Evaluation of Get Going Together – final report

Draft report for Age UK

17th August 2016

Document Control

Document Title	Evaluation of Get Going Together – final report
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Date	17 August 2016

Contents

ES1 Executive Summary

To be completed when content of final report has been agreed.

1 Introduction and methodology

Get Going Together (GGT) is a three-year programme funded by GlaxoSmithKline and managed by Age UK (AUK). The programme aims to improve the health and wellbeing of older people with long-term conditions (LTC) by delivering exercise-based health and wellbeing projects that enable older people to be more physically active. GGT has been delivered by five local Age UK partners in Cheshire, Coventry, Leicestershire & Rutland (LS&R), Oldham and South Tyneside[1].

1.1 GGT aims and objectives

GGT commenced in October 2013. The programme aims to help older people with long term conditions (LTC) to lead more active lives and benefit from improved health and wellbeing through supported access to a range of high and low level exercise opportunities. Exercise-based interventions are tailored to individual and group needs, ranging from one-to-one support in the home to group classes in a community setting. The programme also draws on wider community assets, using volunteers to provide support to older people and the delivery of GGT activities.

As well as improving the physical and emotional health and wellbeing of older people, GGT aims to reduce falls and unplanned GP and hospital attendances. It also seeks to reduce social isolation.

1.2 Programme objectives

The GGT programme objectives are:

- To deliver high level, targeted activities requiring specialist support to 1,620 older people. These are most often provided through one-to-one sessions or in a small group setting and are delivered by qualified instructors. Referrals are primarily through health professionals including falls prevention teams and GPs.
- To deliver low level activities, aiming to support 4,500 older people with less intensive support needs. These activities may be delivered by non-specialist staff or volunteers and referrals are received through a broader range of routes including libraries, community groups, other Age UK services and self-referrals.
- To distribute information and advice (I&A) resources to 90,000 older people. These materials highlight the importance of staying healthy and fit to older people and promote project-specific activities. They are disseminated through a variety of mechanisms including leafleting, social media, professional networking and public events.

1.2.1 Programme design

The five local Age UK partners have autonomy to take different approaches to meet the programme aims and ensure that the design is tailored to the local context. Projects vary in their local contexts, specific rationales for intervention and subsequently their project designs and models of delivery.

However a typical participant pathway or 'journey' through GGT involves:

- Referral from a healthcare professional, from a community organisation, or self-referral;
- A needs assessment undertaken by a member of staff or volunteer at the local Age UK to determine which class(es) the participant might benefit from;
- Participation in one or more one-to-one, small or large group exercises, delivered by a paid instructor or by a volunteer; and
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[1] As of August 31st 2016, Age UK South Tyneside is no longer operating and is now legally known as Age Concern Tyneside South. For the duration of GGT, the organisation was Age UK South Tyneside and so is referred to as such throughout the report.

- Progression through high level to low level activities to sustain involvement in physical exercise (within or beyond GGT).

1.3 Overview of the GGT evaluation

In February 2014, Age UK commissioned ICF to undertake an evaluation of the GGT programme. The evaluation has been undertaken by ICF in three stages delivered between February 2014 and September 2016:

- Stage 1: Scoping, designing the evaluation framework and early findings;
- Stage 2: Interim evaluation; and
- Stage 3: Full evaluation.

The aim of the final evaluation is to answer the following questions:

Question	Final evaluation 2016
Has the intervention improved the health and wellbeing of participants?	✓
Has the intervention reduced the feeling of isolation and loneliness amongst participants?	✓
What have been the experiences of older people participating in this intervention?	✓
What have been the experiences of volunteers participating in this intervention?	✓
Has the intervention helped reduce future costs in the health system?	✓
Does the intervention represent value for money?	✓
Is the intervention a cost-effective way to achieve the outcomes?	✓
Has the I&A element raised awareness of staying healthy and fit as people get older?	✓
Has the I&A element encouraged older people to attend health and fitness activities?	✓

The evaluation framework and scoping report were delivered to Age UK in November 2014 and presented the detailed evaluation approach and early overview of the programme's activities, key participant characteristics and initial lessons learned, respectively. The interim report was delivered in 2015 and focused on progress to date, emerging outcomes and lessons learned. Both reports concluded with recommendations for the continuous improvement of GGT.

This report details the programme level findings from the final stage of the evaluation. It focuses on progress over the course of the three year programme, outcomes, lessons learned and sustainability. Detailed findings for each local Age UK GGT project are available in separate reports.

1.4 Summary of approach and evidence used during the final evaluation

This report draws on a variety of data sources, including;

- Quarterly monitoring reports (QMR) for the first 11 quarters (just under three years) of the programme. These were used in several ways:

- To obtain quantitative data on the uptake, reach and retention of the projects' low and high level activities and information and advice activities;
- To understand the expenditure and income of each local project to support a cost benefit analysis;

- To obtain the view of local partners on progress, challenges and plans for sustainability through quarterly overviews.

- Participant survey data for each locality taken from surveys based on the RAND SF-36 tool. These were distributed to participants in each locality over the course of the programme to monitor health and wellbeing.
- Telephone interviews with local health and social care stakeholders, as well as information and advice stakeholders in each of the five localities to situate the local GGT projects in a wider context and understand the effectiveness of local dissemination.
- Telephone and face-to-face interviews with each of the five Age UK GGT teams including senior strategic staff members to explore project delivery, strategic fit, outcomes and plans for sustainability.
- Interviews with participants and volunteers during visits to each locality and attendance at GGT classes to explore the experiences of older people as well as outcomes.
- Feedback from workshops with Age UK and local Age UK partners to explore local partners' experiences and learning over the course of the programme.

1.4.1 Interviews with stakeholders

- We are very grateful to local Age UK partners for identifying stakeholders, GGT participants and volunteers within their local areas to contribute to the final evaluation. A list of stakeholders, GGT participants and volunteers interviewed as part of this final evaluation are presented in Annex 1. The topic guides used for stakeholder, GGT participant and GGT volunteer interviews are set out in Annex 2.
- We spoke to a range of stakeholders, including public health, third sector providers and healthcare professionals; the inclusion of stakeholders was dependent on availability of those nominated to participate. Those interviewed differed between each locality, however overall they represent a diverse set of stakeholders who have been able to provide valuable insight on the projects' progress, impact and sustainability.

1.4.2 Participant survey response analysis

- GGT participants were invited to complete a survey upon entering the GGT programme and at regular intervals thereafter. The participant survey includes the RAND SF-36 survey questions. The SF-36 questions allow responses to be scored and analysed in eight dimensions of health and wellbