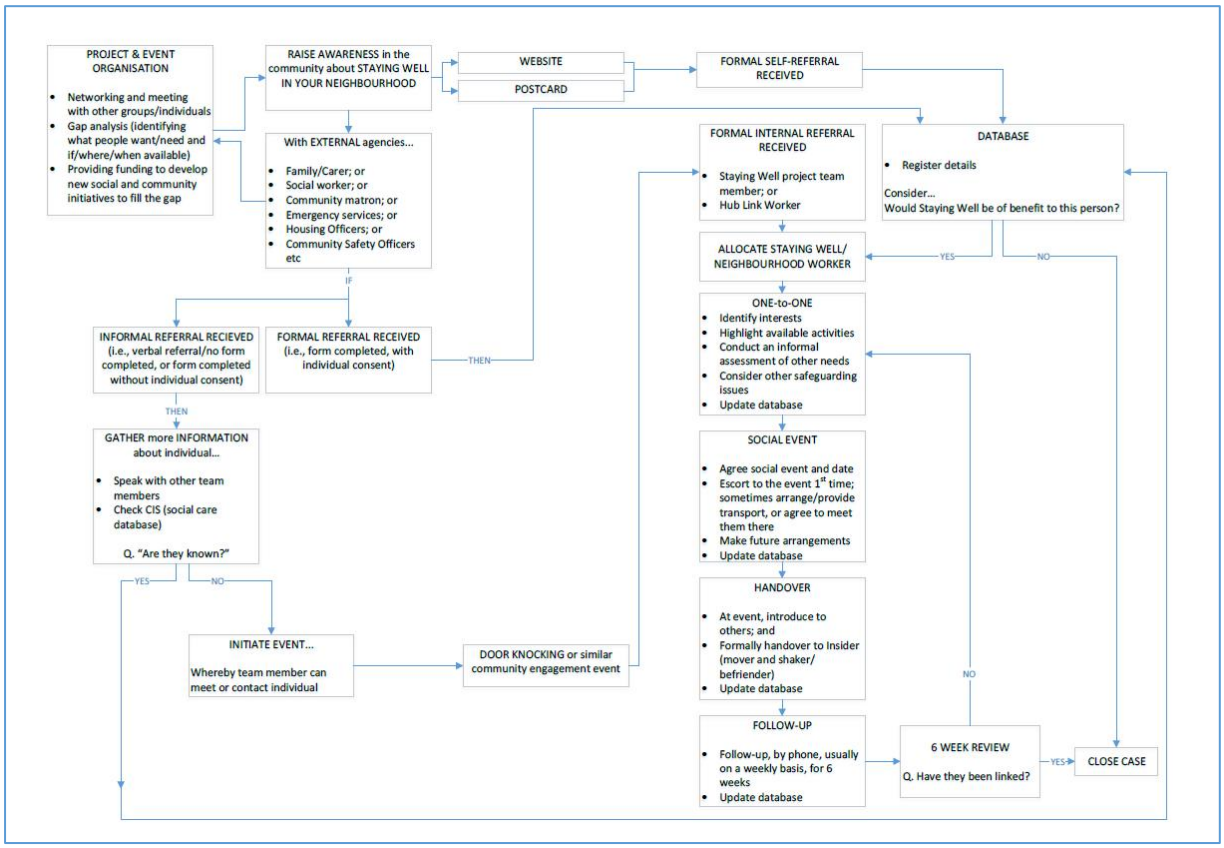
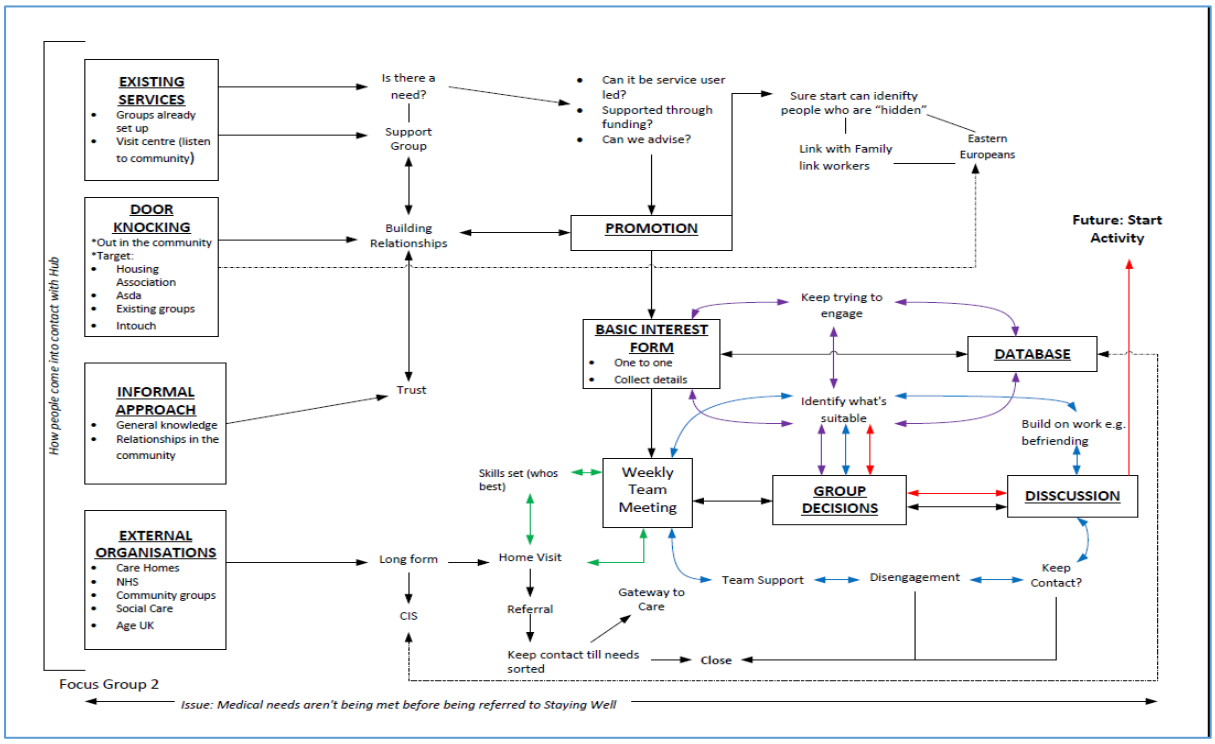


Figure 2: Summary process map detailing Staying Well worker activity (Hub 3).



On receiving a formal referral from statutory services or a self-referral form or telephone call, the actions carried out by each hub were seemingly consistent. First, a check was made on 'CIS', a social care database to assess how far the individual, couple or family were known to adult social care. The individual's (or couple's) details were registered on the database and they were then allocated to the 'Staying Well worker'. At this time, the project workers then made an appointment with the individual (or couple) to carry out a home visit, during which the individual's wishes and wants were discussed and the programme and suitable activities highlighted. For many users, more than one home visit was necessary (Table 1). A series of activities (follow-up telephone calls, emails, referrals to other services) were also carried out to support the older user.

The 'Staying Well' programme mirrored the NST innovative processes in carrying out 'accompanied taster visits'. During the home visit and/ or follow-up phone calls, the user would make a choice of one or, a number of interventions (e.g., lunch club, 'chatty crochet', walking exercise group). The 'Staying Well' worker would then arrange this visit and either ensure transport was provided or transport the older person themselves. They would then introduce the older person to the wider group and stay with them, providing welcome and appropriate support. Such an approach ensured those with cognitive or mental health challenges could be appropriately included. However, it also ensured that those who had perhaps been particularly socially excluded owing to loss of mobility or bereavement could take up opportunities in a supportive and encouraging environment.

The following section details the analysis of anonymised client records, highlighting the referral route, the activity and the placement of the user. We then discuss the second part of the role of the 'Staying Well' worker in supporting and strengthening project capacity and development.

ACTIVITY IN SUPPORTING THE USER.

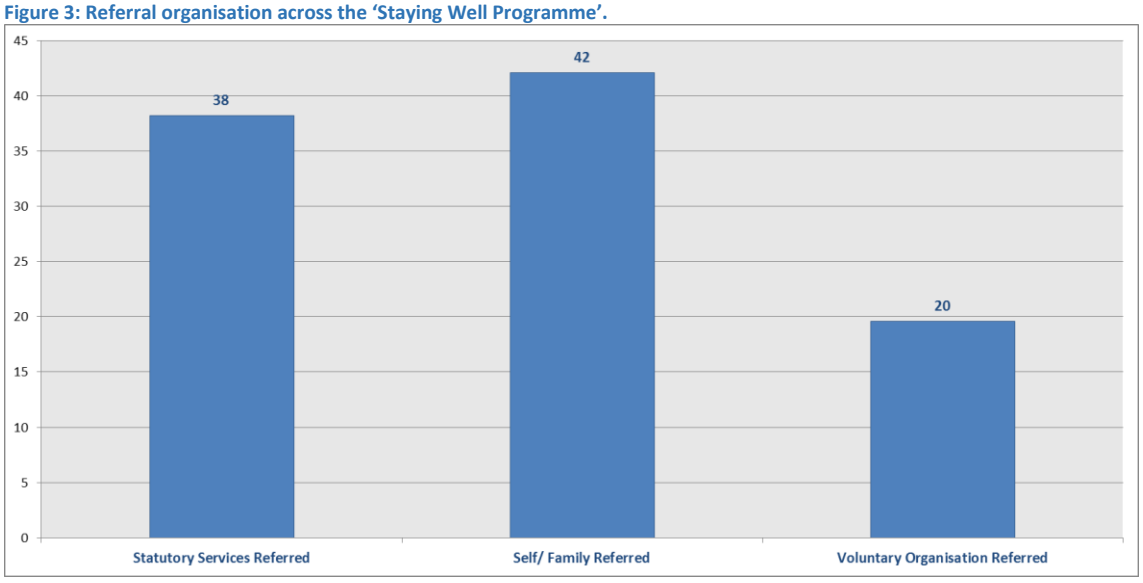
WORKING ALONGSIDE THE USER: DEMOGRAPHICS

A total of 779 users were referred to the 'Staying Well in Calderdale Programme. Of these users, 330 cases were closed (42%) and 446 cases remain open (58%). Details of many of the open cases are not, as yet, recorded on the client database. Users were referred from across the health, social and third sector care environment. Over a third were referred from statutory services (38%), 42 per cent either self-referred or were referred by a member of their family with a further fifth referred by voluntary organisations (see Table 1 and Figure 3 below).

Table 1: Referral organisation

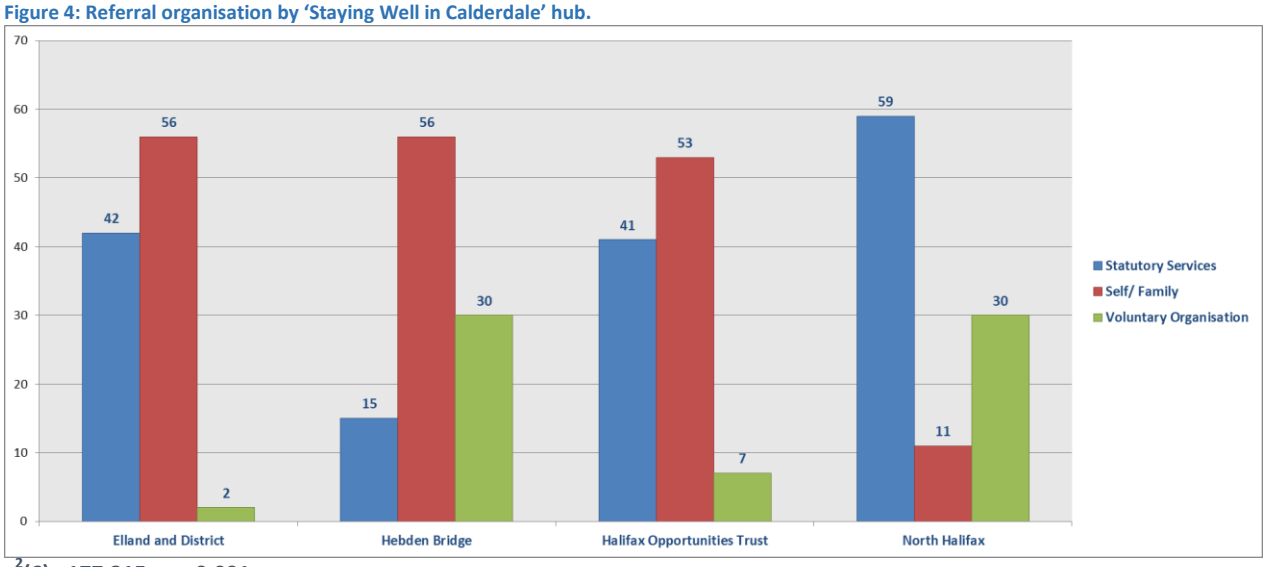
Organisation	% (n)
Adult Social Care	17 (113)
Community Health Services	3 (18)
Community Mental Health Team	2 (8)
Gateway to Care	5 (37)
General Practice	3 (20)
Housing Organisation	1 (9)
Neighbourhood Schemes Team	2 (15)
Police	0.5 (3)
Self/ Family Referral	42 (268)
Social Prescribing	1 (6)
Support at Home	4 (25)
Voluntary Organisation	19 (129)
Totals	100 (667)

Figure 3: Referral organisation across the 'Staying Well Programme'.



Differences in referral patterns were seen across the hubs (Figure 4). In Elland and District, Hebden Bridge and Halifax Opportunities Trust, over half of users 'self-referred' into the 'Staying Well' programme. In contrast, in North Halifax almost 60 per cent were referred by statutory services (e.g., Adult Social Care, Community Health Services, and Police).

Figure 4: Referral organisation by 'Staying Well in Calderdale' hub.



$\chi^2(6) = 177.315$, $p = <0.001$

The mean age of those individuals who accessed the 'Staying Well in Calderdale' programme was 69. Differences were again seen across the hubs. Whilst the mean age of users in Elland and District, Hebden Bridge and North Halifax was similar; those user's accessing Halifax Opportunities Trust were between six and eight years younger. Such a profile fits with the levels of deprivation seen in Halifax Opportunities Trust (see Figure 5 and Figure 6 below).

Figure 5: Mean age of the users accessing the 'Staying Well in Calderdale' programme'.

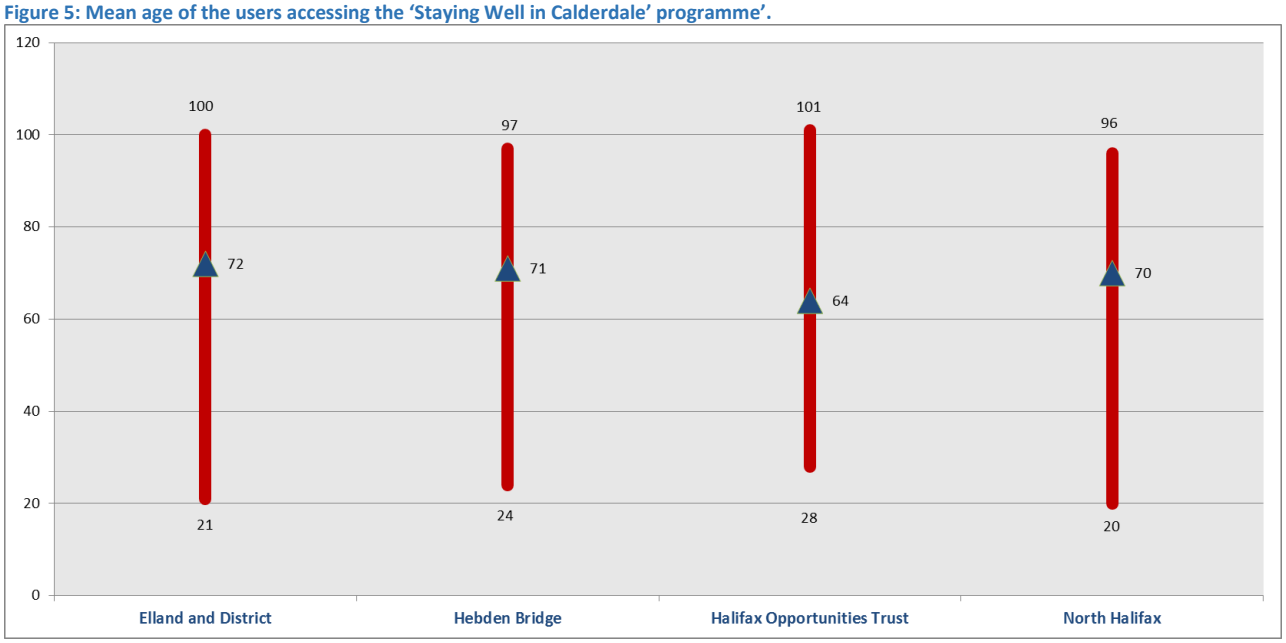
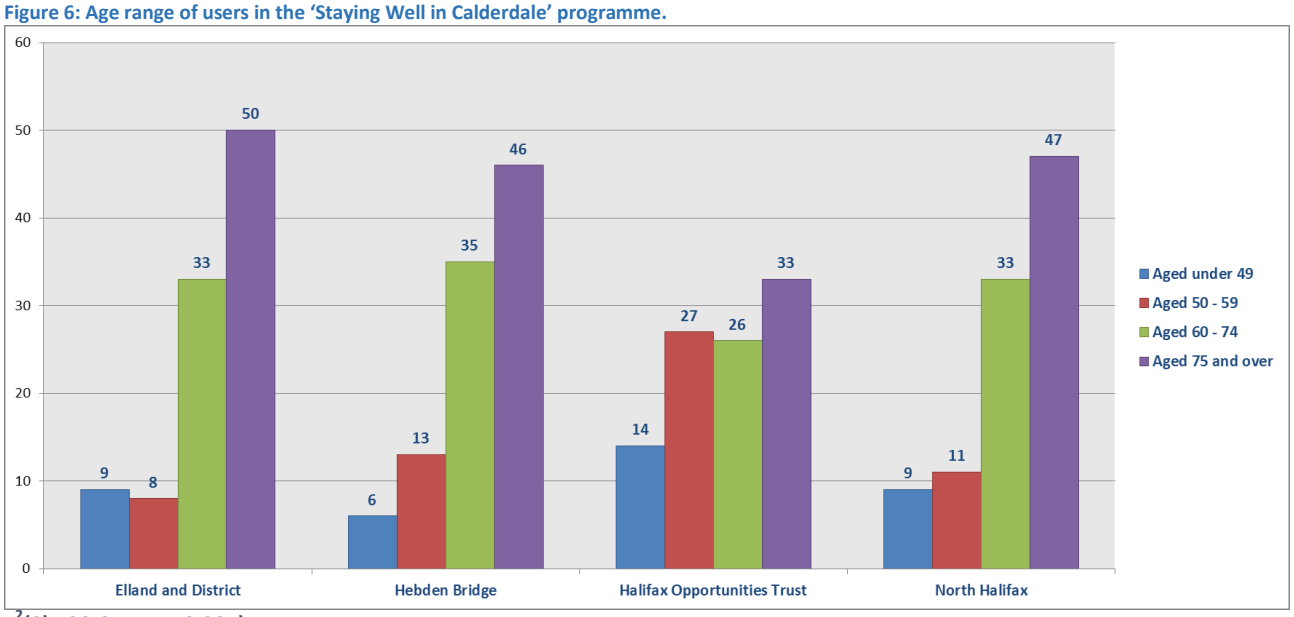


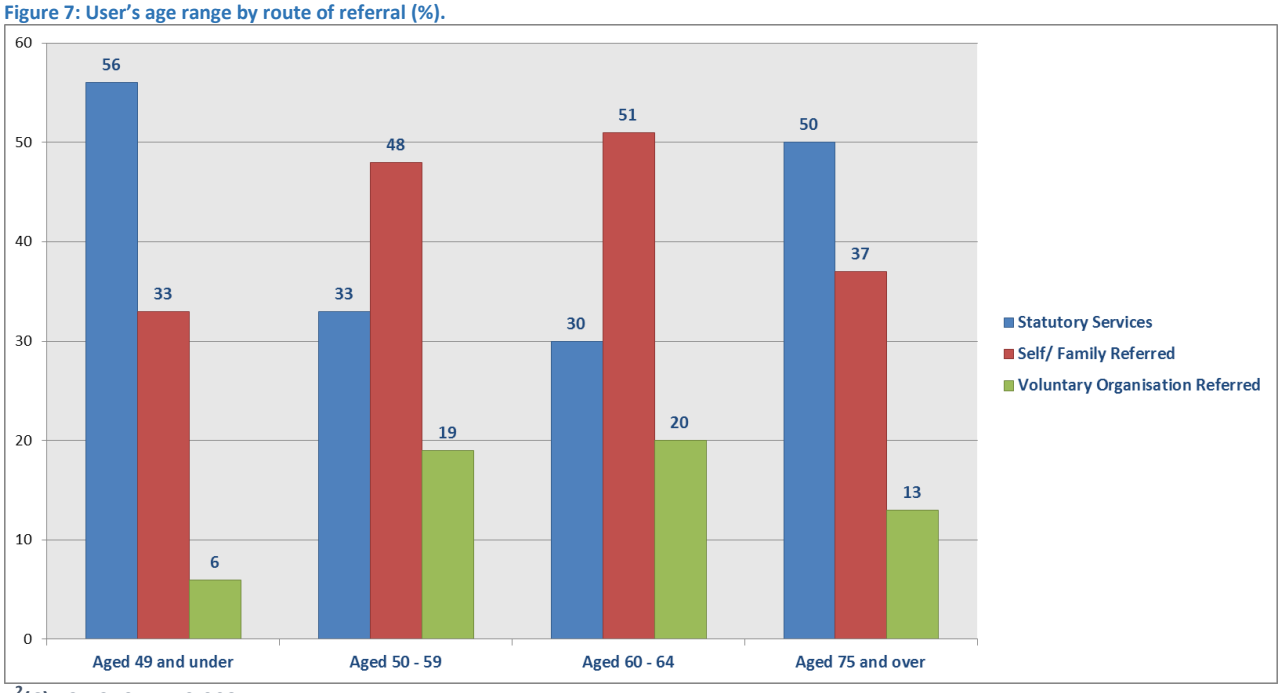
Figure 6: Age range of users in the 'Staying Well in Calderdale' programme.



$\chi^2(9) = 30.614$, $p = <0.001$)

There was a significant association between the age of the user and the referral route. Those younger (aged 49 and under) and older user's (aged 75 and over) were more likely to be referred through statutory services. In contrast, almost half of those aged 50 – 64 were comfortable to self-refer (see Figure 7, below).

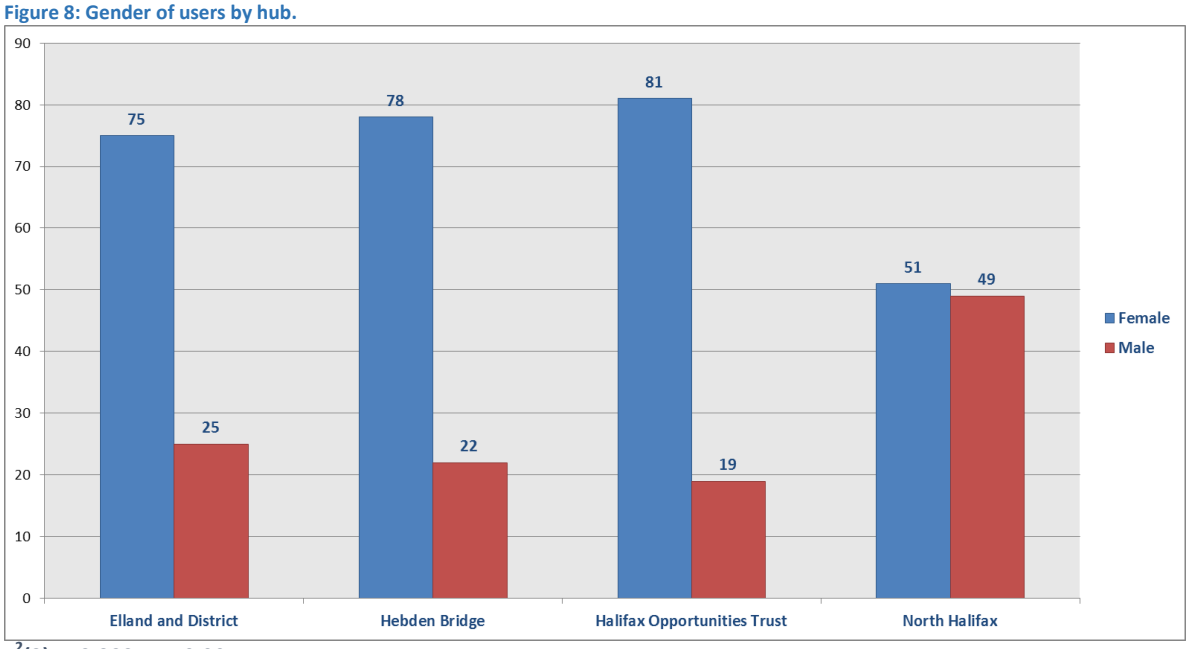
Figure 7: User's age range by route of referral (%).



$\chi^2(6) = 21.240$, $p = <0.003$

Far more women (71%) than men (29%) were referred or self-referred to the programme. Differences were seen across the hubs, with North Halifax working alongside a greater proportion of men than other hubs (see Figure 8, below).

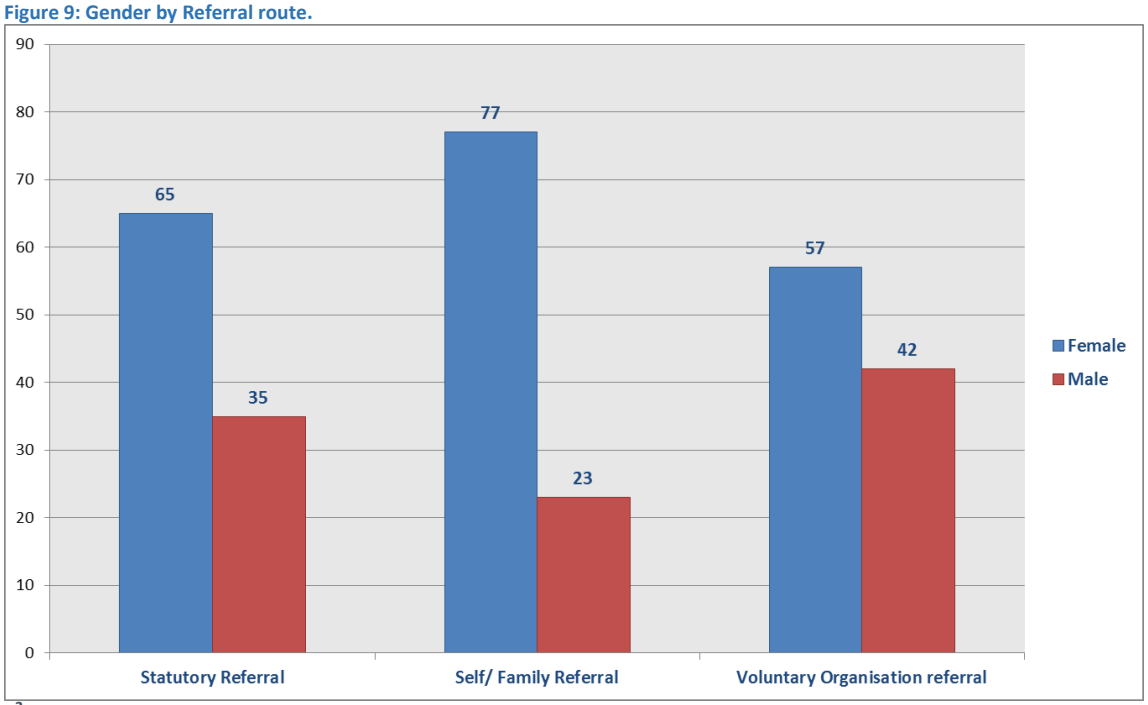
Figure 8: Gender of users by hub.



$\chi^2(3) = 52.322$, $p = <0.001$

Gender was also found to make a difference to the referral route. Women were more likely to self-refer or be referred by their family than men. Similarly, more women than men were likely to be referred by statutory and voluntary organisations (see Figure 9, below).

Figure 9: Gender by Referral route.

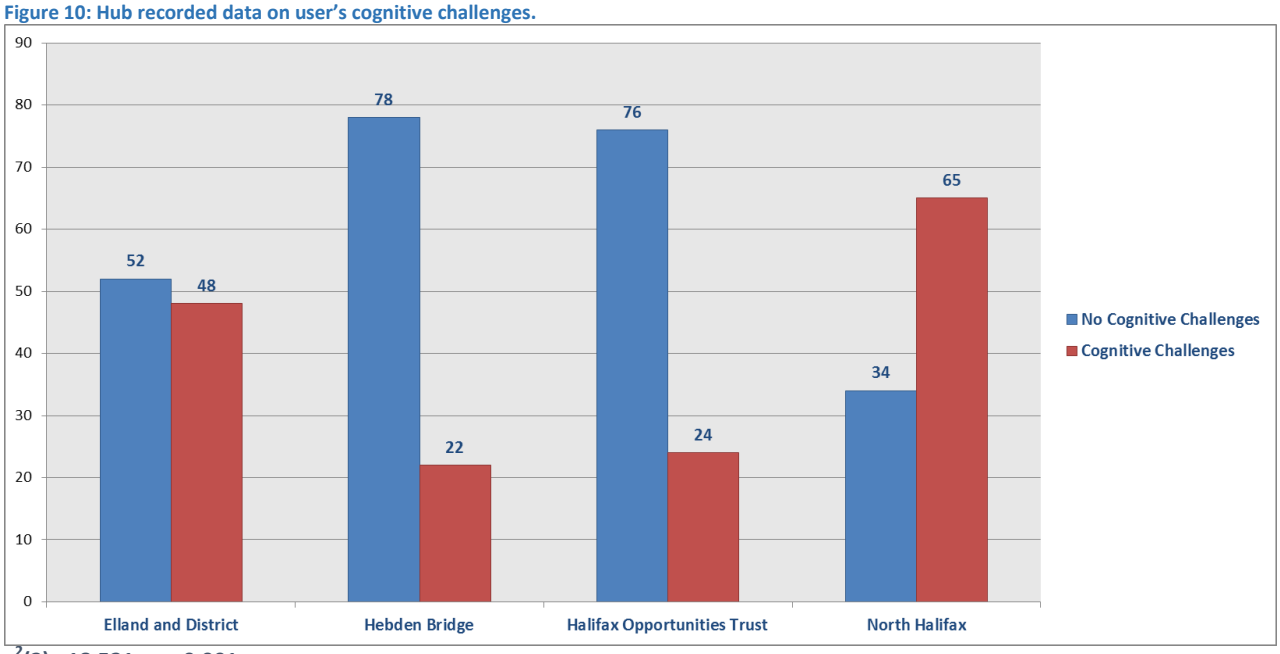


$\chi^2(2) = 17.796$, $p = <0.001$

Through close textual analysis of the notes held on each user, an estimation was made as to the number of long-term conditions and the level of (any) cognitive challenges. Whilst further analysis on such data can only be estimation, such data still provides insight into the level of 'need' of users.

The mean number of long-term conditions discussed (and reported) to the 'Staying Well in Calderdale' programme was 1.37. Almost half of the 'closed' sample were recorded to have at least one long term condition (48%) with a further 38 per cent being identified as having two or more long-term conditions. In only 13 per cent of the sample was there no indication around the number or extent of long-term conditions. This may mean that these individuals did not have a long-term condition. Alternatively, this data was simply omitted from the client notes. Over a third of the sample were identified as having at least some form of cognitive impairment or learning disability (37%). No differences were found across the hubs with regard to the number of long term conditions. Differences were seen across the hubs in working alongside those with cognitive impairment or learning disabilities (see Figure 10, below). In Elland and District almost half of those users (whose case was closed) had cognitive difficulties, whilst almost two-thirds supported through the North Halifax 'hub' living with some form of cognitive 'impairment'. Such differences could be due to either age or referral route. For example, as has been discussed, half of the sample in Elland and District Hub were aged 75 and over and cognitive impairment becomes more prevalent with age. Similarly, North Halifax had the greatest number of referrals from statutory services (e.g., adult social care, community mental health team); the referral perhaps prompted following a full care assessment triggered through increased cognitive debility.

Figure 10: Hub recorded data on user's cognitive challenges.



$\chi^2(2) = 18.521$, $p = <0.001$

WORKING ALONGSIDE THE USER: ACTIVITY AROUND PLACEMENT

It has been discussed above, that following referral of the individual to the 'Staying Well in Calderdale' programme, the project worker would then set up a home visit and/ or telephone call, provide information or signposting and where requested, carry out supported visits (attending the different groups with users). In exploring activity, we use those closed cases for which information is available on the database (330 users).
Where data is available, the mean number of home visits made to users was 0.85 (minimum zero, maximum 6), the total number of visits carried out, 180 (see Table 2). For just over a third of users, a home visit was not carried out (99, 35%). It is likely that some individuals

perceived a home visit unnecessary as they felt able to follow up the information themselves or, if they had been referred through another agency, they may have been comfortable with their existing social networks. Alternatively, the users had specific needs that required a referral prior to being placed as part of the 'Staying Well' programme. As will be discussed, the latter reason was of particular relevance in Halifax Opportunities Trust.

Table 2: Number of visits to the 'Staying Well in Calderdale' users.

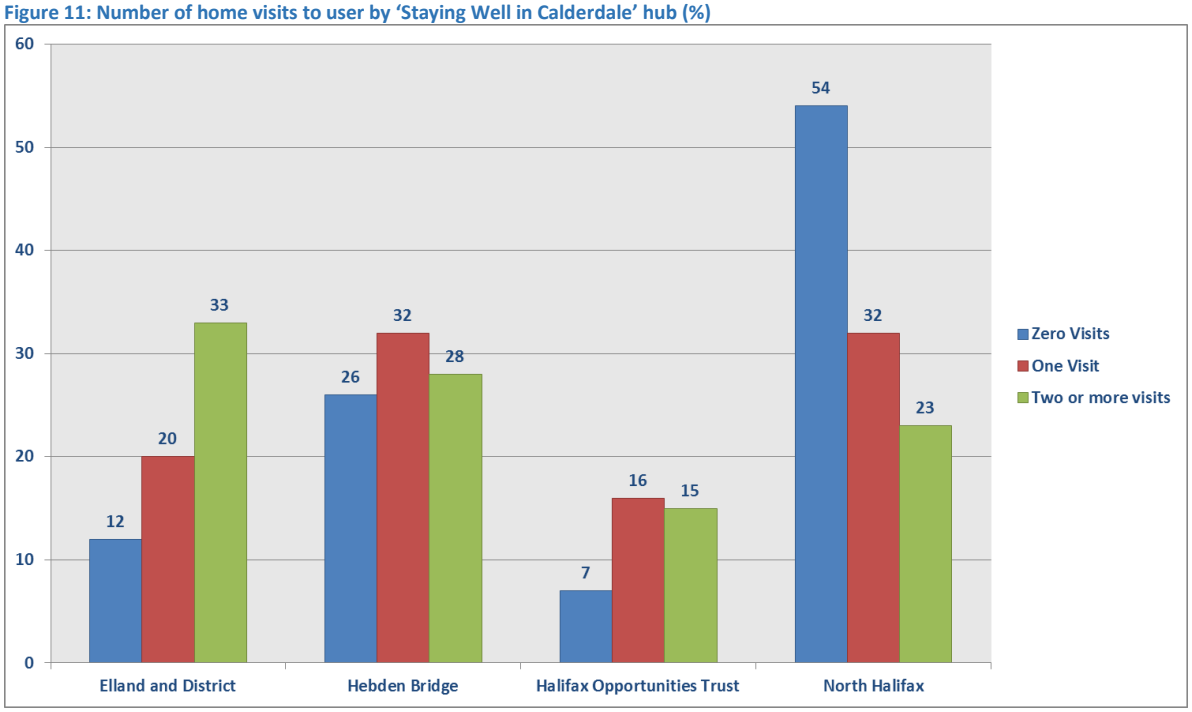
Number of Visits	% (n)
Zero Visits	35 (99)
One Visit	50 (141)
Two Visits	10 (28)
Three Visits	2 (7)
Four Visits	1 (3)
Six Visits	1 (0.5)
Total	100 (279)

The 'Staying Well' worker (or the hub location) would seem to affect the number of visits carried out; Elland and District workers undertaking a greater number of visits (see Table 3 and Figure 11, below).

Table 3: Number of home visits to users by 'Staying Well in Calderdale' hub.

Hub	Mean # of Visits	N
Elland and District	1.15	53
Hebden Bridge	0.91	82
Halifax Opportunities Trust	0.97	36
North Halifax	0.6	108
Total	0.85	279

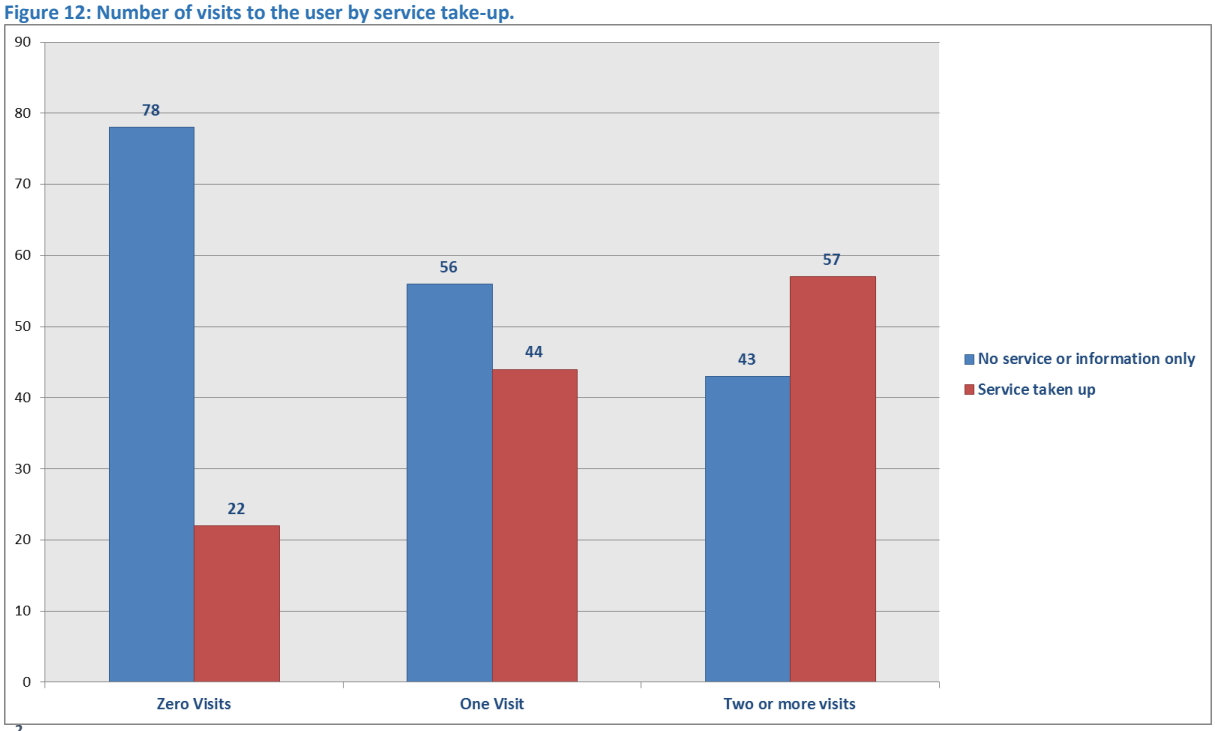
Figure 11: Number of home visits to user by 'Staying Well in Calderdale' hub (%)



There is little information in the 'Client Records' on the time taken for a home visit. However, where this is recorded (a scant 20 records), the average visit is 90 minutes. If travel time is included, it is likely that the 'average' home visit would take 2.5 hours. Given the rurality of Halifax, this could be extended to between three and five hours, although it is recognised that in some areas of Halifax (e.g., Halifax Opportunities Trust), such timescales would be shorter. Applying this 'average' home visit time for the 180 clients that received at least one home visit, a total of 450 hours were spent on home visits across the hub. If this is extended to the full sample, (open and closed) of 776 users, the total time spent on home visits is 1,940 (258 days using a 7.5 hour day).

There is some indication that the number of visits (perhaps not surprisingly) impact on the likely service take-up. If a home visit is not undertaken, just over a fifth of individuals (22%) access a service. In comparison, 44 per cent of user's who received a home visit accessed a service (see Figure 12).

Figure 12: Number of visits to the user by service take-up.



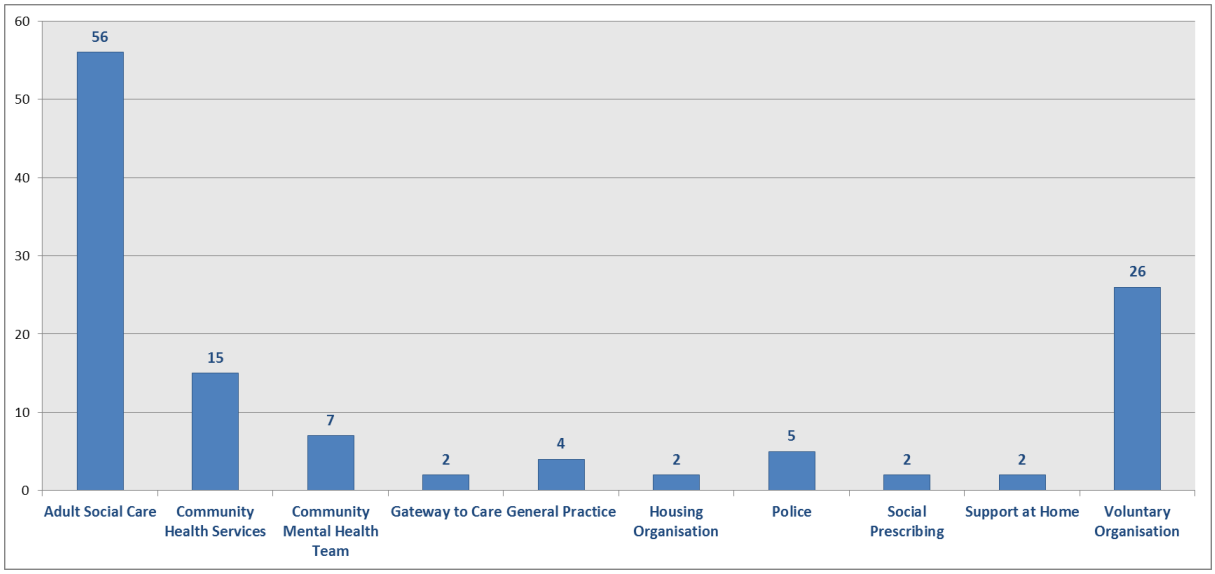
$\chi^2(2) = 18.729$, $p = <0.001$

There is similarly little information on the extent of activity necessary to place a user. Through analysing the user records and bringing together e.g., emails, telephone calls and ad-hoc visits, a mean of five activities (median, four activities) were undertaken for each user (minimum zero, maximum 28), a total of 1,396 actions. Again, there is no recording of the time such actions were taking. However, it is unlikely that each action took less than 30 minutes (from the detail provided around some telephone calls, this may well be much higher). Along with the home visit of 2.5 hours a further 2.5 hours would need to be added in working alongside the user (an average of five hours per user). This would bring the total number of hours necessary to support the total 776 users to a **minimum** of 3,880 hours (517 days, using a 7.5 hour day).

In placing the users (see below), staff liaised with over one organisation (1.22). It is likely that such liaison would have a time implication. No information exists on the time taken to work alongside the user with other organisations, but it is likely that a further 30 minutes would be necessary. The final total of hours per user is 5.5 resulting in a necessary time frame to support 776 users of 4,268 hours (569 days, using 7.5 hour day).

In the liaison with the range of organisations, the main contacts made (82%) were with a range of clinical and operational staff across adult health and social care and voluntary organisations (26%). Discussions were also held with e.g., Community Health Services, Mental Health Teams, Housing Organisations, General practice and in five per cent of cases, the Police; the latter seemingly as a result of safeguarding concerns (see Figure 13, below).

Figure 13: Agencies liaised with by 'Staying Well Programme' (%).



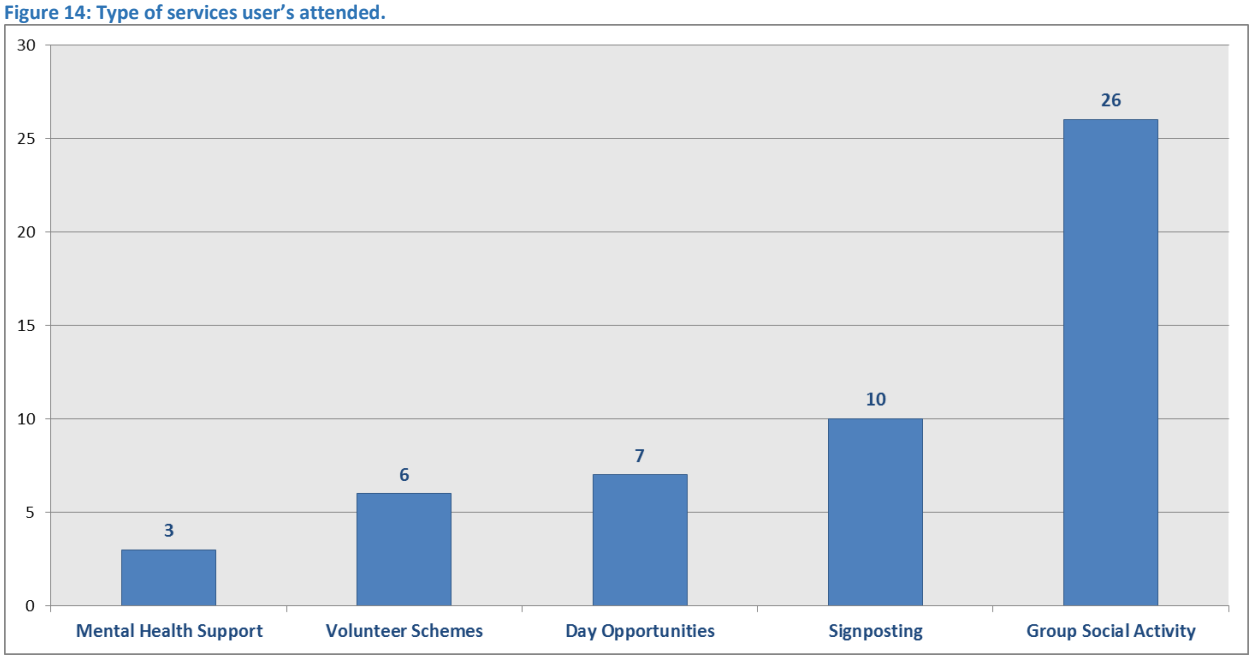
WORKING ALONGSIDE THE USER: PLACEMENT

Of the 'closed' cases for which data was provided, almost a third of individuals (29%) began to attend particular provision. It should be noted that that the majority of cases (a further 417) remain open and the proportion of placed clients or users is likely to increase as they are introduced to the different available activities or interventions. Similarly, whilst only a third of individuals took up the opportunity to attend a particular group or 'class' or 'club', all were provided with information and/ or signposted and many were supported to attend one or two activity groups in making their choice; 'taster sessions'.

It is emphasised that 'signposting' was a proactive activity; referring those with high level needs to specific support. For such individuals, it was first necessary to ensure that appropriate and robust provision was put in place before the individual was 'ready' to access the range of well-being services. Similarly, the provision of information was not a 'passive exercise'. For the majority of users, such information was only provided after a visit and full consultation had been undertaken

Of those that took up the opportunity to attend different groups, over a quarter attended a group social activity (e.g., 'Chatty Crochet', art class, craft class, 'men in sheds', choirs, and university of the third age). Smaller numbers took up day opportunities (e.g., Mustard Seed Lunch club) and or volunteering opportunities (see Figure 14, below).

Figure 14: Type of services user's attended.



Some differences in placement were seen; seemingly dependent on particular individual demographics and geographical location. Perhaps not surprisingly, the age of the user did make a difference to the type of service accessed. It would seem that younger individuals were less likely to attend group social activities (e.g., art classes, choirs, craft groups) or day opportunities (e.g., lunch clubs) and far more likely to be referred onto other services, take up volunteering opportunities or receive mental health support (Figure 15).

There are also (non-significant) indications that those living with some form of cognitive difficulty were more likely to be placed in a range of day opportunities (e.g., lunch clubs); perhaps a more 'traditional' choice. However, over a third (37%) of individuals attended and were welcomed at group social activities (café's, craft groups). It would seem that a great deal of effort was undertaken by outside providers to ensure those with cognitive challenges could be included; one file note discussing how incontinence problems were being managed to enable attendance at a craft club.

Some differences in 'placement' were seen across the hubs (see Figure 16). For example, in Hebden Bridge, a greater number of users accessed group social activity. Similarly, when exploring those individuals needing to be proactively referred to other agencies, over half were supported by Halifax Opportunities Trust. Whilst Elland and District were successful in supporting 'new' volunteers to find places, this was not possible in North Halifax or Halifax Opportunities Trust.

Figure 15: Age and type of service received.

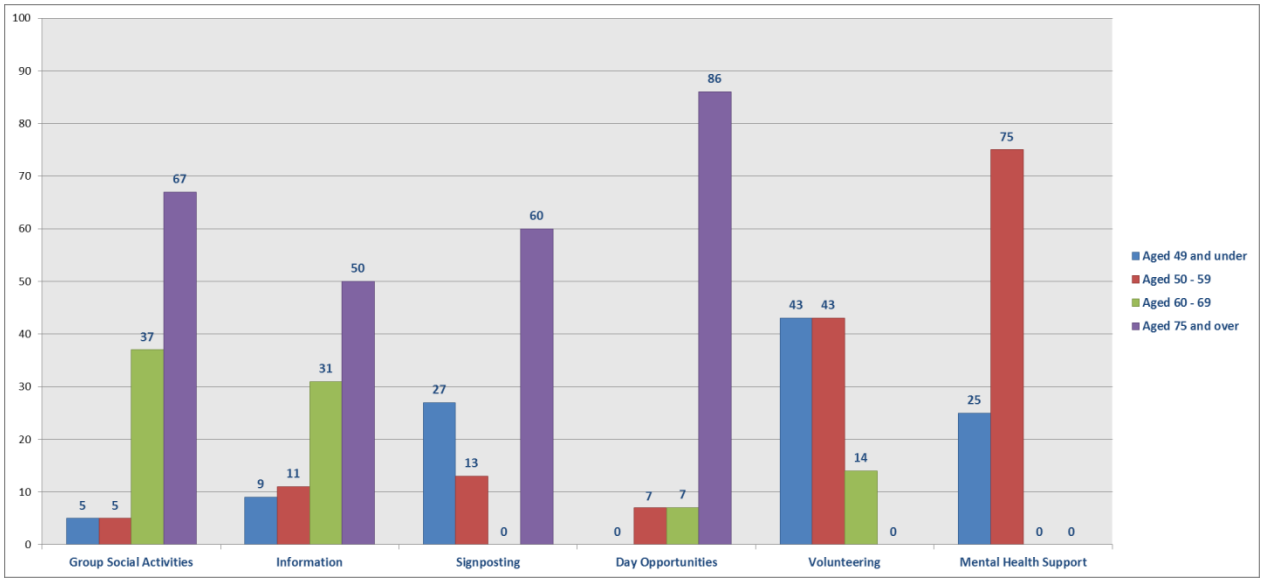
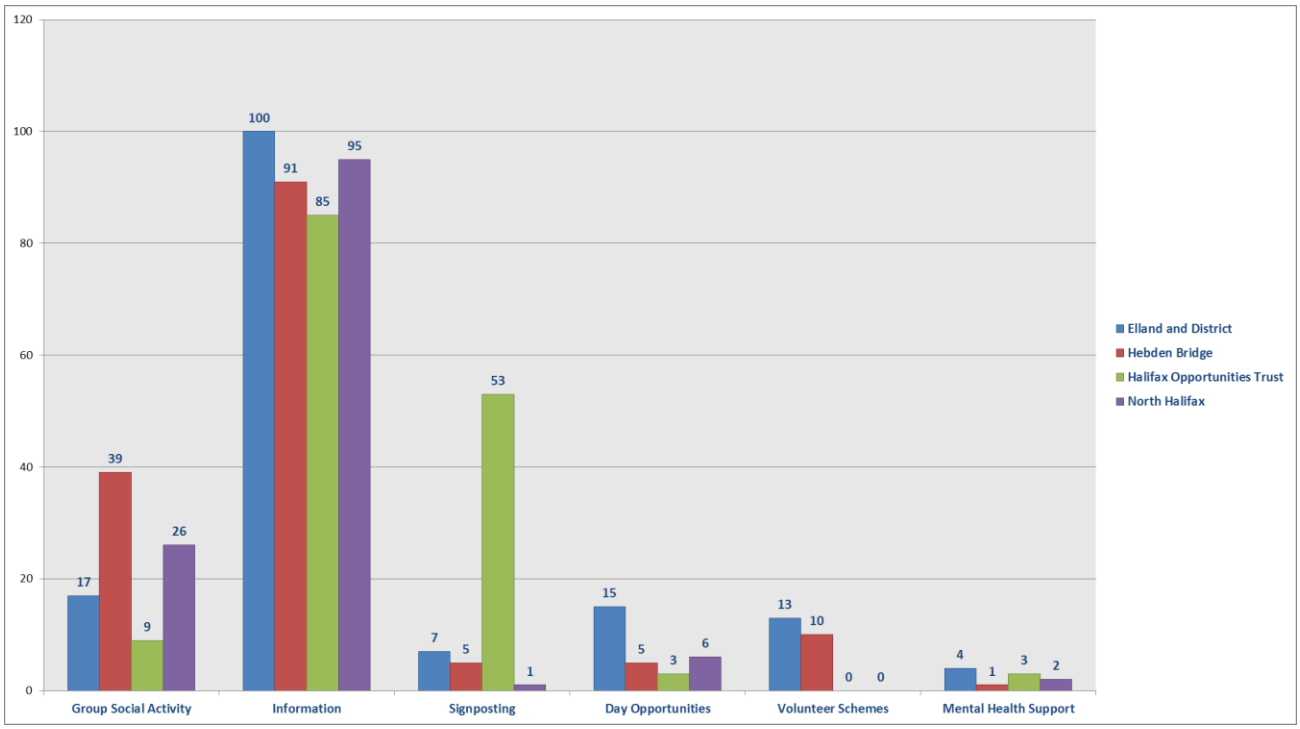


Figure 16: Services users took up by hub.



Such differences are likely to be due to the availability of provision. In the early stages of the programme, the 'market' of available services was developing, with each hub using £50,000 to support the development of specific and sustainable community provision. These initiatives were developed as a response to the needs and wants of the wider community. Different programmes and projects were put in place in different geographical areas, leading to a different pattern of referral. Similarly, it should be noted that such provision takes time to identify and develop. For example, many of the men that were referred to the

Staying Well Programme took up the opportunity of nascent 'men in sheds' programmes. Such provision was not available until at least six months into the programme.

Whilst the placement of only a third of users may seem 'low', it should also be remembered that many of the individuals seen by the hubs had high level needs and required a service that could come to them; rather than provision to which they had to travel. Financial constraints are a very real issue in many of the areas across Calderdale. From the textual reading of the case notes and, as will be discussed below, the interviews; it would seem that even the small amounts of money demanded by community transport is not available to many individuals. The extent of mobility challenges faced by user's also required services that could 'come to the individual'; befriending provision. Identified centrally as a need, further funding was made available to Halifax Opportunities Trust, Elland and District and North Halifax to set up a new befriending services. It is likely that as these develops, far more users will be taking up this particular type of service.

DEVELOPMENT OF LOCAL PROVISION: MICRO-COMMISSIONING

It has been discussed above, that part of the role of the 'Staying Well' programme was to develop community capacity in supporting older people who were lonely and isolated. One way this was carried out was to provide micro-commissioning to local existing and 'new' groups. In drawing on the interview data at the three points (early implementation, interim and exit interviews) all of the hubs identified three main areas to which the monies from the micro-commission should be directed; all of which were coterminous with the wider Calderdale MBC and CCG agenda. These were, community transport, befriending and personal care and support. Funding to address these areas was held 'centrally' and hubs could 'bid' for funds to support these services. In addition, specific local needs were identified at each 'hub' through e.g., listening exercises, commissioning exercises and

Table 4 below, details those projects by hub that have developed (and reported to the evaluation) as part of the devolved micro-commissioning process.

There were a number of initial challenges to implementing the micro-commissioning, with some 'hubs' arguing that there *'needs to be stronger trust between the funders and the people delivering at the bottom'*. The delivery of the micro-commissioning monies to the hubs took time, was *'dribbled out'* and there was a perceived lack of guidance from the centre as to how these monies should be made available to community groups and, perhaps more importantly how to monitor the *'impact and engagement'* of funded projects. This resulted in all hubs taking a slightly different approach to identifying needs in their local communities and funding specific provision.

Hebden Bridge moved quickly to set up the micro-commissioning, requesting that existing or nascent ideas for community provision write up an application to the 'hub'. A steering group was then set up to assess each application and monies were awarded to the

successful projects. Whilst many of the projects were perceived as falling into the three main areas (community transport, befriending, personal care and support), many of those 'befriending' projects more focused toward group social activities, rather than the more

traditional model of a volunteer visiting the older person in their own home. As has been discussed, the typical befriending model being funded centrally. Similarly, in Hebden Bridge, the micro-commissioning demonstrated that there was a real issue with accessibility to buildings; *'a fourth additional barrier to older people'.* Monies were provided to a number of organisations to 'age-proof' the physical fabric of buildings including wheelchair ramps, disabled parking and appropriate lighting.

In North Halifax and Elland and District the approach was slightly different. A range of initial consultations – *'local listening conversations*' - were carried out with stakeholders, residents, faith groups, local organisational steering groups and different local partnerships (e.g., Elland District Partnership) to *'identify the needs of the area, the barriers for people attending activities and the causes of isolation'.* Following such an exercise, local groups were encouraged to apply to the micro-commissioning fund. Through this, a number of existing organisations were funded to expand their provision. For example, funding for new equipment was provided to a local lunch club. More importantly, funding to the club also supported the provision of a 'carer' at each session of the club, ensuring that those with higher level needs (e.g., cognitive or serious health problems) could attend. In addition, new groups were created or developed through peer support. Elland and District supported the implementation of 'Dementia Reading Champions', recruiting local volunteers to read to people with dementia. A paucity of provision to support older men was identified and in response, the 'Men in Sheds Group' was funded. A further necessary and welcome addition to provision in both North Halifax and Elland and District was that of befriending services. For many users in these areas, their health needs (e.g., challenges to mobility) and real financial limitations demanded that any 'provision' should 'come to them'. The set-up and implementation of these befriending services in July/ August 2015 were effective in meeting the local need.

Halifax Opportunities Trust similarly arranged 'listening sessions' with residents and took a different route in applying their devolved funding. They developed their 'hub space'; building a new room that could support a range of local groups. It will be seen below (Table 5 and Figure 17) that that the majority of individuals supported by Halifax Opportunities Trust were drawn from the most deprived areas and minority ethnic communities: *When we started doing some street work in Halifax Opportunities Trust, they didn't talk about older people being lonely and isolated, they talked about women, women being stuck in the house while the men could get out*'. Setting up women's only groups as well as 'English for Speakers of Other Languages' in a 'safe space' was perceived as essential in supporting their specific community need. In addition, a 'befriending scheme' was developed as part of this 'space', *allowing South Asian women who are keen to learn English communication skills to interact and communicate with elderly white British women; both 'pairs' feel valued, more confident and have developed friendships'.*

Table 4: Developed and funded interventions or projects.

Hub	Support of existing community initiatives	New interventions
Elland and District	• Elland and District Partnership: including 'All about Elland' market. • Prospect House Social Club: to support four 'day trips' and address sustainability of the group • Elland Tuesday Club: to support 'day trips' and sustainability of the group. • Able and Disabled Club: to support funding of coach hire and sustainability of the group. • Cartwheel Lunch Club: new equipment and the employment of a carer at each session to ensure those with higher level needs could attend. • Bethesda Ladies Group: support to link members to community transport and a range of events. • 'Chit Chat Group' trips and music classes' • Clay House Park Gardening Group: funding for new equipment, financial and practical support to publicise and recruit volunteers. • Elland Golf Club T'ai Chi: initial support with marketing and funding of tutor hire. • Cross Hills Methodist Church: addressing transport issues and explore ideas for further social provision. • Community Transport Calderdale: to develop specific transport support in Elland, recruit volunteers and link together community groups.	• "It's Only Me Befriending': one-to-one befriending service for over 50s in Elland and surrounding areas. • 'Elland Transport': dedicated community transport service linked to social groups in Elland to provide free transport to and from community groups. • 'Dementia Reading Champions': providing sessions in a range of care settings (e.g., care homes, sheltered housing) and focusing on reminiscence through poetry and song. • 'Let's Just Do It for Elland': (Christmas): volunteer provided Christmas dinner. • 'Adult Brass': beginner's lessons for older people to take up an instrument. • 'Cake and Company': Coffee morning. • 'Staying Well trip's: Six assorted trips throughout the year including e.g., theatre, flower shows, concerts. • 'Church House Games afternoon': weekly games activity. • 'Southgate Holiday at Home': three days of activities themed around different holiday destinations. • 'Restart Fitness': weekly exercise group for female cancer patients/ survivors. • 'Diabetic Support Group': weekly support group for diabetics. • 'Staying Well Games Morning': weekly games morning. • 'Sing Out Loud': fortnightly singing group for individuals living with dementia. • Wheel Chair Enabling Society: peer to peer support across the group and for those with disabilities.

Table 4/ Cont.: Developed and funded interventions or projects

Hub	Support of existing community initiatives	New interventions
Hebden Bridge	• 'Age-proofing' buildings. • 'Heptonstall Village Team': luncheon clubs, social themed events and day coach trips. • A range of lunch clubs. • Group social activities: including support and facilitation to: Cake and Conversation' social group, Chatty Crochet, Chatty Café, Allsorts.	• 'Café Culture': a monthly group • 'Saturday Tea Time Classics': at the Hebden Bridge Picture House. • 'Film Club': Luddendenfoot Civic Institute. • 'Physical exercise groups': e.g., Pilates. • 'Tea and IT groups': weekly groups to ensure older people are able to access a range of computer programmes. • 'Cake and Conversation': a weekly social group activity. • 'Arts and Crafts': a range of weekly groups. • 'Gardening Group': a weekly group for all those interested in gardening. • Singing groups (e.g., Singalong with Jon). . • Drama Groups (e.g., Washday workshops).
Halifax Opportunities Trust	• Extending the 'hub space' to include a dedicated community room.	• Dementia awareness social activities. • Women's circle • Chit Chat group and gentle exercise • Cooking classes (Asian and English) • Diabetes awareness groups (including exercise and diet) • Befriending scheme • Luncheon clubs • Asian women cycling groups • IT group.
North Halifax	• Lunch clubs • Physical exercise support (e.g., fitness classes, dance classes)	• Men's only group • 'Men in sheds' • Phoenix Radio • Dementia Café • Chit chat clubs and coffee clubs.

BARRIERS AND FACILITATORS TO THE DELIVERY OF THE PROGRAMME

The early implementation interviews highlighted a number of barriers to setting up and ensuring delivery of the 'Staying Well' programme. These included the overall management structure, concerns around duplication and necessary learning between organisations; all underpinned by early communication challenges.

A number of participants stated that there was a lack of clarity around the management structure. In the early stages of the programme, participants felt that they were working to a *'top-down hierarchical structure'.* Whilst there was a named single project manager, participants argued that the lines of accountability were still blurred and unclear. Some participants stated that they perceived the real authority in delivering the programme and subsequent objectives lay in other senior individuals from across the different organisations, (Calderdale MBC, Calderdale Local Authority and the existing Neighbourhood Scheme Teams), as well as that of the Steering Group. Such perceived diffuse authority was seen as contributing to the different and changing emphases around the aims and objectives of the programme. At a very basic level, some participants argued that their job descriptions and roles and responsibilities bore no resemblance to the job that they had become tasked with. This lack of shared clarity as to the programme structure and processes was seen as resulting in a number of *'extremely frustrating'* delays in necessary early decision-making. For example, whilst it was recognised that part of the role of the programme was to enhance and support community capacity, there were delays in deciding how the micro-commissioning would be devolved to the 'hubs' or indeed how this should be structured and monitored. As we have discussed, this led to the hubs adopting different mechanisms in devolving the monies to community organisations. Some participants argued that this lack of defined project management and overall guidance from the centre resulted in them having to *'unravel an extremely complex tangled ball of string*'; the necessary work around individual structures and processes taking up much of the first nine months.

Perhaps the greatest barrier stemming from this perceived 'hierarchical structure' was the placement of the 'Staying Well' programme workers. As we have described above, all were employed by Calderdale MBC yet, placed in locality area 'hubs'. All the workers were required to be part of the 'hubs' and to work closely with their NST colleagues, yet the responsibility for on-going tasks and roles was centrally managed. This led to the 'Staying Well' workers feeling that they were being pulled in two directions, unclear as to from whom they should take direction. As the 'Staying Well' staff became further embedded into the hubs, working effectively with their colleagues and communities, this lack of clarity did dissipate as the programme moved forward; *'we began to ignore all of the strategic and managerial confusion and misdirection and just got on with it'*.

It was argued by some participants that the lack of clarity around management and consequent focus of the 'Staying Well' programme led to duplication of provision. One participant used the example of social prescribing, whilst others applied the range of befriending services to demonstrate the lack of *'a common agenda or pooled resources'.* In the former, it was discussed that North Bank Forum were awarded £50,000 as part of the 'Staying Well programme' to provide volunteer social prescribers in GP surgeries. In addition, it was argued that the 'Staying Well workers' were required to work closely with their GP practices, that the NHS already had 'Community Champions' working out of the

same surgeries as the volunteer social prescribers and that the local South West Yorkshire Partnership NHS Foundation Trust were carrying out similar activities to signpost and support user's well-being: *'There are five different approaches to Social Prescribing, which is daft'.* Similarly, a number of participants stated that although monies were to be made available to support 'befriending', there were already existing schemes that were not being appropriately accessed or used.

It was recognised by participants that many of the early implementation challenges arose from the different structures and processes of the disparate organisations. In the early stages, each organisation, health, social and third sector care, wished to continue to apply their 'normal' operational procedures. This meant that each organisation was at points resistant to their colleagues' ways of working: *'What we are finding is when we start to set up things, there is a level of resistance because [other organisations] are not used to our way of working, so then suddenly their decision-making stops and it is very hard to unblock the blockages'.* Whilst this finding reflects the implementation of similar innovative programmes (e.g., see Forder et al., 2012, Windle et al., 2009) the necessary learning required to implement effective multidisciplinary programmes substantially adds to the implementation time-frame.

The challenges described above were perceived as compounded by the lack of communication across the programme. *'We have no form of communication, so we don't know what each other are supposed to be delivering'.* Again, such findings are far from unique. Ensuring appropriate communication channels and identifying individuals is often a 'work in progress' in the early stages of implementation (Windle et al., 2009; Glendinning et al., 2008).

However, despite these early implementation barriers, the interim interviews (undertaken a year after the start of the project) described a very different picture: *'It felt like we were treading water for a while, but it feels as though a dense fog has cleared*'. From analysis of the interim interviews, it would seem that the main reason for such a change was that the responsibility for delivering the project outcomes had been devolved to the four hubs: *'There was no clarity of roles or responsibilities initially, but since the responsibility now rests with the hubs, I think everyone is quite clear on what needs to be done'.* However, the movement of such responsibility from the 'centre' to the hubs took 10 months which *'caused a lot of friction and left us [the hubs] quite vulnerable'.*

Whilst there was a recognisable delay in implementation, the 'Staying Well' staff and the wider hubs had started to shape and deliver local provision that reflected the needs of the communities. Closer relationships with the local communities had been developed and new partnership, with the GP surgeries and police had been set-up. Those concerns that were discussed were focused more on how best the hubs could support individuals and wider communities, in particular how they could negate the perception of *'flash-pan projects that provide money and support which then disappeared'.* The focus in the interim interviews was on sustainability of the programme and its projects. Nevertheless, the majority of the participants recognised the short project time-frame to achieve a wider culture change across communities: *'The project has not been run for long enough, whilst we've started the process it needs a lot more time to work through and for people to perceive things to be better'.*

At the time of the final interviews, the successes of the 'Staying Well' programme were detailed. Participants emphasised the huge amount of work that had been carried out in building community capacity. Similarly, they discussed the 'successes' in supporting older people to identify and attend activities, managing and mitigating social isolation and loneliness (see

Table 4). However, there were still concerns from some participants that whilst some responsibilities had been devolved, decisions were continued to be made centrally, with the hubs consulted at a later stage. *'It has been a lesson learned time and time again through this project – if you don't talk to us early on enough it won't work, you need to talk to the people who are operationally delivering the project rather than having a meeting at some strategic level and saying what we just do'.*

A continuing barrier throughout and discussed by the majority of participants was the lack of a robust relationship with GP practices. In the initial interviews, the proposed relationship with GPs was welcomed by participants, recognising them as a central partner to achieving the primary outcome, a reduction in loneliness and social isolation. Whilst the 'Staying Well' workers slowly developed relationships with their local GP practices (Elland and District, North Halifax and Hebden Bridge), the proposed full involvement of GPs across the hubs did not materialise. *'All of a sudden in the dying throes of the programme, a handful of GP surgeries are on board and have identified 1,600 individuals on the frailty index – it's just laughable'.* However, such cooperation was only achieved through providing financial 'incentives'; five GP practices being paid to run the electronic frailty index against their practice list in order to emerge those patients that could be referred to the 'Staying Well programme'. Participants recognised that such incentives were valid in ensuring identification of users as well as implementing and improving better relationships with the GPs. However, many questioned the time-frame of such an initiative: *had this come at the start of the project – absolutely brilliant, but doing this now opens us up to real reputational damage'*.

The main strength and facilitator to the programme was the close working relationships in and between the 'hubs'. It would seem that the developing relationship with the wider community ensured perceived achievement of some of the core aims; in particular, the ability to sustain the community development following withdrawal of funding. *'The collaboration between the hubs has been quite unique and a powerful influence in how things need to be done as well as seek some form of sustainability for what has been achieved'.*

SECTION TWO: ACHIEVING THE PROJECT AIMS

The projects were tasked with a number of outcomes; reducing individual social isolation and loneliness, improving individual well-being, improving intersectoral systems and supporting the move toward cohesive and connected communities. The following sections report against these aims.

IMPROVING USER OUTCOMES: LONELINESS, SOCIAL ISOLATION, QUALITY OF LIFE, HEALTH-RELATED QUALITY OF LIFE AND CHANGES IN DEMANDS ON PRIMARY CARE.

INTRODUCTION

In exploring the impact of the programme on users, data is drawn from the questionnaire that was administered to the user at introduction to the programme and four months later (see Appendices). The questionnaire included a range of validated measures:

- a scale to assess levels of loneliness and social isolation (de Jong Gierveld and Kamphuis, 1985)
- a measurement of social networks (Lubben and Gironda, 2004)
- a measure of perceived quality of life (Bowling et al., 2002); and
- the EQ-5D to measure health-related quality of life (Dolan et al., 1995).

In addition, a number of questions were added to assess if change in service use was seen (e.g., GP appointments, visits from the community nurse) and a range of demographic items recorded (e.g., marital status, permanent accommodation, work status).

The questionnaire was completed at base-line (introduction to the programme) by 375 individuals. The follow-up questionnaire necessarily suffered from attrition, users either 'dropping out' of the programme or facing deteriorating health and well-being. The final sample of users across the programme who completed a questionnaire at two time points was 192 (51%).

Five outcomes were explored as part of the evaluation and these are reported below, following a discussion of the overall demographics and number and type of reported long-term conditions.

- Changes in reported loneliness
- Changes in reported social isolation
- Changes in health, health status and health-related quality of life;
- Changes in quality of life; and
- Changes in service use.

DEMOGRAPHICS: DEPRIVATION, AGE, SEX, ETHNICITY, MARITAL STATUS, ACCOMMODATION.

Whilst one of the central aims of the 'Staying Well in Calderdale' programme was to alleviate, mitigate and prevent social isolation and loneliness, there was also a recognition that the project should 'break down barriers'; ensuring those users most usually excluded were identified and bought into the different projects and provision (e.g., BME communities, most deprived communities). The project was effective in ensuring wide inclusion, with over half of the users (55%) drawn from the most deprived areas (see Figure 17).

Deprivation, perhaps not surprisingly given the range of geographical locations, differed across the hubs. However, there are still indications that the programme workers proactively targeted those areas of social deprivation. For example: in Elland and District, over half (58%) were drawn from the most deprived areas; in North Halifax over three-quarters (79%) were resident in the most deprived areas whilst in Halifax Opportunities Trust almost the total sample (81%) were resident in the most deprived areas as measured by the Index of Multiple Deprivation. Even in Hebden Bridge, perhaps the least deprived area, over a third of the sample (36%) were drawn from more deprived areas (see Figure 17 and Figure 18).

Figure 17: Users living in deprived areas (%)

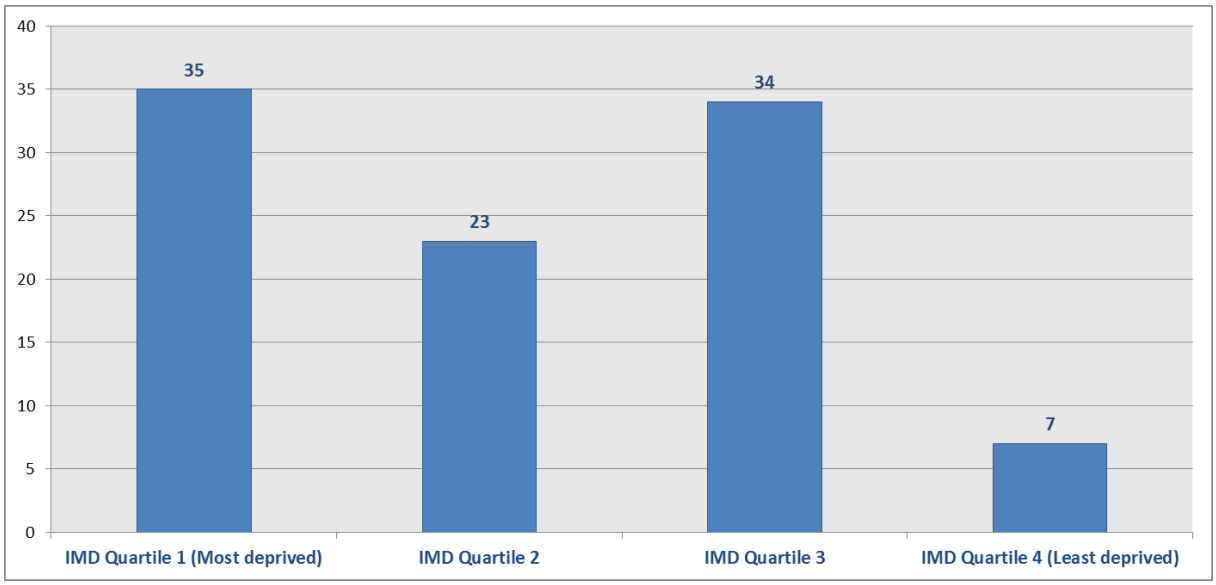
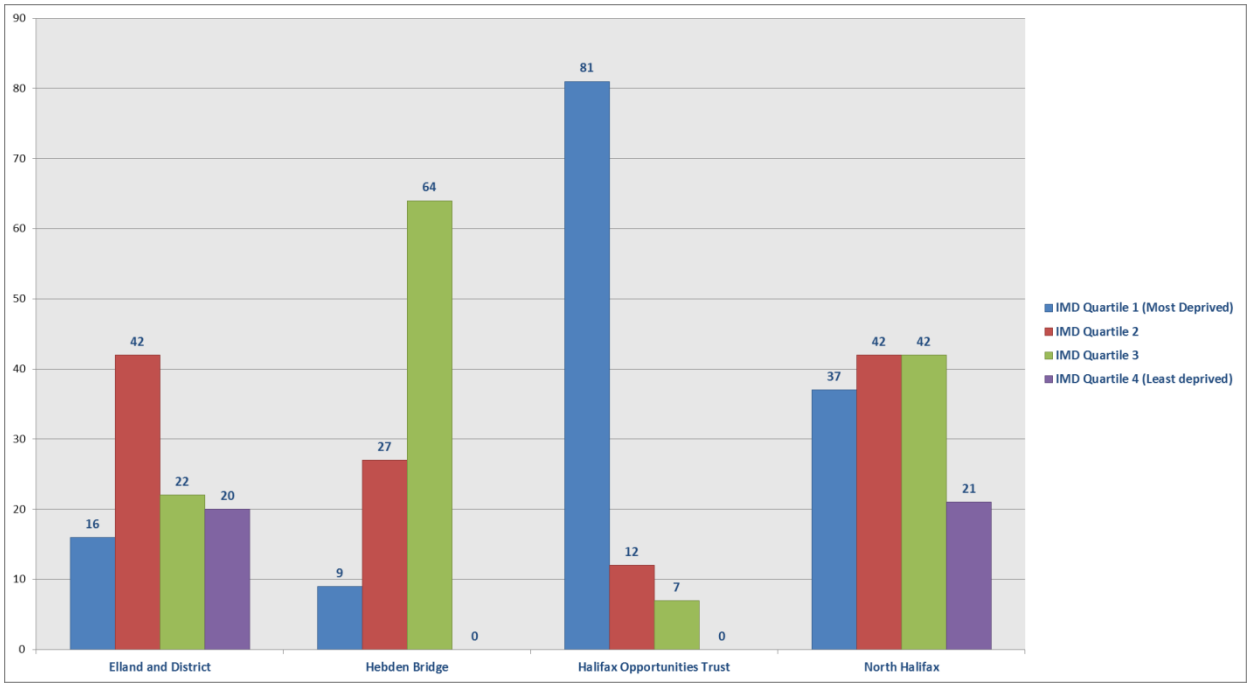
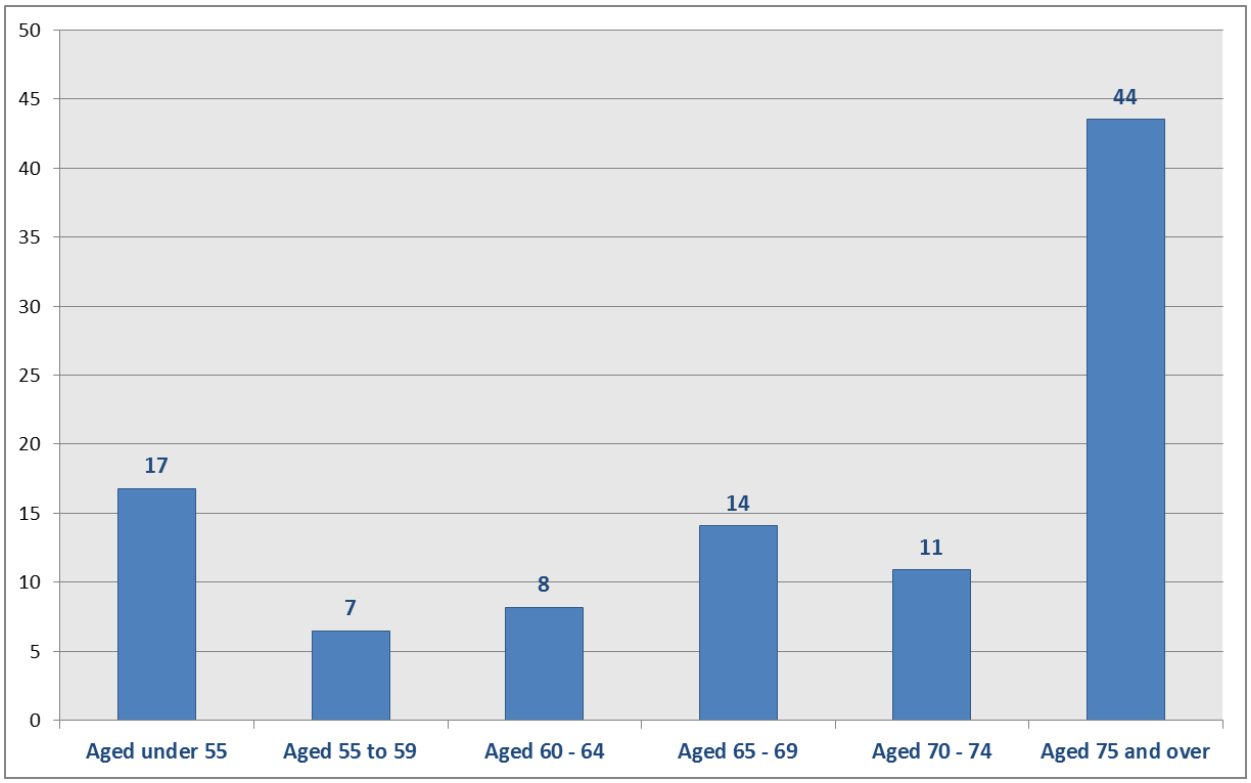


Figure 18: Users living in deprived areas by hub (%)



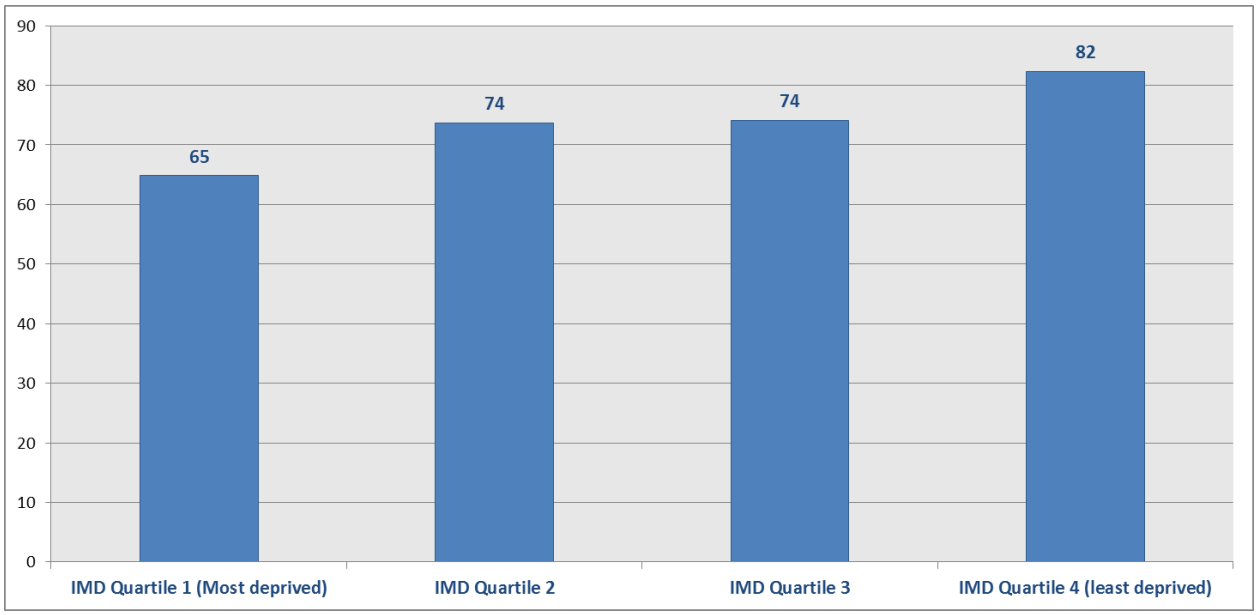
Over three quarters of the sample (77%) were aged 60 and over, with one in four aged 75 and over (see Figure 19)

Figure 19: Age range of users (%)



It was found that older users were more likely to live in areas of lesser deprivation. As will be discussed in exploring the outcomes, deprivation has an impact on e.g., levels of loneliness, social isolation and health-related quality of life.

Figure 20: Deprivation by mean age.



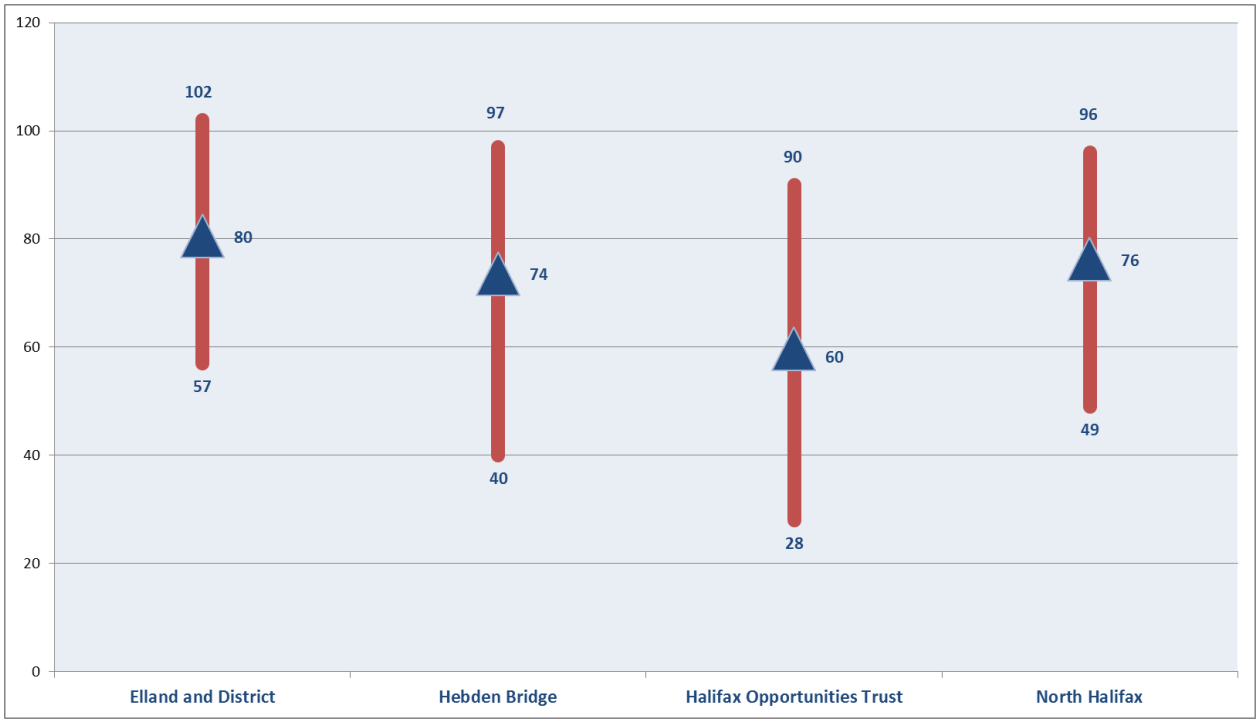
F(3) =8.502, p=<0.001

The age of users differed across the hubs (Figure 20). Elland and District worked with the oldest 'old' (mean age of 80), Hebden Bridge and North Halifax had a similarly older population (mean age 74 and 76 respectively) whilst Halifax Opportunities Trust worked with a younger population (mean age of 60). In comparing Halifax Opportunities Trust with their hub partners, users were 20 years younger than those in Elland and District (p=<0.001), 13 years younger than those in Hebden Bridge (p=<0.001) and 16 years younger than those in North Halifax (p=<0.001).

Almost the total sample who completed the questionnaire at two time points were women (85%), although this did differ across hubs (Figure 21 and Figure 22, below). For example, in North Halifax the perhaps more usual, one third/ two-third division was seen, with 25 per cent of the questionnaires being completed by men. This finding is slightly different from those users that the hubs worked alongside (see, Figure 8, above), with fewer men completing the questionnaire at two time points.

Just over three-quarters of the sample (76%) were White British or White other, with a further fifth identifying as Asian or Asian British Indian (1%), Asian or Asian Pakistani (20%) or Asian or Asian British Bangladeshi (1%). Given the placement of the 'Staying Well' workers, there are obvious differences across the hubs. In Elland and District, Hebden Bridge and North Halifax almost the total sample identified themselves as 'White British or White other. In contrast, 75 per cent of those users drawing support from Halifax and who supported to complete the questionnaire, identified as Asian or British Asian (see Table 5).

Figure 21: Mean age of users by hub.



F(3) =25.176, p=<0.001

Figure 22: Sex by hub (%).

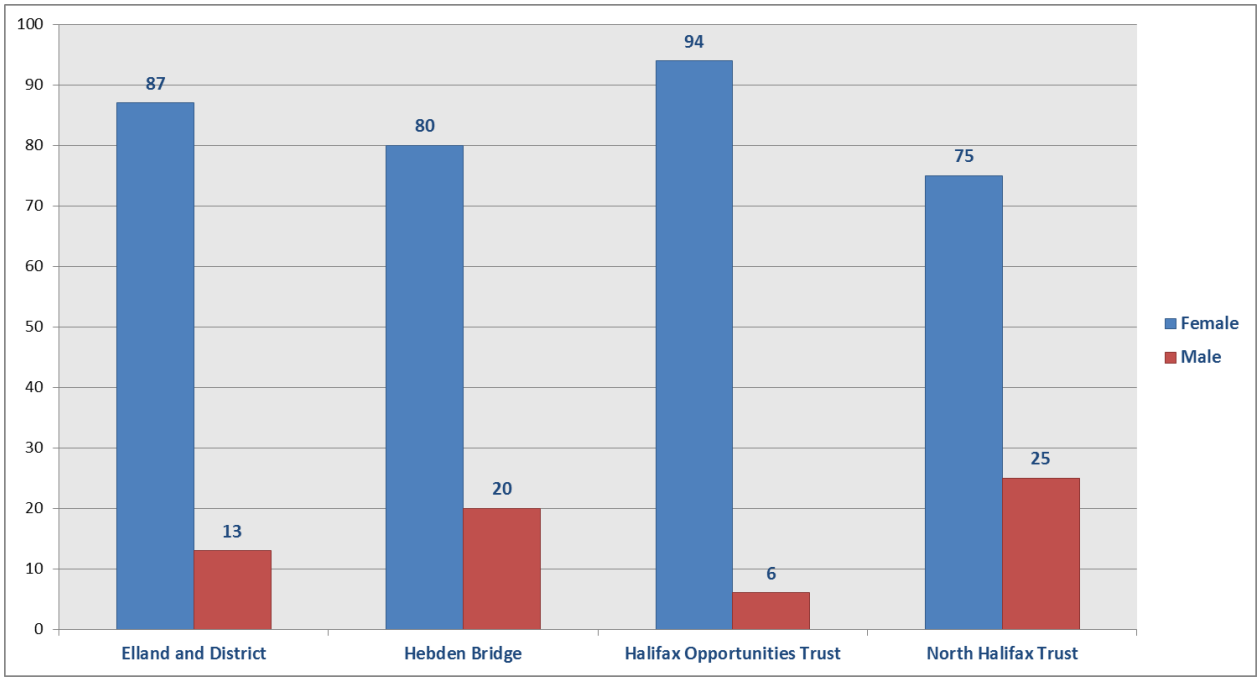


Table 5: Ethnicity by Hub

Hub	White British or White Other % (n)	Asian or British Asian % (n)
Elland and District	98 (42)	2 (1)
Hebden Bridge	98 (64)	2 (1)
Halifax Opportunities Trust	25 (14)	75 (41)
North Halifax	24 (100)	0 (0)
Totals	**77 (144)**	**23 (43)**

The questionnaire also requested users to indicate their marital status. This particular question was included as we know from prior research that those individuals who are single, divorced or widowed are more likely to become lonely or socially isolated (Cattan et al., 2003; Windle et al., 2009, Windle et al., 2010). Almost two-thirds of the sample (64%) identified as single, divorced or widowed, indicating that support was being provided to the appropriate population (see Table 6).

Table 6: Marital status of those users that completed the questionnaire, % (n).

Marital Status	% (n)
Single / never married	9 (17)
Married	32 (61)
Widowed	41 (79)
Divorced	14 (27)
Totals	96 (184)

Over half of the sample reported that they 'lived alone' (58%) with a further, almost one in 10, living with a family member. A third of the sample lived with their spouse (see Table 7). No differences were found between the hubs.

Table 7: Living status of those users that completed the questionnaire.

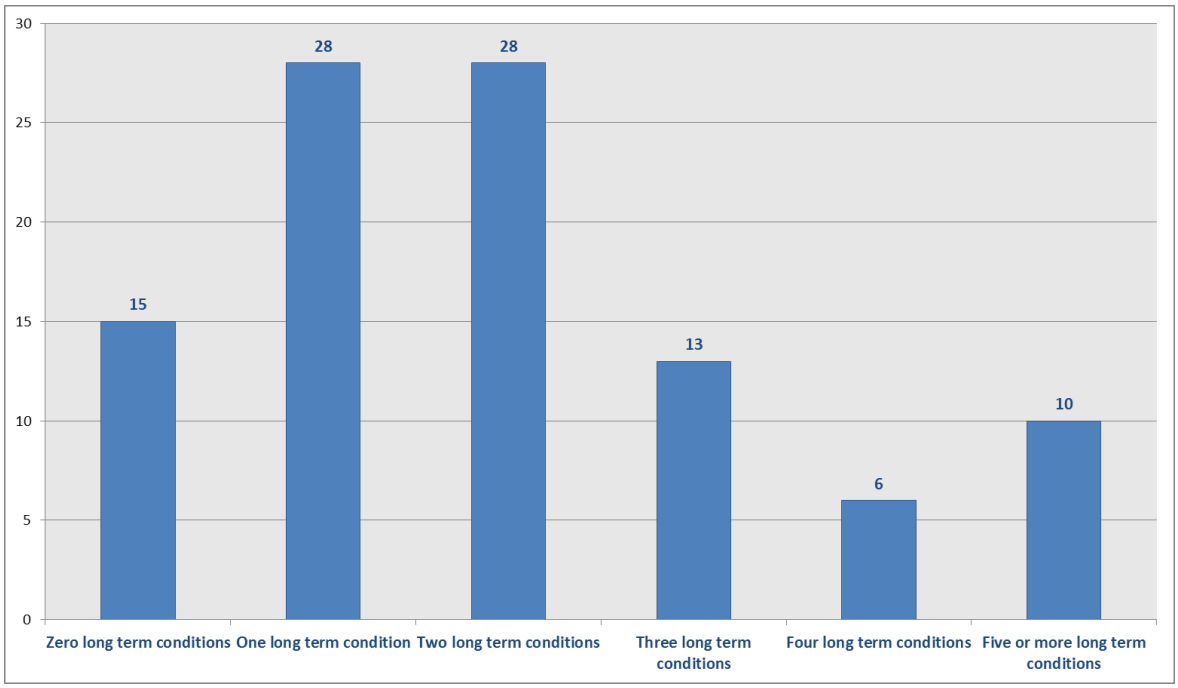
	% (n)
Lives Alone	58 (108)
Lives with Son/ Daughter or Parents	17 (9)
Lives with Spouse or Partner	32 (60)
Totals	100 (185)

Finally, we asked users to state their type of accommodation. Again, this gives an indication of risk of loneliness and social isolation as well as identifies those individuals who may be at particular risk owing to 'transitory' or 'temporary' accommodation. However, almost the total sample lived in their own housing, with 10 per cent reporting that they were tenants of a registered social landlord. There were some (non-significant) differences across the hubs, with slightly more individuals drawing support from Halifax Opportunities trust as tenants of a social landlord. However, such a finding is likely given that Halifax Opportunities Trust has higher levels of deprivation when compared with their other hub partners (see Figure 18, above).

LONG-TERM CONDITIONS

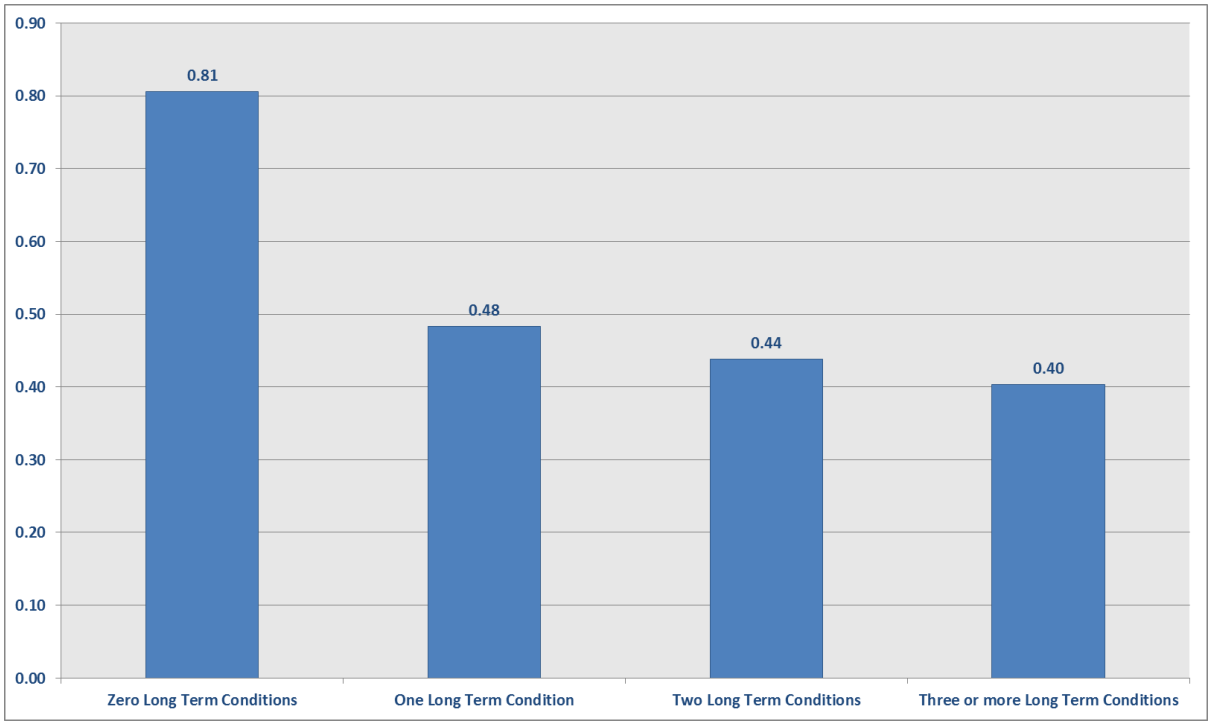
Loneliness and social isolation is likely to be affected by the levels of mobility an individual may have, as well as their levels of health. Long-term conditions are becoming the 'norm' for individuals over 65 (Fortin et al., 2004) and our sample demonstrated this. Over three-quarters (85%) reported at least one long-term condition, over half (57%) reported two or more long conditions, with almost a third (29%) stating they had three or more long-term conditions (see Figure 23).

Figure 23: Number of reported long-term conditions.



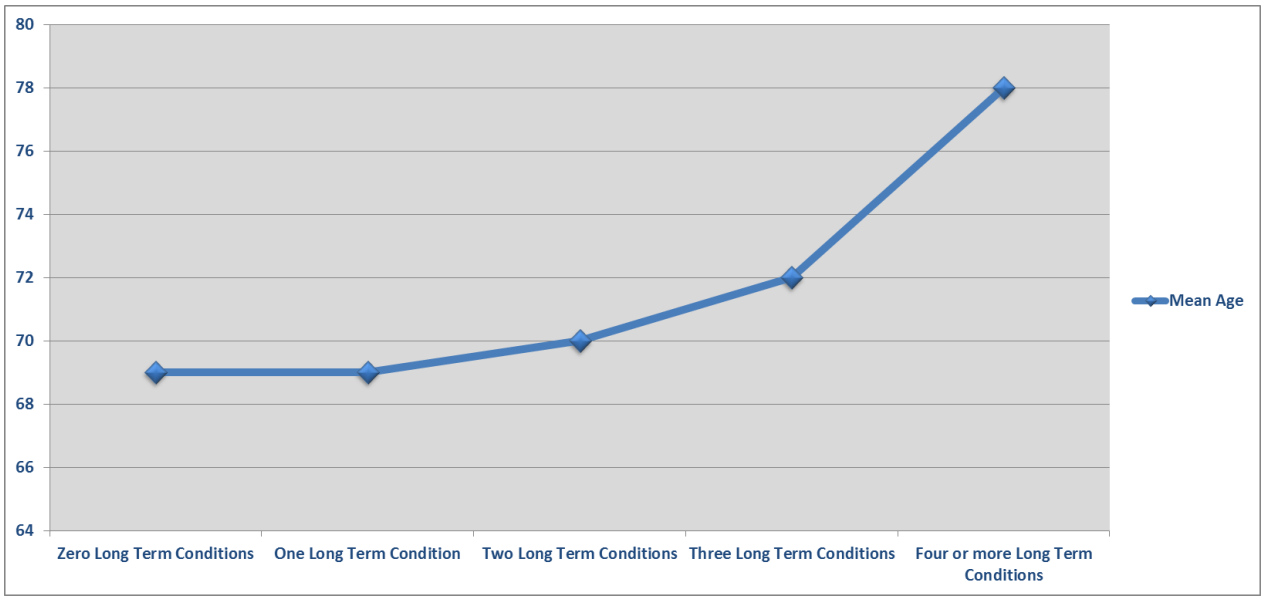
The effect of long-term conditions on health-related quality of life is clearly demonstrated in this sample. As can be seen from Figure 24, (below), those with no long term conditions report 81 per cent of 'perfect health' (0.81) as compared with 48 per cent of 'perfect health' reported by those with one long-term condition; a 40 per cent deterioration in health-related quality of life.

Figure 24: Health-related quality of life (EQ-5D) by number of long-term conditions.



As would be expected, the age of the individual affected the extent of long-term conditions; the older the user, the greater the number of reported long-term conditions (Figure 25).

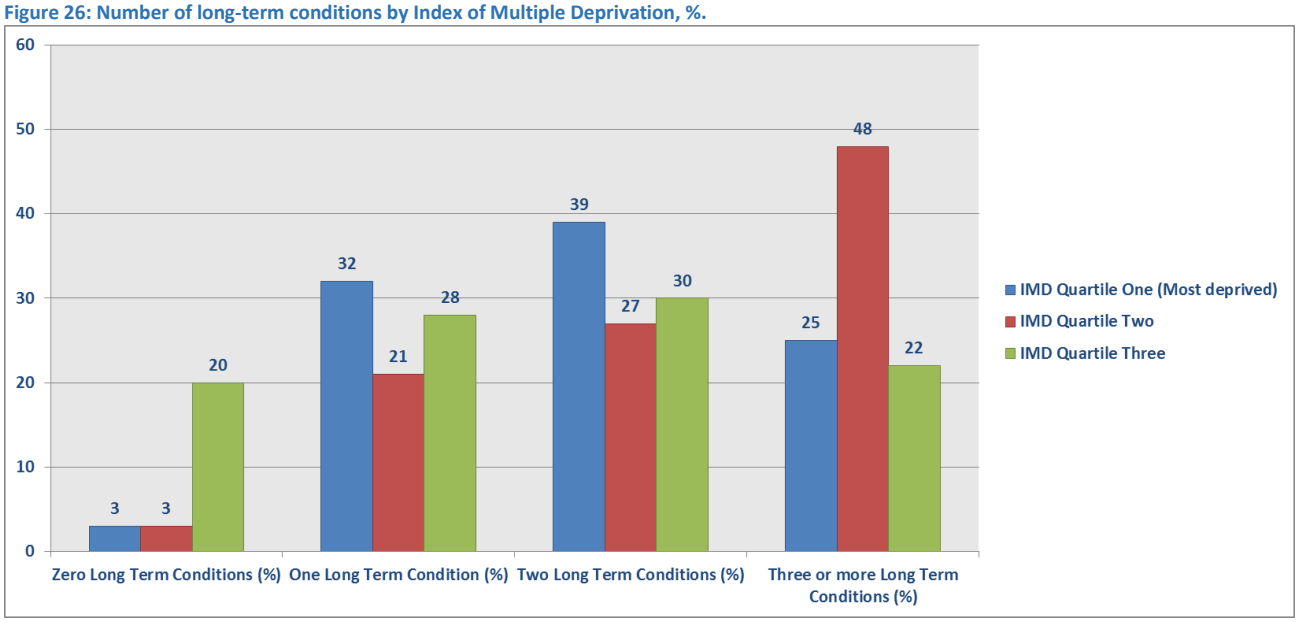
Figure 25: Age by number of long-term conditions.



Deprivation has long been known to affect the health and well-being of individuals (Marmot and Wilkinson, 1999; Marmot, 2010). In exploring the number of long-term conditions reported against the level of deprivation (see Figure 26, below) it was found that a greater proportion of those users living in the most deprived areas (IMD Quartile One and Two), reported more long-term conditions; almost the total sample (97%) reporting one or more

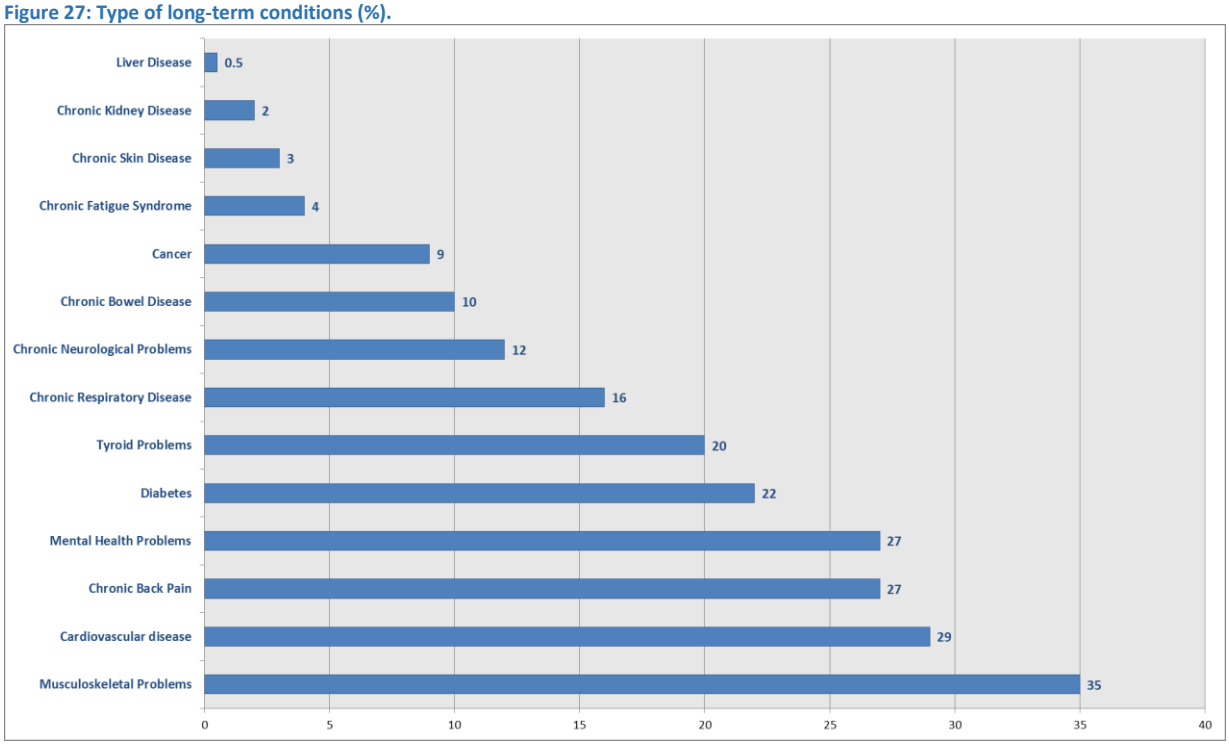
long term conditions. In comparison, a fifth (20%) of those living in a less deprived area reported no long-term conditions.

Figure 26: Number of long-term conditions by Index of Multiple Deprivation, %.



Users were asked to indicate the 'type' of long-term condition with which they were living. It can be seen from Figure 27, that over a third of individuals reported musculoskeletal problems (35%), almost a third had been diagnosed with some form of cardio-vascular disease (29%), over a quarter were living with mental health problems and over a fifth had diabetes (22%). Musculoskeletal problems and cardiovascular disease are both likely to limit mobility, leading to a higher risk of social isolation or loneliness. Similarly, those living with mental health problems may find 'plugging into' social support systems particularly difficult.

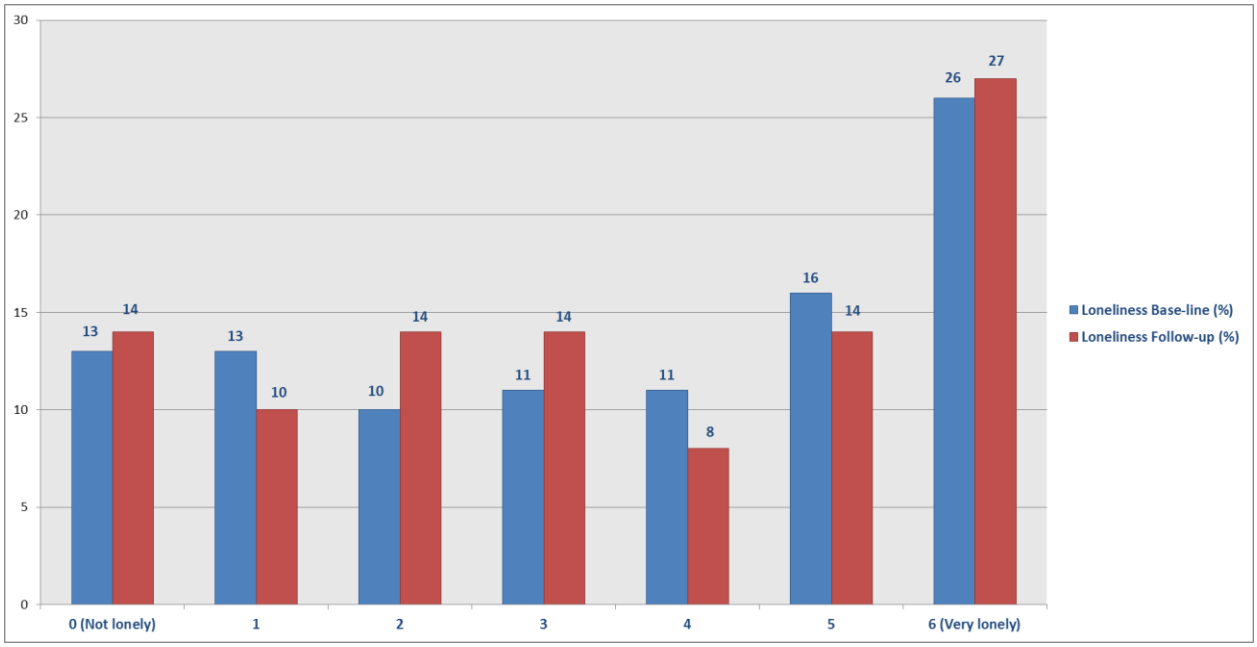
Figure 27: Type of long-term conditions (%).



CHANGES IN LONELINESS

The changes in loneliness were recorded through the use of the de Jong Gierveld Loneliness scale (Geirveld and Kamphuis, 1985). This scale runs from 0 (not lonely) to six (very lonely). At base-line, almost two-thirds of the sample (64%) identified themselves as lonely or very lonely (scoring three or above). At follow-up, this had fallen to just over half the sample (53%), a fall of 17 per cent (see Figure 28). However, such a change was not statistically significant. It was found overall that the mean 'score' fell slightly from 3.60 to 3.41. However, again, this was a non-significant change.

Figure 28: Overall changes in loneliness (%, weighted).



In exploring the changes in loneliness by hub, it can be seen that three of the four hubs were successful in reducing loneliness (see Figure 29). A statistically significant reduction in loneliness was seen in the Elland and District hub (t (41)=2.215, p=<0.04). However, it should be noted that despite little change seen in Halifax Opportunities Trust, the users had a greater number of long-term conditions and lived in areas of higher deprivation. It can be seen that as deprivation decreases, the levels of loneliness similarly decrease (Figure 30).

Those living in slightly less deprived areas not only have lower levels of loneliness, but for those living in IMD Rank Quartile 2 and Quartile 3, there is a positive change in loneliness. Those living in the least deprived areas are older (see Figure 20) and similarly have a greater number of long-term conditions (see Figure 25); both factors likely to affect how quickly loneliness can be ameliorated.

Figure 29: Changes in loneliness by hub (weighted).

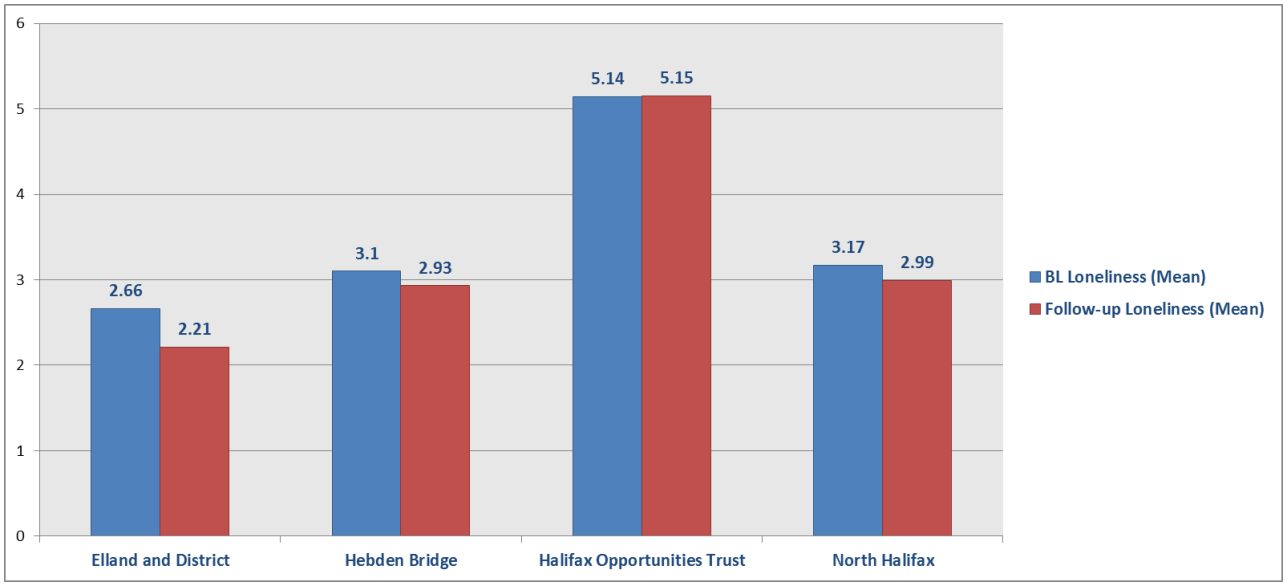
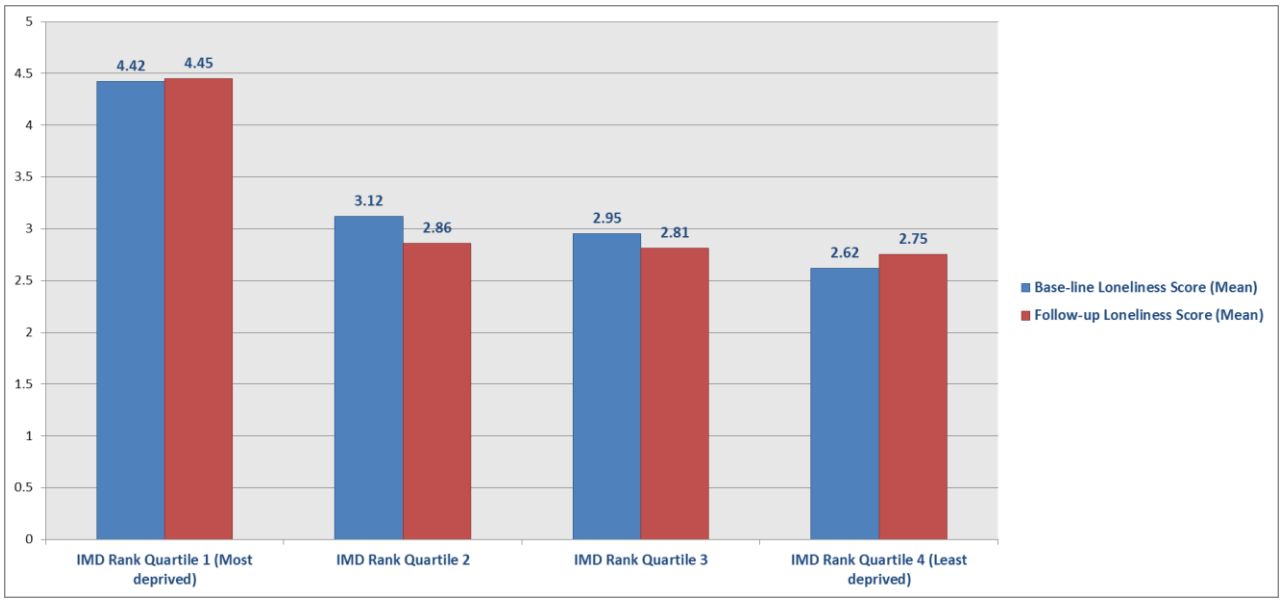


Figure 30: Changes in loneliness by levels of deprivation (mean).

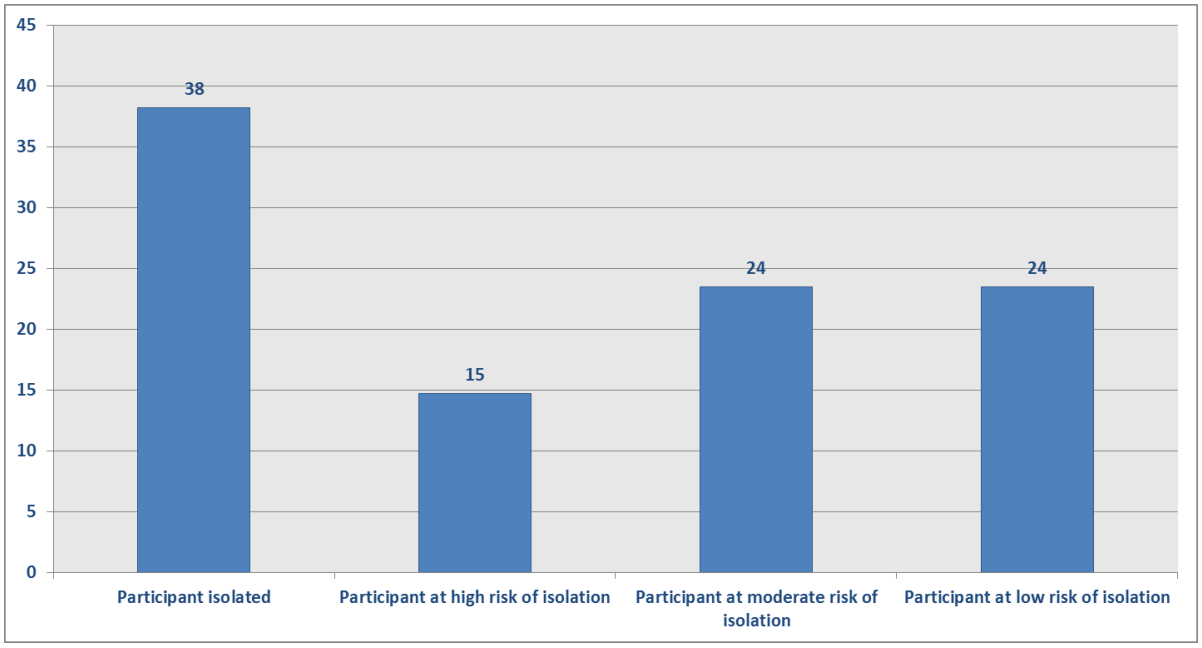


***F*(3) =29.768, p=<0.001**

CHANGES IN RISK OF SOCIAL ISOLATION

To assess how far the programme (and projects) was able to change user's risk of social isolation, the Lubben Social Network Scale was used (Lubben and Gironda, 2004).
In exploring the base-line risk of social isolation, it can be seen from Figure 31 that over two-thirds of the sample (71%) were either isolated, at high or moderate risk of isolation. Less than a quarter (24%) were at low risk.

Figure 31: Base-line risk of social isolation (%)



Differences were seen across the hubs at base-line (Figure 32). In Halifax Opportunities Trust, over three-quarters of the sample were either isolated or at high risk of social isolation. Similarly, in North Halifax, over two thirds (67%) were isolated or at high risk of isolation.

However, despite the extremely hard work that staff carried out with users and the wider community; little change was found (see Figure 33). For those participants who reported that they were isolated or were assessed as being at high risk of isolation, just over 1 in 10 'moved' to be at moderate or low risk. That is, of the 85 individuals (100%) who were isolated or at high risk of isolation, 10 individuals (12%) were at moderate or low risk following the intervention, with 75 individuals (88%) remaining either isolated or at high risk of isolation. Similarly, of the 41 individuals (100%) who were at moderate or low risk of social isolation at base-line; 19 users (46%) were assessed as either being isolated or at high risk of isolation following the intervention. That is, they became more (rather than less) isolated.

Figure 32: Risk of social isolation at base-line by hub (%)

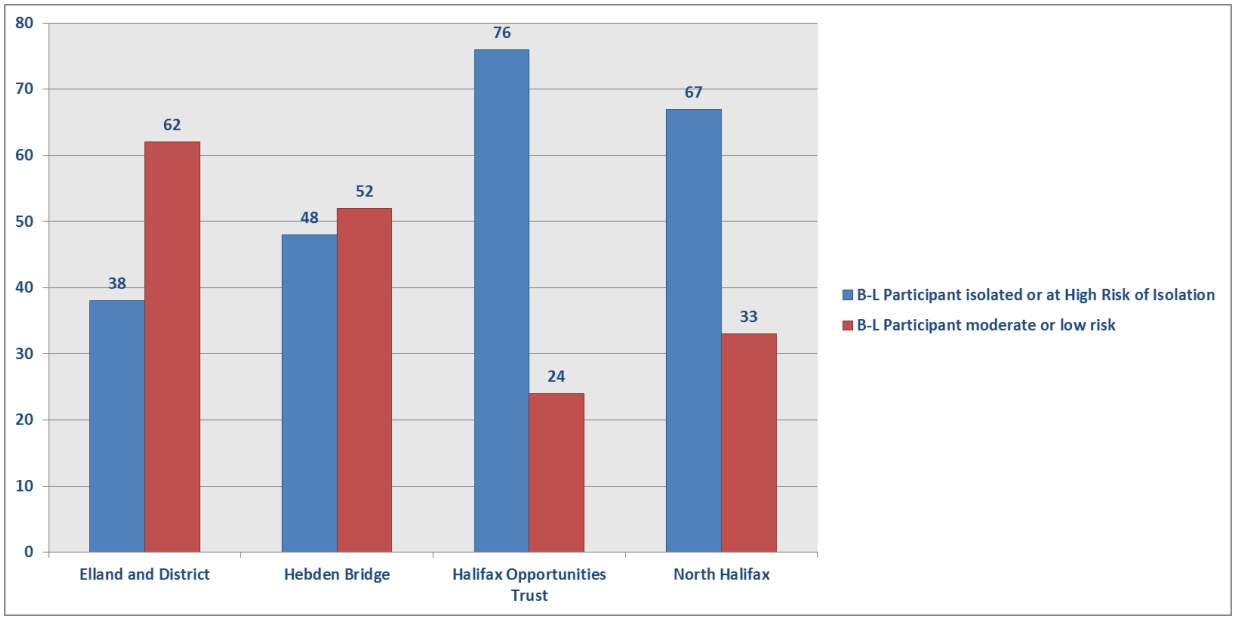
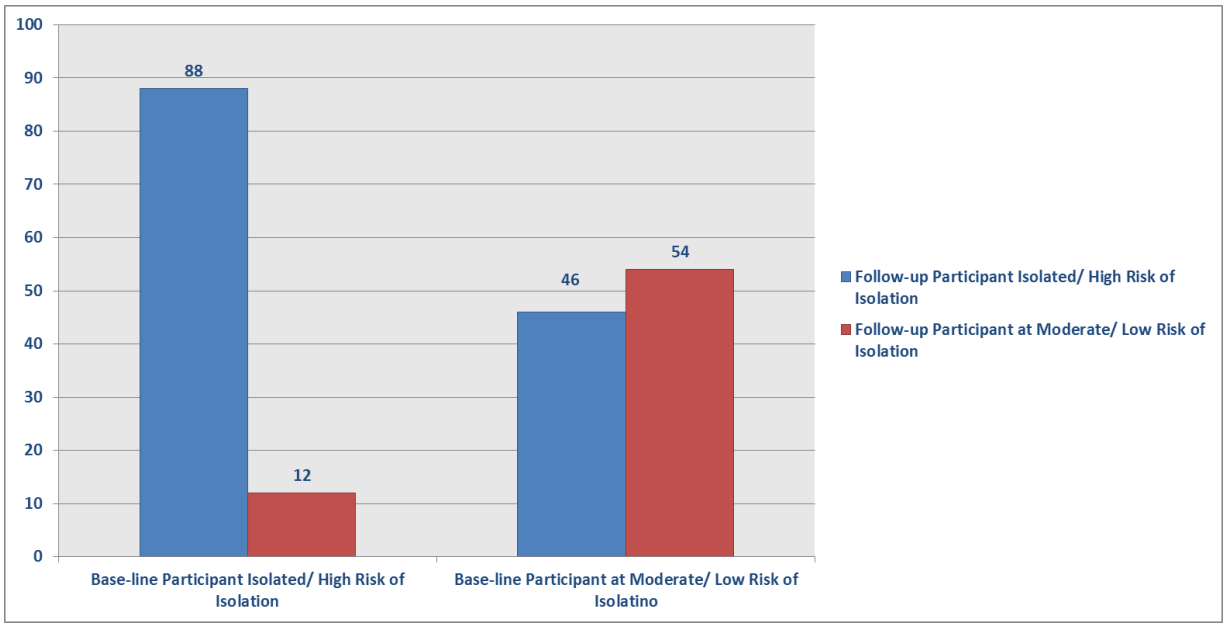


Figure 33: Changes in risk of social isolation, base-line and follow-up (%).



***Fisher's Exact Test*, p=<0.001**

It can be argued that such limited change is due to the multi-factorial nature of social isolation. For example, if individuals had discussed their needs with a 'Staying Well' worker, but had yet to be placed in an intervention (or indeed had selected to 'opt-out'), they may have become more aware of their social isolation. As such, users may have been more willing to 'admit' their levels of social isolation and perhaps respond more 'accurately' (or honestly) in the questionnaire. A further rationale can be found in the overarching delays in developing the market of services; at least six months after the 'Staying Well Programme' had started. As a hub worker commented: *'the [project] has been running for the last six to eight weeks, but it should have been available eight months ago. It took almost two months to secure a decision from Calderdale to even establish the scheme'*. Similarly, although

community transport was extended, with many hubs making links with different organisations, this again was delayed.

As we discussed above, (see Figure 19), over four in ten of the users that completed the questionnaire were aged 75 and over and, of these, over half the sample (58%) reported two or more long-term conditions. Their age and likely mobility will limit how far they can be integrated into existing or new well-being services. As a Staying Well worker argued: '*The reason for the befriending scheme is that you can throw community groups and transport at people, but sometimes there are just too many barriers or complications. Having someone come into your home is more suited to that person's need'.* However, the befriending service was not available to users until 10 months into the 'Staying Well Programme'. As such, for those who completed the questionnaire prior to September 2015 such a service would have been unavailable; limiting the likely change for this particular population.

Finally, the levels of deprivation will impact on how far individuals can be socially included. It was clear from the textual analysis of the user notes that financial deprivation severely limited take-up of services. Even the (relatively) cheaper option of community transport (£10) was seemingly beyond the budget of many users.

CHANGES IN HEALTH-RELATED QUALITY OF LIFE

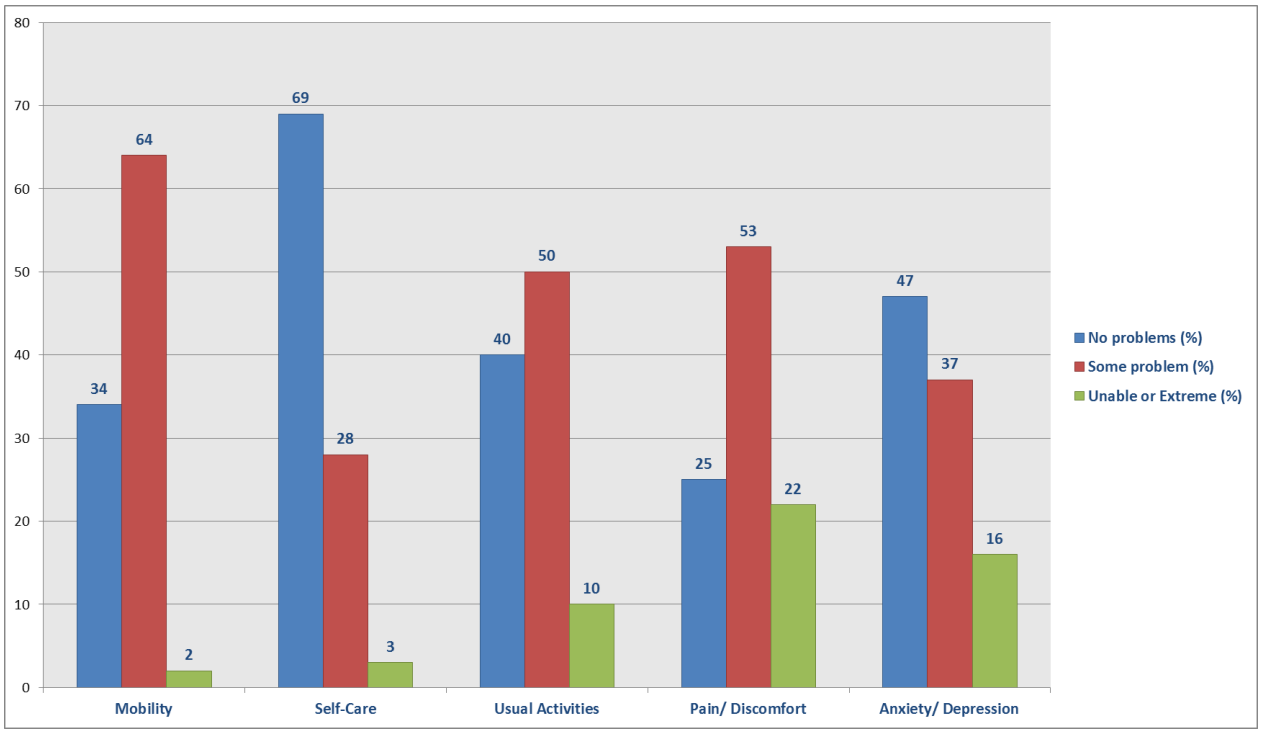
To explore the impact of the 'Staying Well in Calderdale' programme on users' reported changes in health related quality of life (HRQoL), we used the robust and validated tool of EQ-5D (http://www.euroqol.org/). This measure has three parts. The first assess five key 'domains: mobility, self-care, usual activities, pain/ discomfort and anxiety/ depression. Individuals are asked to indicate their level of difficulty in carrying out these tasks within each domain: 'no problem', 'some problems' or 'great problem/ unable to do the task'. For example, within the domain of pain/ discomfort, users are asked to state:

- I have no pain or discomfort, OR
- I have moderate pain or discomfort, OR
- I have extreme pain and discomfort.

Users' responses are then scored and the changes between pre-and post-intervention are assessed. The second part of the EQ-5D asks users to indicate how they feel that their 'general level' of health has changed: whether it has got better, stayed much the same, or got worse. Finally, users are asked to indicate how good or bad their health state is on a 'thermometer' that runs from zero (worst imaginable health state) to 100 (best imaginable health state).

The majority of the sample identified some difficulties across each of the different domains (Figure 34). Almost two- thirds of individuals (64%) identified that they had some problems with mobility; almost two-thirds of users (60%) either had some problems or were unable to perform their usual activities; three-quarters reported moderate or extreme pain and discomfort (75%), whilst over half (53%) indicated that they were either moderately or extremely anxious or depressed.

Figure 34: Proportion of users that identified challenges across the different domains (%).

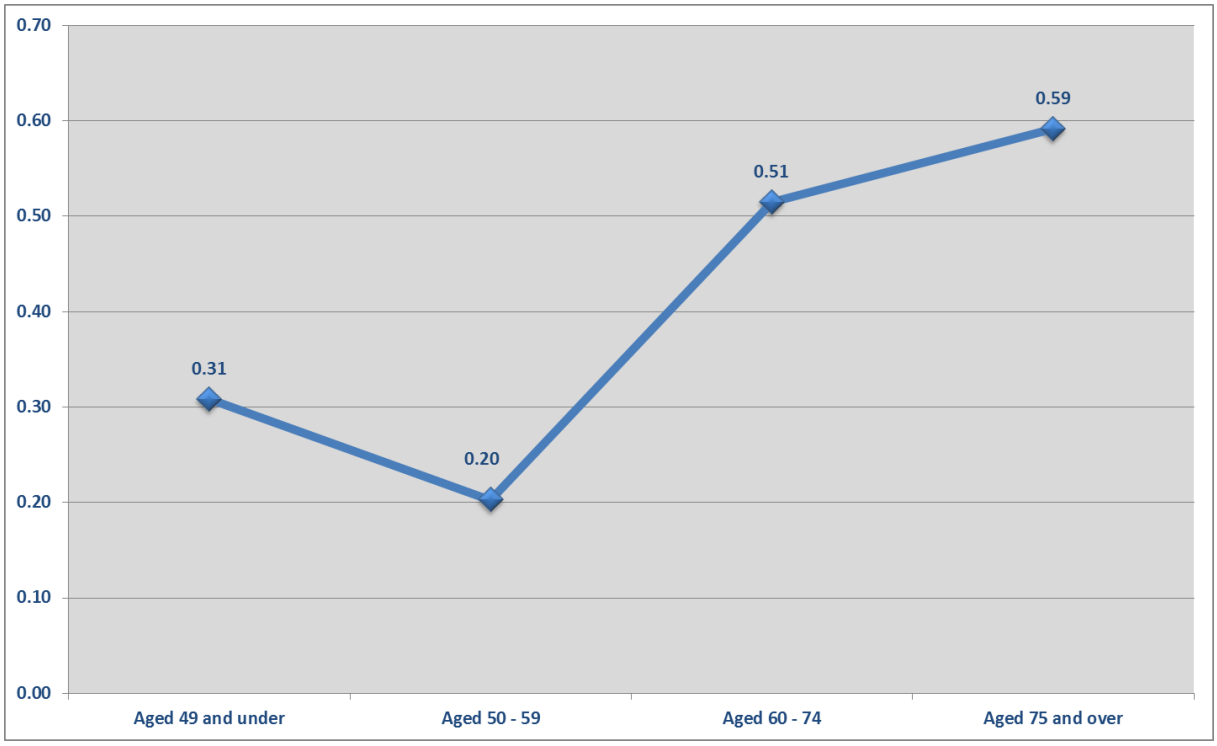


The base-line EQ-5D scores reflect such challenges and, perhaps counter-intuitively, it can be seen that those aged 75 and over report a higher health-related quality of life, (59 per cent of 'perfect health), when compared with their younger counterparts (see Figure 35). Nevertheless, all ages demonstrate low base-line scores when compared to the overall population (Table 8). Those aged 65 to 74 report scores that are over a quarter lower (26%) than the overall population, whilst those aged 75 and over report scores a fifth lower (19%). Perhaps most surprisingly, are the scores seen in the age group 55 to 64; 20 per cent of 'perfect health'. In the overall population, such scores are only reached by frail older people (aged 85 and over) often on admission to residential or nursing care.

Table 8: Base-line EQ-5D scores, overall population and 'Staying Well' in Calderdale sample.

Age Range of User	Overall Population	Staying Well' in Calderdale
Aged 55 - 64	0.80	0.20
Aged 65 - 74	0.78	0.57
Aged 75 and over	0.73	0.59

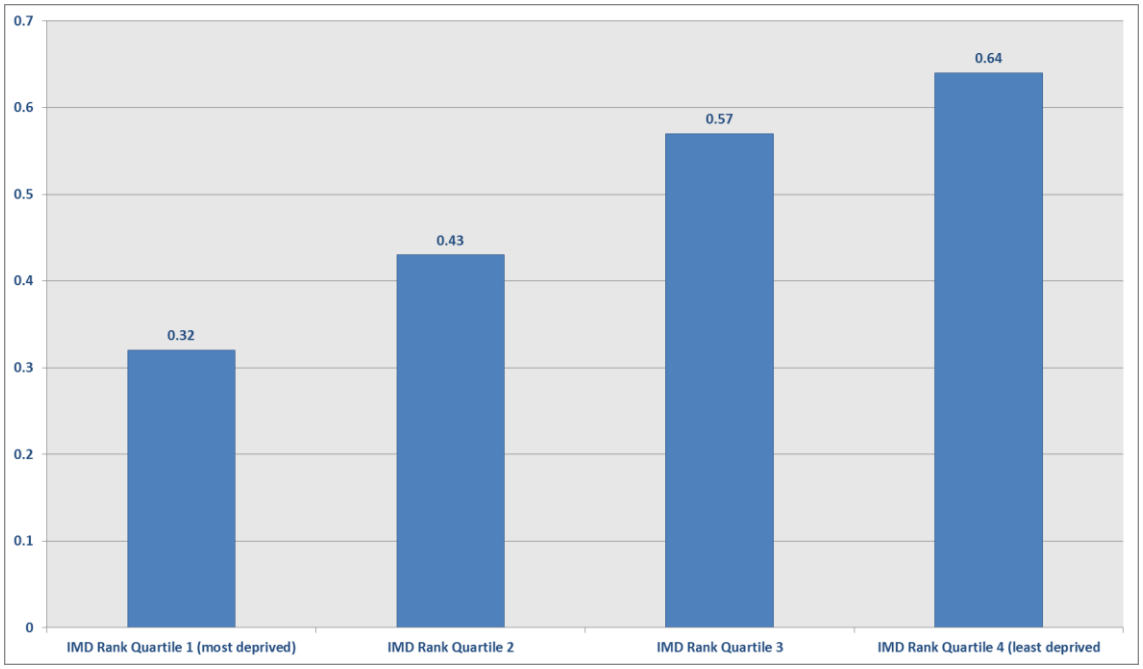
Figure 35: Base-line EQ-5D scores by Age.



Part of the rationale behind such 'low' EQ-5D scores are the number of long-term conditions reported by users; over three quarters of the sample reporting at least one long-term condition (see Figure 24, above). A further variable that is likely to impact on the EQ-5D scores is that of deprivation (see Figure 36). In our sample, it can be seen that there is a 50 per cent difference in reported EQ-5D scores (mean) between those living in the most deprived as compared to those in the least deprived those individuals living in the least deprived areas. Those in the most deprived areas reported 32 per cent of 'perfect health' compared to 64 per cent of 'perfect health' in the least deprived areas. Such differences in scores as a result of deprivation levels were reflected in the hubs (Figure 37). As discussed above (see Figure 18), all of the hubs worked alongside users who had high levels of deprivation, although almost the total sample (81%) in Halifax Opportunities Trust were resident in the most deprived areas.

In exploring the change in health-related quality of life, it might have been expected that a positive change would be seen. If individuals are effectively embedded in well-being services, a change in levels of anxiety and depression may result, support may be provided to the individual to carry out 'usual activities', including that of a social life. When we explored the mean change in EQ-5D scores, we saw some deterioration following the intervention (see Table 9). However, this was a small 'deterioration' and was non-significant. Similarly, this 'deterioration' of five percent is within the parameters of what would be expected for this particular population (Windle et al., 2009)

Figure 36: EQ-5D score (mean) by levels of deprivation.



***F*(3) =7.142 p=<0.001**

Figure 37: Base-line EQ-5D scores (mean) by hub.

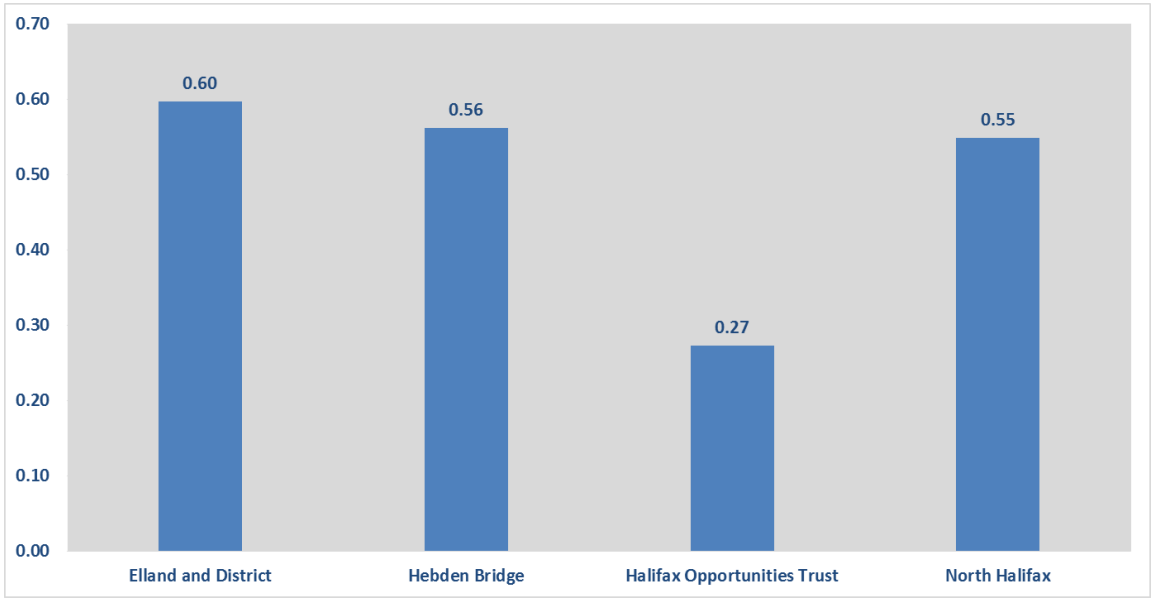
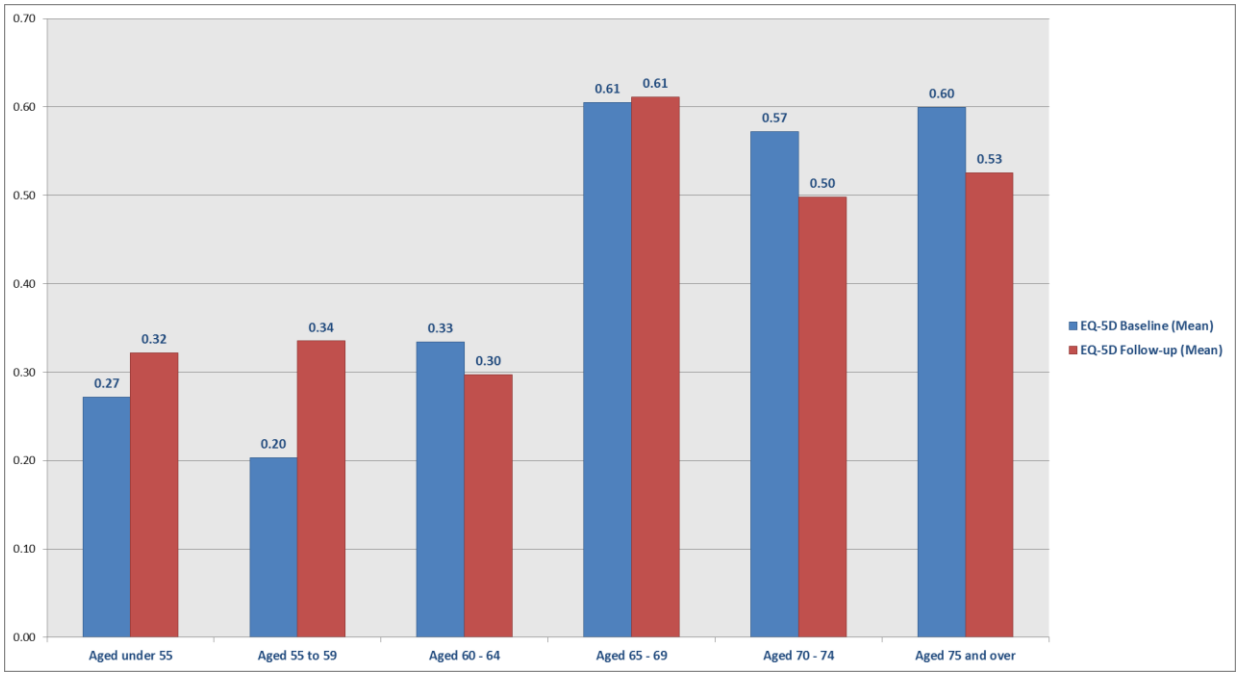


Table 9: Change in mean EQ-5D scores before and after the intervention.

Intervention time-line	Mean EQ-5D scores
Base-line EQ-5D Score	0.49
Follow-up EQ-5D Score	0.46

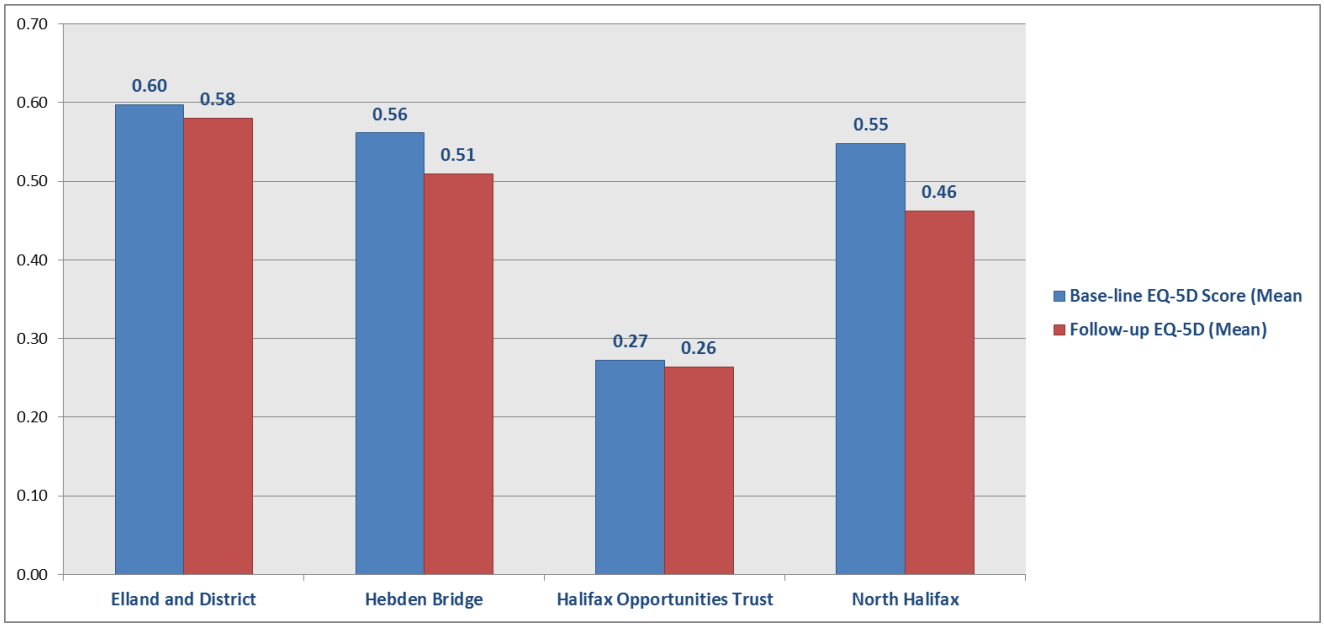
In exploring the differences in the EQ-5D change by age range, there are indications that the mean overall deterioration was not found in those aged 60 and under (Figure 38). Those aged under 55 reported an improvement of almost a fifth (18%) in their health-related quality of life, moving from 27 per cent to 32 per cent of 'perfect health'. Those aged 55 to 59 reported a large improvement of over two-thirds (70%), moving from 20 per cent to 34 per cent of 'perfect health'. In contrast, differing levels of deterioration are seen by older participants, with those aged 79 and over reporting a deterioration of 11 per cent. Nevertheless, such changes were non-significant, owing to the small numbers within the sample.

Figure 38: EQ-5D changes (mean) by Age Range.



It was reported above, that the hubs worked alongside different age ranges and levels of deprivation (see Figure 18 and Figure 21) and that the initial EQ-5D base-line scores differed across hubs (see Figure 39). Whilst health-related quality of life deteriorated across all hubs, there were continuing differences. The greatest deterioration of user's health-related quality of life was seen in North Halifax, a deterioration of 16 per cent. The smallest deterioration (3%) was seen in Halifax Opportunities Trust. However, again, such findings are not statistically significant and need to be treated with some caution. In particular, as we will discuss below, individuals self-reported that their 'health status', (how user's perceived their health), had improved over the time frame of the programme.

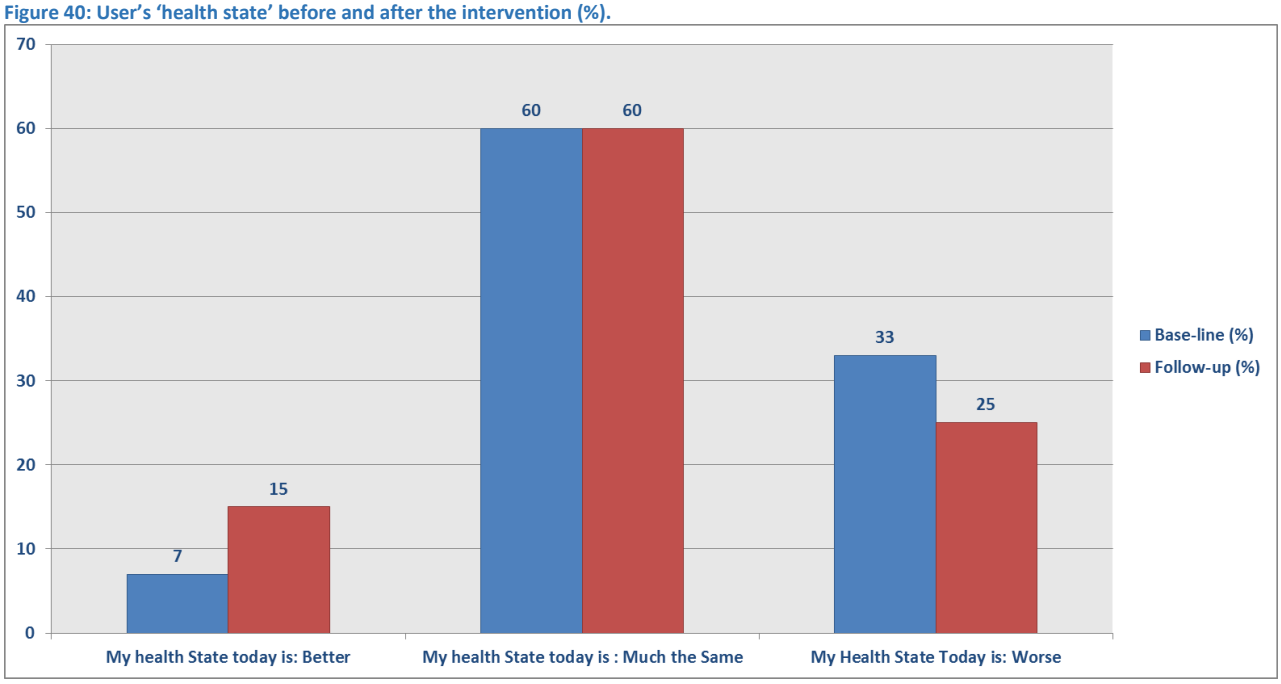
Figure 39: Changes in EQ-5D mean scores by hub (weighted).



CHANGES IN SELF-REPORTED HEALTH STATUS

As part of the EQ-5D, users were asked to state whether their 'health state' on the day that they complete the questionnaire is: 'better', 'much the same' or 'worse'. It can be seen from Figure 40, that almost a quarter of users (24%) reported their health state was 'worse'; with the proportion of users reporting their health state was 'better', doubling.

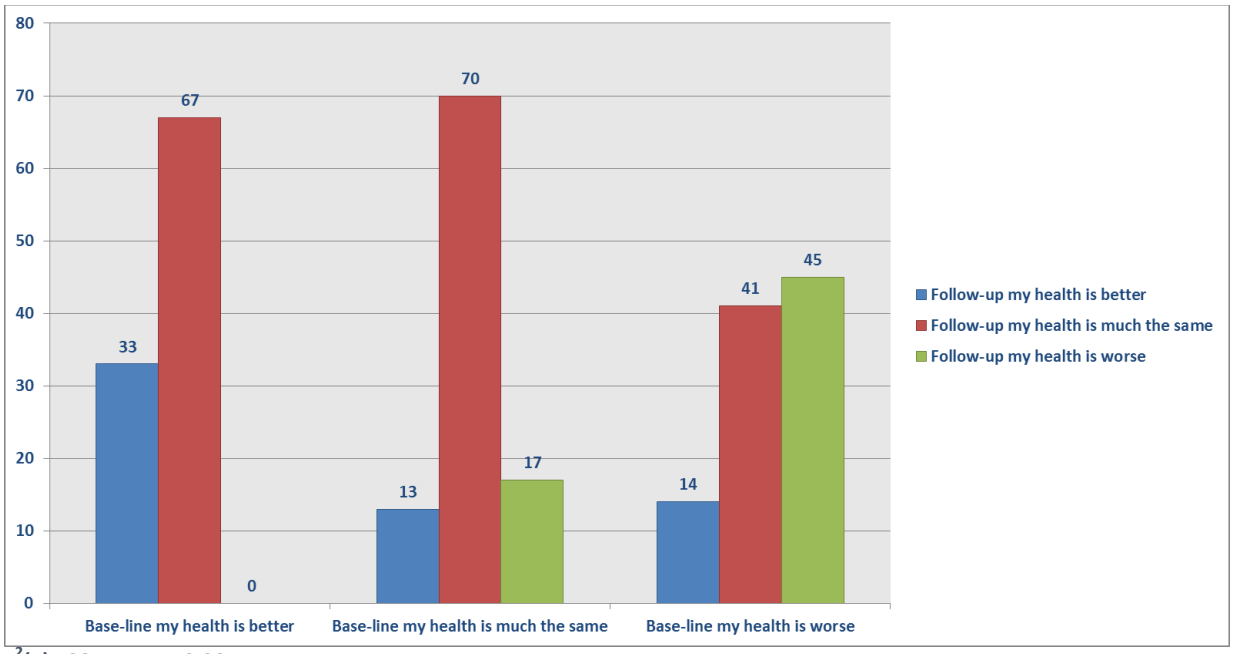
Figure 40: User's 'health state' before and after the intervention (%).



z=-2.71, p=<0.001

In exploring the 'direction' of change, it can be seen from Figure 41 that of those individuals who reported their health was 'worse' at base-line (100%), over half (55%) reported that their health was either 'much the same' or 'better'. Similarly, of those that reported their health was 'better' at base-line (100%), a third were able to respond that their health was 'better' at follow-up.

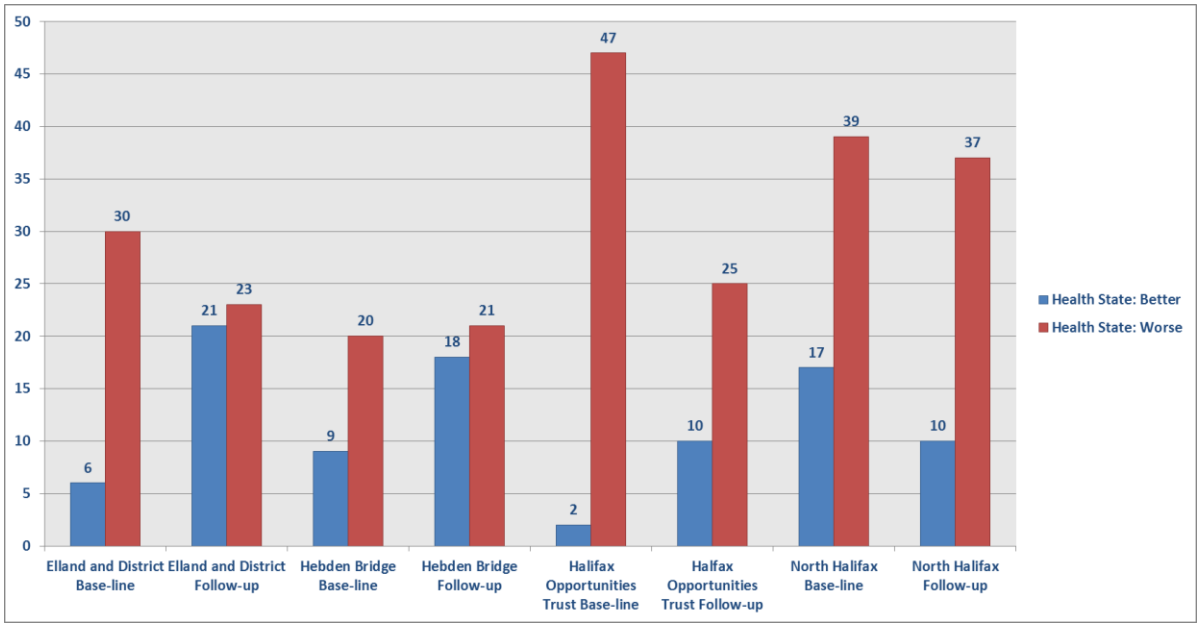
Figure 41: Changes in health status from base-line to follow-up (%)



$\chi^2(4) = 23.447$, p=<0.001

Differences were seen across the hubs (see Figure 42). Fewer individuals in Elland and District, Halifax Opportunities Trust and North Halifax reported that their health was 'worse'. Whilst there was a small increase in Hebden Bridge, a greater number of individuals reported that their health was 'better'. The changes in Halifax Opportunities Trust were significant (z=-2.781, p=<0.01).

Figure 42: Changes in health status from base-line to follow-up by hub (%)



CHANGES IN THE VISUAL ANALOGUE SCALE (VAS)

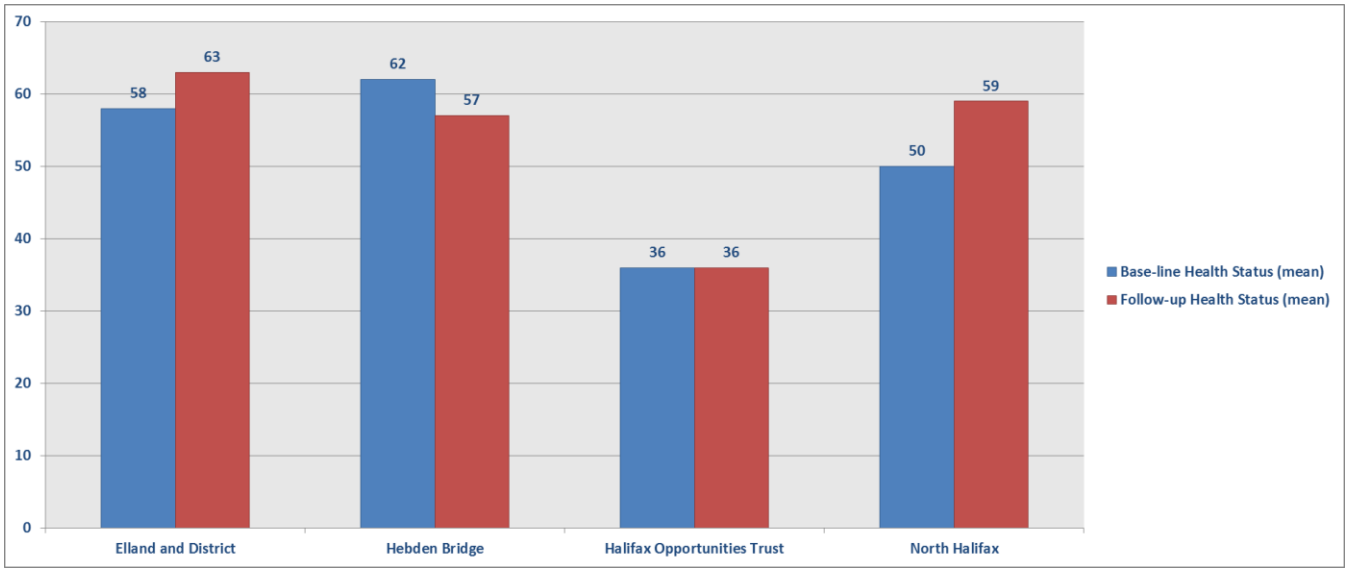
The final part of the EQ-5D asks users to indicate how good or bad their health state is on a 'thermometer' that runs from zero (worst imaginable health state) to 100 (best imaginable health state). In contrast to the reported health status, a small (and non-significant) change was reported (see Table 10). At base-line user's identified that their health status was around 53% of a 'best imaginable health state', and this did not change at follow-up.

Table 10: Visual Analogue Scores at base-line and follow-up (mean).

VAS Base-line	52.69
VAS Follow-up	53.16

However, this aggregate change does 'disguise' differential changes across the hubs (see Figure 43). It was found that users who accessed the Elland and District 'Staying Well Programme' reported a significant 10 per cent improvement in their health status (*t* (37)=-2.34, p=<0.03). Those individuals included in the North Halifax hub reported a greater improvement in their health status; almost a fifth (18%). The latter was not statistically significant, owing to the small sample size. It is worth noting that those individuals in Halifax Opportunities Trust reported no change in their health status. It could be argued that given the low EQ-5D scores of the sample, the levels of deprivation and that three-quarters of the sample were drawn from minority ethnic communities, the likely finding would have been a deterioration in perceived health-status. Far from being a negative finding, such a lack of change could be argued to be positive.

Figure 43: Change in VAS by hub.



The only hub in which we see user's reporting that their health state has deteriorated is that of Hebden Bridge, a reduction in health status of eight per cent. Such individual's reported the highest 'levels' of health status (62% of best imaginable health state) and 42 per cent of the sample in Hebden Bridge were aged 75 or over. As such, it may be that health status would be unlikely to increase given the number of long-term health conditions, age and levels of mobility. However, again, this is a non-significant finding, so care does need to be taken in any interpretation.

CHANGES IN OVERALL QUALITY OF LIFE

Within the questionnaire there was a single question that asked individuals to 'rate' their quality of life as a whole. Such a question by necessity is multi-factorial. Perceived as consisting of *'happiness, life satisfaction, well-being, self-actualisation, freedom from want, objective functioning, balance, equilibrium, prosperity, fulfilment, psychological well-being, the good-life, enjoyment'* (Rapley, 2003), participants will inevitably interpret this question according to their individual circumstances, preferences and beliefs. Expecting well-being services to affect such a global measure may not be appropriate. Similarly, the time-frame of measurement (four months), may not be long enough to capture any embedded life changes. For example, some users who completed the questionnaire at both time points may have been provided with transport to attend a lunch club. Such support may have reduced anxiety about obtaining transport, but it is unlikely that such provision would impact on a 'global' measure. One 'Staying Well' project worker is unlikely to be able to change a person's overall quality of life in the time-frame required for the responses (maximum of four months), however holistically they have approached their work.

In exploring responses to this question, again, we have the impact of age (Figure 44) and deprivation (
Figure 45). Those aged under 60 are more likely to respond that their life is 'bad, very bad', or 'so bad it could not be worse' than older participants. For example, almost a third (29%)

of those aged 49 and under indicate that their life is 'bad' and for those aged 50 to this rises to over a third (34%). In contrast, half of those aged 75 and over indicate that their life is 'good, very good, or so good it could not be better'; only 1 in 10 perceiving their life as 'bad', 'very bad' or 'so bad it could not be worse'.

It is not surprising that those who live in areas of higher deprivation report lower quality of life (Figure 45). Just over a quarter of participants (28%) in IMD quartile 1 stated their life was 'good', 'very good' or 'so good it could not be better'. In contrast, well over half of the sample (57%) living in the least deprived area (IMD Quartile 4) reported their life as 'good'.

Figure 44: Base-line overall quality of life by Age (%).

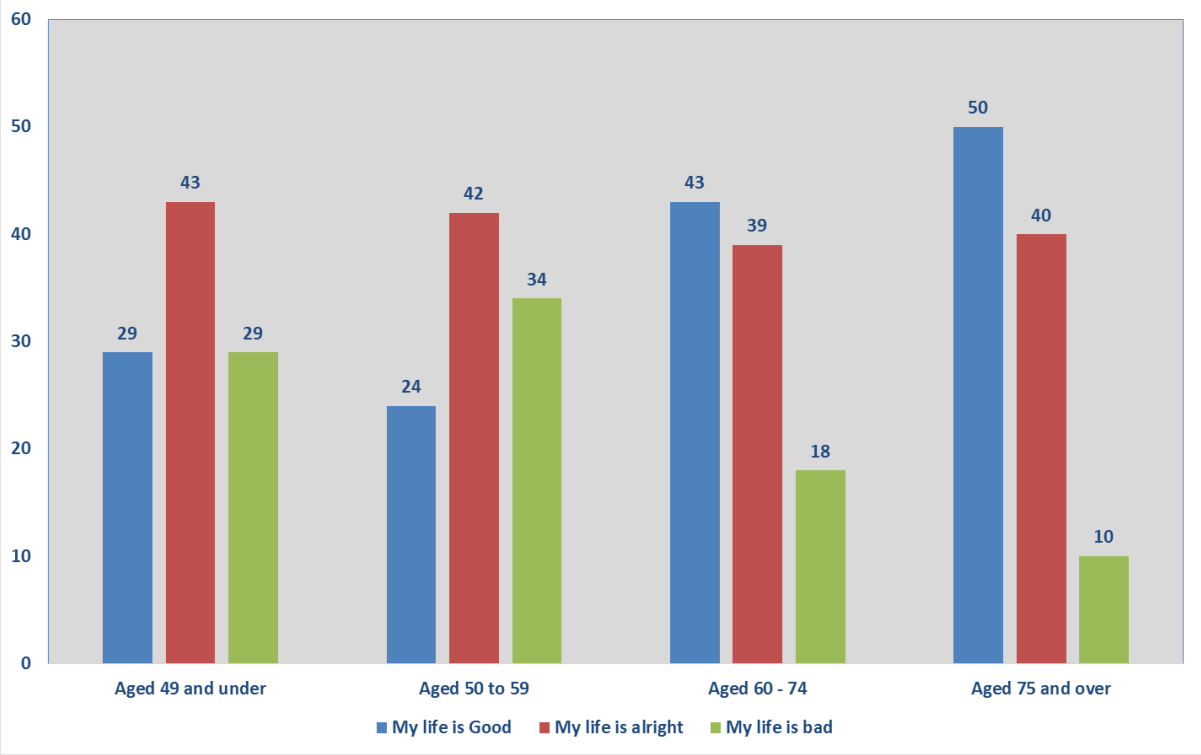
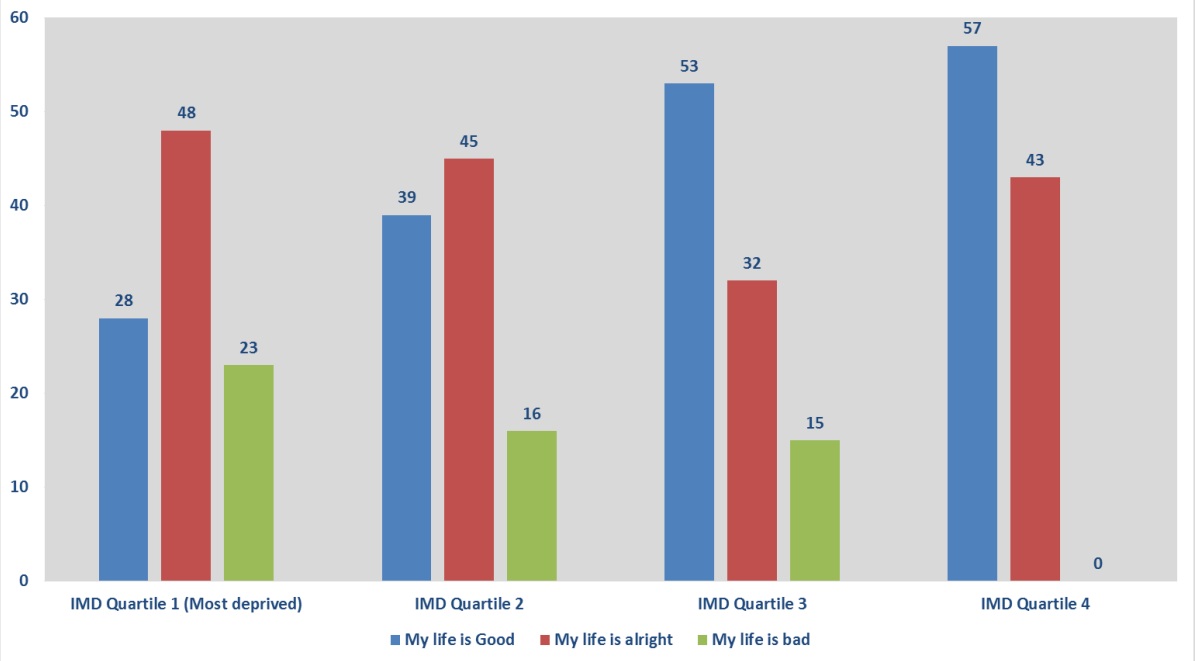


Figure 45: Base-line overall quality of life by deprivation (%)

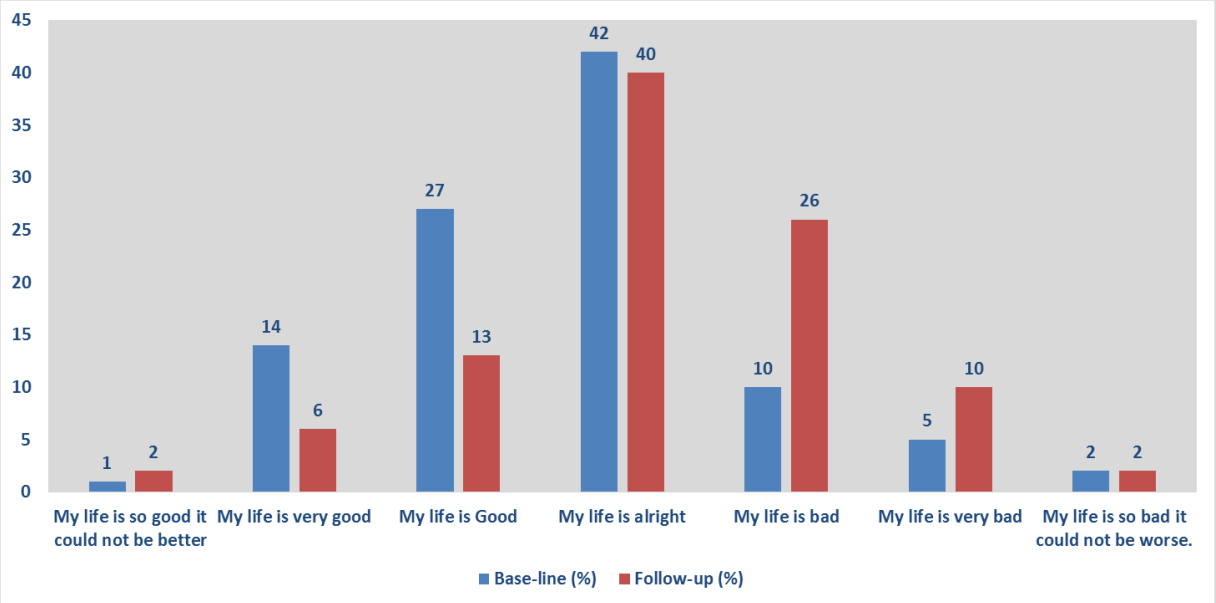


In exploring the changes in health-related quality of life, there are indications that individuals perceived their life as getting worse, although this is not a statistically significant finding for all groups. For example, at base-line, almost a fifth of the sample (17%) stated that their life was 'bad', 'very bad' or 'so bad it could not be worse'. This perception around their life increased proportionally to well over a third (38%) following the intervention (see Table 11 and Figure 46).

Table 11: Self-reported quality of life before and after the intervention (%)

	Base-line (%)	Follow-up (%)
My life is so good it could not be better	1	2
My life is very good	14	6
My life is Good	27	13
My life is alright	42	40
My life is bad	10	26
My life is very bad	5	10
My life is so bad it could not be worse.	2	2

Figure 46: Self-reported quality of life before and after the intervention (%).



From these findings, we have a statistically significant reduction in quality of life for those living in the most deprived area (z=-2.291, p=<0.03) and the younger age group (z=-1.994, p=<0.05). However, care needs to be taken in interpreting these findings.

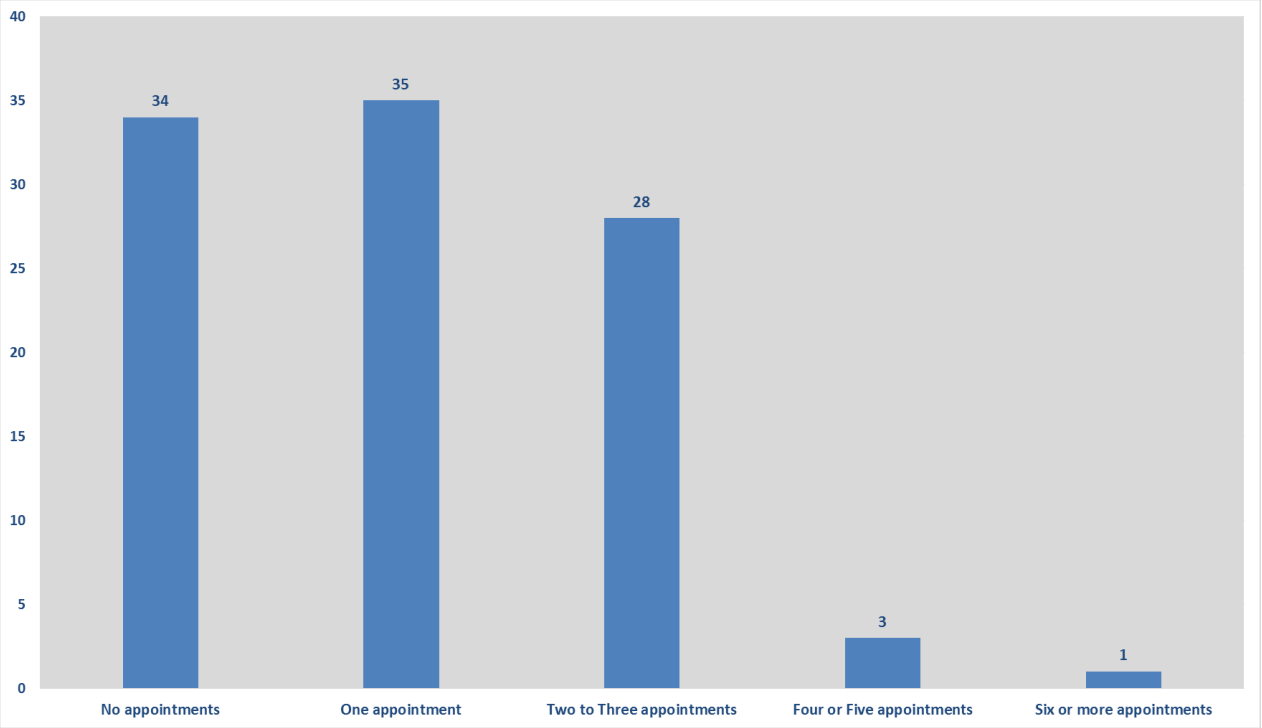
CHANGES IN SERVICE USE

Participants were asked to indicate if they had used particular services before the intervention and during/ following any support from the 'Staying Well Programme'. These included care services, GP visits at the surgery, GP home visits and community nurse visits.

Just under a third of users (32%) stated that they had used some form of care services four months prior to any contact with a particular hub. At base-line, three people (2%) had meals delivered to their home and this did not change at follow-up. This lack of change may be the result of users being signposted and attending local lunch clubs (see Figure 14, above) ensuring appropriate nutrition and social engagement. Similarly, few individuals reported attending a day centre (three individuals at base-line and six at follow-up). Whilst just over 1 in 10 of the participants reported seeing a social worker or care manager, no change was seen following the intervention (12% at both time points). A small (non-significant) increase was seen in the number of people receiving home care or home help (3%).

A third of the sample (34%, 65) had not seen a GP four months prior to their initial contact with the 'Staying Well Programme'. Of those who had attended the GPs, just under a third of users (32%) had attended two or more appointments (see Figure 47, below).

Figure 47: Number of GP appointments at base-line (%).



It has been demonstrated by prior research (e.g., Pitkala et al., 2009) that individuals who are socially isolated or lonely will often have higher GP service use, attending for a social, rather than medical need. In exploring the self-reported levels of loneliness by number of GP appointments, it can be seen from Table 12, below that the individuals who are lonelier would seem to attend a greater number of GP appointments. However, as we discussed above, levels of loneliness are also affected by the number of long-term conditions and levels of deprivation. As can be seen from

Table 13, as the number of GP appointments at base-line increases, the deprivation levels decrease (individuals are drawn from more deprived areas) and the number of long-term conditions increase.

Table 12: Number of GP appointments at base-line by loneliness score (mean)

Number of GP appointments	Loneliness Score (mean)
Zero appointments	2.77
One appointment	3.75
Two or more appointments	3.98

F(2) =5.62 p=<0.005

Table 13: Number of long-term conditions, IMD Rank and total loneliness score by number of GP appointments at base-line

Number of GP appointments	Number of Long-term conditions (mean)*	IMD Rank (mean)**	Total loneliness Score (mean)***
Zero appointments	1.73	14856	2.77
One appointment	1.95	12684	3.75
Two or more appointments	2.5	9453	3.98

* *F*(2) =3.62 p=<0.03 ** *F*(2) =6.42 p=<0.003 *** *F*(2) =5.62 p=<0.005

We also explored the same variables at follow-up. It can be seen from Table 14, that similar patterns exist for the number of long-term conditions and IMD Rank. That is, the former increases with the number of appointments; whilst the later decreases (individuals who are more deprived are more likely to have a higher number of appointments). However, what differs in the data following the intervention is that whilst levels of loneliness do increase, these are no longer statistically significant in explaining the difference between the numbers of GP appointments. The number of long-term conditions has the greatest effect. This may mean that the number of GP appointments the participants attended were appropriate.

Table 14: Number of long-term conditions, IMD Rank and total loneliness score by number of GP appointments at follow-up.

Number of GP appointments	Number of Long-term conditions (mean)*	IMD Rank (mean)**	Total loneliness Score (mean)***
Zero appointments	1.64	14721	2.9
One appointment	1.77	12370	3.4
Two or more appointments	2.39	10847	3.8

* *F*(2) =4.508 p=<0.02 ** *F*(2) =3.527 p=<0.04 *** *F*(2) =2.44 p=<0.09 (non-significant)

An increase was seen in the number of GP appointments following the intervention. Of those individuals who had no appointments (n=61), just over half the sample (54%, n=33) similarly attended no GP appointments in the four months following the intervention. The remainder of the sample (46%) attended one or more. In exploring those individuals that had one appointment over the four months prior to the intervention, almost a third (29%, n=19) repeated this pattern. However, almost half the sample increased the number of GP

appointments (48%, n=31), with only around a quarter reducing their GP use (23%, n=15). Finally, of those that had two or more GP appointments four months prior to the intervention, nearly three quarters of the sample maintained this service usage following the intervention (74%, 45). Less than a fifth reduced their service use to zero appointments (18%, 11), (see Table 15).

Table 15: Number of GP appointments at base-line and number of GP appointments at follow-up (%).

	Follow-up zero GP appointment	Follow-up one GP appointment	Follow-up two or more GP appointments	Totals
Base line zero GP appointments	**54**	21	25	100 (61)
Base line one GP appointment	23	**29**	48	100 (65)
Base line two or more GP appointments	18	8	**74**	100 (61)

z=-2.462, p=<0.01

However, the question remains as to what particular variable is interacting with the number of GP appointments. That is, is the increase in GP appointments due to greater levels of loneliness, or is it that levels of loneliness are affected by deprivation levels and number of long-term conditions and thus, we see an increase in GP appointments?

To explore this question we carried out a multinomial logistic regression to 'model' the data. In our model, we included: the IMD Rank, loneliness score, number of long-term conditions, EQ-5D score and age of the participant. This model was statistically significant ($\chi^2(10) =36.956$, p=<0.001) and three variables were statistically significant when exploring two or more GP appointments over four months as compared with no appointments over four months. What this model demonstrated was that for this population, loneliness did not seem to be a factor in attending their GP. In contrast, attendance at the GPs was seemingly linked with a medical need. Those with a higher number of LTCs, were 1.4 times as likely to attend two or more appointments (p=<0.03); those from more deprived areas were 1.6 times as likely to attend two or more GP appointments, whilst those with a higher EQ-5D score (better health), were, not surprisingly, 84 per cent less likely to attend two or more GP appointments.

IMPROVED INTERSECTORAL WORKING

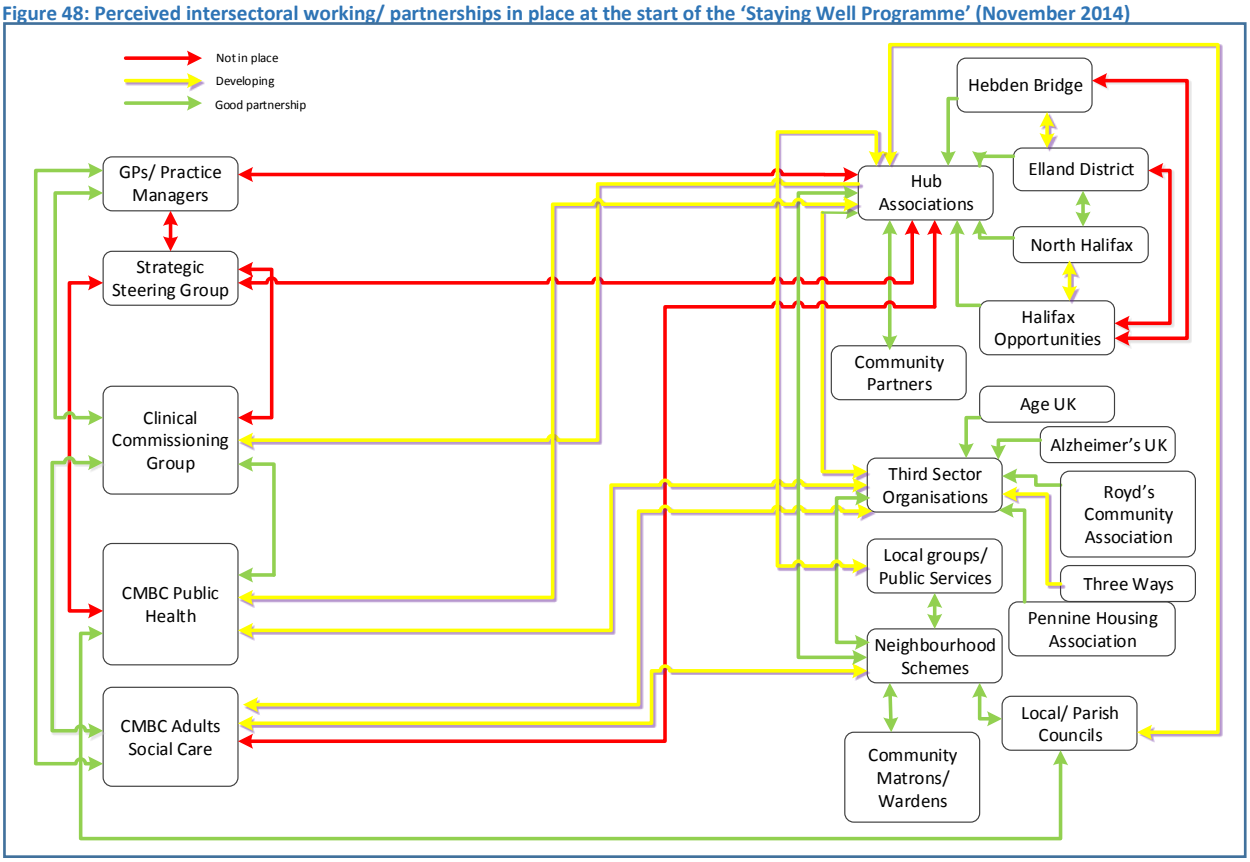
The boundaries between health, social and third sector care have long been regarded as problematic for older people who require community based support. Over the last decade, the government has sought to promote joint working practices between agencies, to the extent that collaboration is now at the core of social and health care policy (e.g., DH 2014, NHS England 2014). In exploring if the 'Staying Well' programme was able to improve partnership and intersectoral working across the health, social and third sector environments, we draw on data from the interviews.

At the beginning of the programme, there was a general consensus that the delivery of the programme would require *'different partners, stakeholders and organisations to work together positively and effectively, understanding others values, skills and experiences to achieve a common outcome'*. Participants recognised that if effective partnership working was to be achieved, there would need to be an openness to sharing information, an appreciation of organisations strengths and weaknesses and an outcome focused strategy.

However, at the start of the programme, there were seemingly few strong connections across the entirety of the health, social and third sector environment in Calderdale. Whilst participants highlighted good relationships between Adult Social Care, Public Health and the Clinical Commissioning Groups, it was also detailed that there was a perceived divide between the nascent 'Staying Well' project workers and statutory services (see Figure 48, below). It could be argued that such a finding at this stage in the project was as a result of the early implementation of the programme, as other third sector organisations (e.g., Age UK) argued that there was good developing partnerships or relationships between their organisation and the wider statutory services.

Along with a 'divide' between the 'hub' associations and statutory services, there was little perceived contact across the 'hubs' as well as their 'sister' third sector organisations. In exploring some of the reasons behind this, it would seem that the continuing perceived 'competition' (for clients as well as funding), was still prevalent at the beginning of the programme: *'community groups are very tight with their people and their target figures, they don't like sharing'*. In addition, some participants argued that there also seemed to be a separation between the 'Staying Well' project workers and their Neighbourhood Scheme Team colleagues: *'There seems to be a bit of an artificial divide between the 'Staying Well' workers and the NST workers. I know that they've got different client basis, but I would have moved to put them together straight away, because at the moment you've got that differentiation between the two different types of* workers'. However, in contrast, other participants perceived that the 'Staying Well' workers were *'strangled and confused with the NST*'.

Figure 48: Perceived intersectoral working/ partnerships in place at the start of the 'Staying Well Programme' (November 2014)

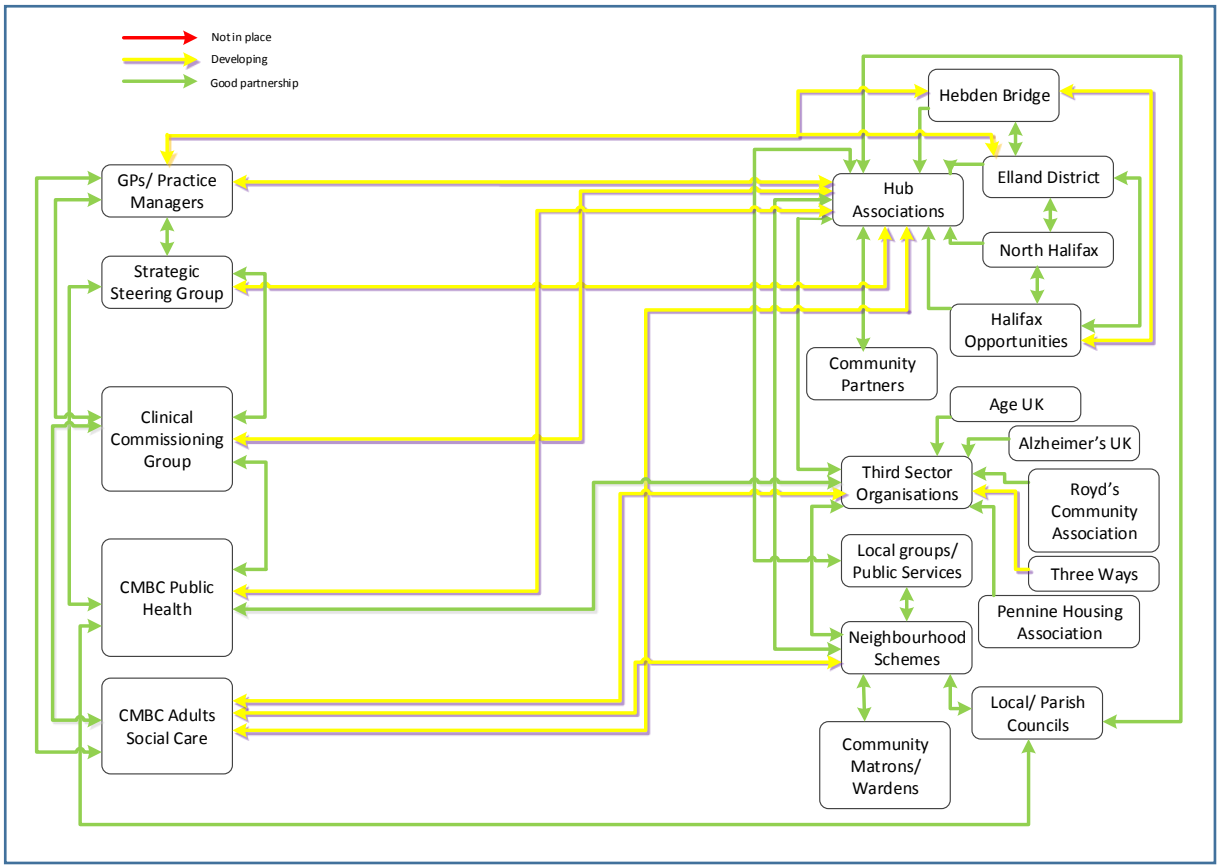


We have discussed above that at the start of the programme there were no relationships between local GPs or the hubs and, this proved to be a continuing barrier throughout: *'a major Achilles heel of the programme'*. Participants argued that direct contact with the GP practice managers were undertaken by a number of 'hub' leads and 'Staying Well' Project workers, in particular in Elland and District, Hebden Bridge and North Halifax. However, the main perceived weakness at the start of the project was that the 'Clinical Commissioning Group' was not effectively involved: *I still have a concern that health hasn't really been particularly well engaged, they were there from the outset and then kind of wandered off'*. Participants felt that this 'arms-length involvement' undermined the project aims and objectives': *Strategic Partnerships and the signing up of organisations have been really difficult, in particular the engagement of health colleagues. The Clinical Commissioning Group, despite funding the initial start-up, didn't think through what that meant. They were prepared to put the money in, but didn't actually put the organisational knowledge in to make it work.*

Nevertheless, as the Programme moved forward, relationships and partnerships across the health and social care environment were perceived as improving or improved (see Figure 49, below). The Steering Group of the programme was perceived as having made appropriate and strong links *'building bridges between people that might not normally happen'.* Similarly, the strength of the relationships between the hubs and the wider community provision was self-evident; *It [the Staying Well Programme] has enabled other organisations who once wouldn't have crossed paths to now be working together'*. In addition, the work carried out over the programme to ensure that social isolation and

loneliness could be addressed through intersectoral partnerships was perceived as a huge benefit to the wider health and social care environment. It was recognised by participants that continuous (and difficult) learning had been necessary with honest and transparent conversations required. As many participants argued, *'if nothing else it [the programme] will have enhanced the understanding and the skills we have with the group of partners. Good networks and infrastructure has been established that will help further and future partnership working'.*

Figure 49: Perceived intersectoral working/ partnerships toward the end of the 'Staying Well' programme (March 2016).



It would seem that 15 months after the start of the programme, the Clinical Commissioning Group was perceived as being better involved: *'I think that it's got them engaged and got them thinking about different ways of dealing with clinical problems'.* However, full inclusion into the 'Staying Well programme was not achieved despite this involvement and the 'incentives' to GPs to identify those patients for whom a social intervention would support their well-being. *I think engaging primary care in a more effective way would have been key to the successes of some elements of the work; focusing around referrals from GPs and reducing their workload by signposting patients to appropriate services. So those links needed and need to be stronger, not just looking at a few practices, but where all GP practices across the area are aware of and refer into the 'Staying Well' programme'.*

CONNECTED AND COHESIVE COMMUNITIES

Whilst successes were seen in developing robust and long-term intersectoral working or partnerships, perhaps the central effectiveness of the 'Staying Well' programme was in developing and strengthening cohesive or connected communities. This was done in three ways: micro-commissioning existing and nascent community-led projects; identifying and supporting existing community projects enabling each to know of the other and work together; and in the involvement of community organisers on each hub local steering group.

We have already highlighted actions and successes in micro-commissioning and its role in '*shaping and delivering services to ensure they reflect the needs to engage and strengthen communities'*. Nevertheless, it is important to highlight the types of provision that were perceived as particularly important in improving community cohesion or connection. For many participants, the range and extent of group social activities was perceived as a driver to connect communities: *'Within our community, we've got activities running every day, 10 activities a week with a core of at least 60 – 70 individuals involved.* Other participants detailed that it was the type (rather than extent) of projects that would be effective in developing community cohesion. Befriending was perceived as a core intervention, although it was recognised that a range of models (structures and processes) needed to be applied. In some areas, the 'traditional' model of a volunteer visiting an older person in their home was successful, building volunteer capacity and a wider recognition of the need to mitigate social isolation and loneliness. In other areas, the befriending model was necessarily intergenerational and cross-cultural, pairing younger British-Asian women with older White women. As the participants argued, improving community cohesion *'has to be done by stealth, you don't make it obvious, what you want are activities that occur naturally and without people realising that's what you are doing. It just happens that people make friends with each other, share and talk. And that's how you improve community cohesion'*.

For other participants, community transport was likely to be central in ensuring 'connected communities'. All of the hubs identified particular groups of (often) volunteer drivers that could support transport to activities as well as necessarily enhance daily living tasks; shopping and contact with friends and relatives. The hubs concentrated on making connections with previously 'hidden' groups: *It's an organisation that we haven't worked before, but we are now collaborating together'.*

Supporting the celebration of a range of faith-based festivals was also facilitated by hubs. Participants highlighted working alongside volunteer groups that provided Christmas lunches to a range of lonely and social isolated older people, facilitating (and transporting) individuals to attend Halloween parties involving all populations and cross cultural communities as well as raising awareness around different faith-based celebrations (e.g., Eid).

The 'Staying Well' project workers, working alongside their 'hub' teams, spent a great deal of effort to identify the (often) separate community groups and activities. As we have discussed, in the early stages of the process, three teams carried out 'listening meetings'

with the wider community in order to profile and map existing provision, whilst the fourth ensured early micro-commissioning. It was recognised that the identification of the range of community groups across the different localities task was both complex and time-consuming: *'10 months in and I am now finding out about lots of community groups that I never knew existed*'. This 'mapping' work and the overall facilitation (rather than annexation) provided by the 'Staying Well' workers ensured that these separate (often unknown) community groups, could begin to work together. In the early stages, the strengths of the 'Staying Well' project workers were that they were able to facilitate initial links: *'We are getting that network of support between the local organisations delivering those activities to older people; so now they are all linked with each other'.* As the project moved forward, and the 'Staying Well' brand became 'recognised' across the four hubs, the '*community development work*' began to become self-generating. People and community groups were coming forward, contacting the hub workers and asking how they could appropriately work together. The hubs began to *'galvanise the local spirit of the* area'. At the time of the final interviews (March 2016), the 'hubs' had been able to ensure greater levels of partnership: *'there were many groups that existed in isolation. What we've been able to do through the 'Staying Well' programme is to get them working together. And, when you have people working together, everyone delivers their best. "That is what 'Staying Well' has allowed us to do. Whatever happens with the funding, we will have had a long-term impact here".*

The structure and process of the different hubs also ensured appropriate early community engagement, perceived by participants as a central tranche in supporting the development of community cohesion and connection. One particular process that was seen as effective were the local hub steering groups, which bought together a range of community representatives, champions and older people. Initially, such involvement supported the identification and development of appropriate and relevant interventions (e.g., 'Men-in-Sheds'). However, it was clear from the interviews that such involvement strengthened and embedded the attitude (or indeed ideology) of *'together we are stronger*'. Many of the hub participants concurred with the argument that: *'I think 'Staying Well' has already ensured increased community cohesion. One factor is our local steering group which has helped developed lots of local networks with organisations and community activities'.*

It could be argued that the impact (and outcomes) of the links, partnerships and work done to strengthen community capacity was most strongly demonstrated in the community reaction to the 'boxing-day' floods across Calderdale. '*The flooding illustrated a massive feeling of community cohesion, it was a perfect platform in time of crisis for the community to come together and support each other'.*

SECTION THREE: COST-EFFECTIVENESS

The aim of cost-effectiveness analysis is to look at the relative costs of different courses of action, compared to their effects. There is not generally an attempt to turn the outcomes into a common money metric – when that is needed, then a cost-benefit analysis (or social return on investment, SROI) is called for. With several different sites for the interventions, it may be possible to make some kinds of comparisons between different projects to contrast the level of outputs for a given cost input. Cost-effectiveness relates to the cost of providing particular outputs, such as the number of people seen, the number of home visits, and so on. It is also possible to try to capture data on a common outcome metric such as Quality-Adjusted Life Years, or QALYs. A value of one QALY means a further year of life spent in perfect health, with death equating naturally to a value of zero QALY. A year spent with quality of life evaluated as being half of the best possible equates to 0.5 QALY, and so on. Questions obviously arise about the best way of measuring such concepts, and indeed deeper philosophical questions about the comparative valuations of different health states.

Under current guidelines, NICE (the National Institute for Health and Care Excellence) considers that spending £20,000 or less is worthwhile for an addition of 1 QALY. Where the cost is between £20,000 and £30,000 per QALY gained that *may* also be deemed to be cost effective, but that is subject to additional conditions – such as the level of confidence in the calculation, and the presence of other substantial benefits associated with any intervention. In other words, an evaluation costing (ballpark figures) around £800,000 to be cost-effective would need to be associated with a gain of around 40 quality-adjusted life years (assuming health gains were the only benefit).

The EQ-5D is a validated measure of quality of life that may be used to inform the calculation of QALYs. It is a key measure used in the survey, and provides us with a means of evaluating the cost-effectiveness of the intervention(s).

As a hypothetical, though with values close to that of this project:

a) £800,000 spent equates to needing about 40 extra QALYs to count as cost-effective.
b) If 800 service users were then included as part of the project, then to gain that extra 40 QALYs would require an *average* increase in EQ-5D scores of 0.05.
c) It is also possible for a project to be regarded as cost-effective following a smaller improvement; assuming a throughput of 800 cases and a QALY cost of £30,000 (the practical NICE limit) requires an increase in EQ-5D scores of 0.033.

On the cost side, it is also important to consider the costs of the project which are one-off or 'sunk', which would not recur if the project were to be scaled up. These are not generally included in the analysis of cost-effectiveness, and would not be necessary for enlarged projects. Such set-up costs can include the cost of evaluating pilot initiatives, or initial recruitment that may not need to be repeated if projects were to be continued. Taking these points into account, the following Table 16 sets out the scale of the task expected.

Table 16: Project costs and QALY

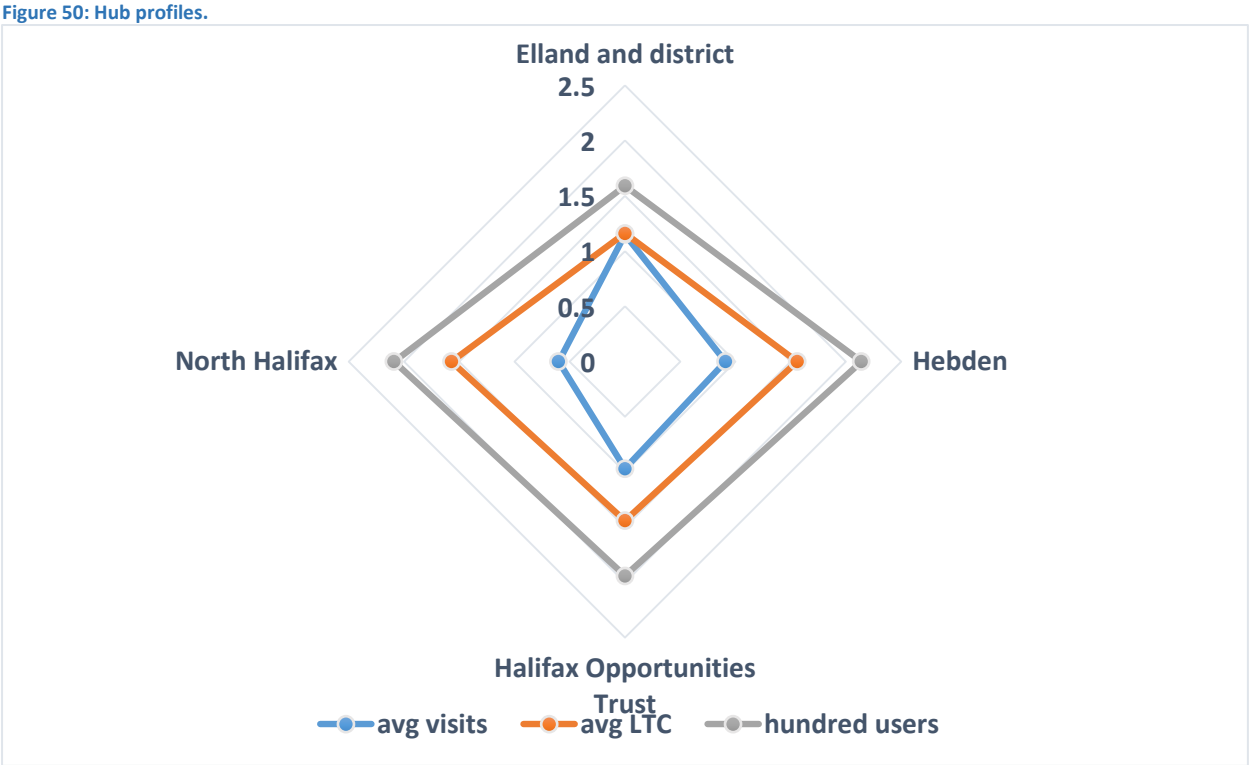
Concepts	Numeric figures
Total Budget	£846,614
Budget, less research cost, and minus digital development (assumed to be one-offs)	£736,614
Number of QALYs needed to be clearly classed as cost-effective	36.8
Number of QALYs needed to be possibly classed as cost-effective	25.6
Number of cases included in project (activity analysis file)	776
Improvement required per case seen (in EQ-5D scores)	0.047 (0.032 for best case scenario)

This tends to clarify the hypothetical example, and indicating that an improvement of around 0.05 would be sufficient on this kind of number of people seen.

Of course we are aware from our earlier analysis that the picture on changes in these scores is rather more mixed. However, it is also quite clear that improvements of this magnitude are certainly feasible, and did take place for the younger groups (aged younger than 60) on average. The EQ-5D scores of those aged under 55 rose by around 0.05, and by 0.14 for those in their late 50s. The scheme would have easily cleared any thresholds for cost-effectiveness had those results been replicated across the age range.

There did not seem to be great differences in the profile of activities undertaken in each hub. The following 'radar chart' illustrates this (see Figure 50), for size of number of users, average visits made, and average number of long-term conditions. However, there were some differences in the use of emails and phone calls, which were rather more common within Elland and district.

Figure 50: Hub profiles.



SECTION FOUR: CONCLUSION

The 'Staying Well' programme was a complex intervention. Originally funded for one year, it has been twice extended to ensure that communities and individuals could be continued to be supported. The findings from the programme (to date) are mixed.

Overall, the 'Staying Well' programme as a 'brand' is now well-recognised and accessed across the different localities. The 'Staying Well' workers were successful in identifying lonely and socially isolated individuals. They used both 'passive' publicity and more proactive modes of recruitment, including time consuming (but effective) 'door knocking'; identifying areas of their locality with high prevalence of older people and approaching them directly. However, their hard work was often negated, owing to the lack of involvement of GPs until almost 15 months into the project. '*One of the underlying assumptions were that GPs were absolutely crucial in reaching the right people; it should have been a fruitful part of the programme'*. In particular, such involvement may well have increased the number of individuals referred and improved the (initially slow) rate of referral during the time-frame of the project: *'To a large degree we were fishing for referrals in the dark. The users would have been in the GP surgery records and we just didn't have any access. This meant that we had to rely on a lot of 'foot-slogging' to try to make contacts with the 'right' people'.*

In making sure that users could be signposted to the most appropriate projects, the micro-commissioning monies was seemingly particularly effective, allowing existing community groups to be strengthened and gaps in provision 'filled' through the introduction of nascent projects. The 'Staying Well' workers provided efficient and effective support to users, carrying out lengthy home visits and accompanying them to 'taster-sessions'. It was found that such innovation ensured that users continued to attend their selected intervention. We found that with a single (average 90 minute) home visit and accompanied visit to the intervention, almost half the users took up a particular activity; a group social activity, day opportunity or volunteering. In addition, the wider activity necessarily demanded to effectively micro-commission services (i.e., identifying partners, community organisations and projects), ensured effective delivery of two of the secondary aims; improvement in intersectoral working and community cohesion.

Where there was perhaps less obvious success was in the primary outcome of a reduction in loneliness, with only a small (and statistically non-significant) reduction found. However, aggregate data can often 'hide' changes and this proved to be the case. In exploring the changes in loneliness by each hub locality, it was found that three of the four hubs were successful in reducing loneliness and in Elland and District hub this was a statistically significant finding. We found no change in the levels of social isolation; users still perceiving themselves as socially isolated as they had been before the project. However, care does need to be taken in interpreting these findings. The impact of the intervention was measured a 'scant' four months after the user's initial contact (referral) with the 'Staying Well' programme. As we have reported, the average time it took to work alongside the users in identifying, selecting and 'matching' them with a particular intervention was three months. It may well have been that many users had only just started to access their selected

activity on receipt and return of our follow-up questionnaire. It would therefore be unlikely that any change would be seen in social isolation; a multi-factorial and complex concept.

In exploring the secondary objectives of changes in health-related quality of life, self-perceived health status and self-perceived health state, there were contrasting findings. In analysing the mean change in overall health-related quality of life, a small (non-significant) deterioration of 0.03 was seen. This is within the parameters of what would be expected for this particular population; over four in 10 users were aged 75 and over and half the total sample (58%) reported two or more long-term conditions. Nevertheless, when we looked at this finding against further variables, it was found that those users aged 55 and under reported an improvement of almost a fifth (18%) in their health related quality of life, whilst those aged between 55 and 59 reported a two-thirds improvement (70%). This means that these users went from e.g., not being able to carry out their usual activities or being depressed and anxious, to once more being able to continue activities and enjoying areas of their lives that they valued. We also found that in contrast to the objective measure of health-related quality of life, user's reported that their health state had slightly improved. There were differences seen across the hubs, with users who accessed and were supported by 'Elland and District' hub reporting a (statistically significant) 10 per cent improvement in their health status. Similarly, in the North Halifax hub, users reported a greater improvement in their health status of almost a fifth (18%).

Again, contrasting findings were demonstrated when we looked at the overarching quality of life, finding a (statistically significant) reduction in quality of life for those living in the most deprived areas and the younger age group. It is recognised that quality of life is another multi-factorial concept and it can be argued that overarching changes on such a broad concept were unlikely to be demonstrated in four months. However, such reductions are in strong contrast to the (objective) measure of health-related quality of life. As we have discussed, it was the younger users who demonstrated the greatest improvement in their health.

It has been demonstrated by prior research that individuals who are socially isolated or lonely will often have higher GP service use, attending for a social rather than medical need. We found that users took up a greater number of GP appointments following the intervention than they had before their contact with the 'Staying Well' programme. However, we found that levels of loneliness were not impacting on this finding. Those with a higher number of long-term conditions were more likely to attend two or more appointments in the months following the intervention, whilst those reporting 'better health' were less likely to attend the GP. As such, it would be unlikely to see any change in GP use as the need for this population was seemingly medical, rather than social.

Our final task of the evaluation was to explore if the programme achieved cost-effectiveness as measured against changes in health-related quality of life. Whilst the 'Staying Well' programme has yet to achieve full cost effectiveness, improvements of the necessary magnitude to ensure cost-effectiveness are certainly feasible.

Whilst the findings were mixed, the programme has demonstrated a number of strengths and outcomes, particularly in improving intersectoral working and community cohesion. One particular hub, Elland and District, also illustrated reductions in loneliness and

improvements in health status. Whilst all the hubs and 'Staying Well' workers provided efficient, effective and long-term support to their users, there were small differences in how the 'Staying Well' worker in Elland and District seemingly carried out their role that may have resulted in these findings. On average, a greater number of home visits, phone calls and emails were carried out to support each user and, as we have discussed, the greater the number of visits, the more likely the user is to take up a particular activity; in consequence, leading to a reduction in loneliness. Similarly, and perhaps owing to the geography of Elland and District, there was some indication that partnerships were able to be made with a wider range of community groups.

The evaluation mirrored the 'Staying Well' programme in that it was necessarily short-term and low-cost, with changes in primary outcomes monitored for only four months. That there have been positive changes found across a number of outcomes (loneliness, health status, intersectoral working and community cohesion) reflects well on the overarching programme; particularly given the huge barriers in implementation. All those indicators not yet achieved are in the right 'direction of travel'. It is therefore recommended that the programme is continued.

REFERENCES

Beecham, J. K. and Knapp, M. R. J. (1992) 'Costing psychiatric interventions', in G Thornicroft, C. Brewin & J. Wing (eds) *Measuring Mental Health Needs*, Gaskell, London.

Bowling, A., Banister, D., Sutton, S., Evans, O. and Windsor, J. (2002) A multidimensional model of the quality of life in older age. *Ageing and Mental Health*, 6, 4, 355-71.

Cattan, M., et al., (2003) Alleviating social isolation and loneliness among older people. *International Journal of Mental Health Promotion*, **5**(3), 20-30.

de Jong Gierveld J., and Kamphuis, F. (1985) The development of a Rasch-type loneliness scale. *Applied Psychological Measurement*, 9 (3), 2889 – 2899.

Department of Health (2014) Care and Support Statutory Guidance: Issued under the Care Act 2014. London, Department of Health. (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf Accessed 9 May 2015)

Dolan, P., Gudex, C., Kind, P. and Williams, A. (1995) *A Social tariff for EuroQol: results from a UK general population survey*. University of York: Centre for Health Economics, York.

Forder, J., Jones, K., Glendinning, C., Caiels, J., Welch, E., Baxter, K., Davidson, J., Windle, K., Irvine, A., King, D. and Dolan, P. (2012) *Evaluation of the personal health budget pilot programme*. PSSRU, University of Kent: Canterbury. Available at: www.york.ac.uk/inst/spru/research/pdf/phbe.pdf (accessed 4 September 2015).

Glendinning, C., Challis, D., Fernandez, J., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M. and Wilberforce, M. (2008) *Evaluation of the Individual Budgets Pilot Programme: Final Report*. Social Policy Research Unit, University of York: York. Available at: http://php.york.ac.uk/inst/spru/pubs/ipp.php?id=1119 (accessed 9 September 2015).

Hawkley, L.C., Thisted, C.M., Cacioppo, J.T. (2010) Loneliness Predicts Increased Blood Pressure: 5-Year Cross-Lagged Analyses in Middle-Aged and Older Adults. *Psychology and Aging*, **25** (1):132 – 41.

Holt-Lunstead, J., Smith, T. B. and Layton, J. B. (2010) *Social relationships and mortality risk: A meta-analytic review*. PLoS Medicine 7(7), e1000316, doi: 10.1371/journal.pmed.1000316

Holwerda, T. J., Deeg, D. J. H., Beekman, A. T. F., van Tilburg, T. G., Stek, M. L., Jonker, C. and Schoevers, R. A. (2012) *Feelings of loneliness, but not social isolation, predict dementia onset: results from the Amsterdam Study of the Elderly (AMSTEL)*. Journal of Neurology, Neurosurgery, and Psychiatry 85(2), 135–142.

Lubben, J., Gironda, M. (2004). *Measuring social networks and assessing their benefits.* In Social Networks and Social Exclusion: Sociological and Policy Perspectives. Eds. Phillipson, C., Allan, G., Morgan, D. Ashgate, London.

Mead, N., Lester, H., Chew-Graham, C., Gask, L. and Bower, P. (2010) *Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis*. British Journal of Psychiatry 196(2), 96–100

NHS England, (2014) Five Year Forward View. http://www.england.nhs.uk/wpcontent/

Pitkala, K. H., Routasalo, P., Kautiainen, H. and Tilvis, R. S. (2009) *Effects of psychosocial group rehabilitation on health, use of health care services, and mortality of older persons suffering from loneliness: a randomized, controlled trial*. The Journals of Gerontology. Series A, Biological Sciences and Medical Sciences 64A(7), 792–800.

Rapley, M. (2003) *Quality of Life Research: A Critical Introduction*. Sage Publications, London.

Valtorta, N. K., Kanaan, M., Gilbody, S., Ronzi, S., Hanratty, B. (2016) Loneliness and social isolation as risk factors for coronary heart disease and stroke: systematic review and meta-analysis of longitudinal observational studies. *Heart*, doi: 10.1136/heartjnl-2015-308790.

Windle, K. (2015) *What role can local and national supportive services play in supporting independent and healthy living in individuals 65 and over?* Future of Ageing: Evidence Review, Foresight, Government Office of Science. Available at: https://www.gov.uk/government/publications/future-of-ageing-preventive-health-and-social-care-services (accessed 11 October, 2015).

Windle, K., Essam, N., Vos, J., Godoy Caballero, A., Phung, V.-H., Sirdifield, C., Siriwardena, N. and McKay, S. (2014) *Evaluation of the Admission Avoidance Programme*. University of Lincoln. (http://eprints.lincoln.ac.uk/15073/1/Admission%20Avoidance%20programme_Report_13%2006%2014.pdf, Accessed 9 May 2015).

Windle, K., Francis, J. and Coomber, C. (2011) *SCIE Research briefing 39: Preventing loneliness and social isolation: interventions and outcomes.* SCIE: London. Available at: www.scie.org.uk/publications/briefings/briefing39 (accessed 9 September 2015).

Windle K, Perkins M, Janssen D, Ellis K, Knapp M and Henderson C (2010) *Evaluation of Kent INVOKE POPP Programme* https://shareweb.kent.gov.uk/Documents/adult-Social-Services/invoke/invoke-evaluation-full.pdf

Windle K, Wagland R, Forder J, D'Amico F, Janssen D and Wistow G (2009) *National Evaluation of Partnerships for Older People Projects: Final Report*. PSSRU, University of Kent, Canterbury. Research funded by Department of Health Policy Research Programme. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111240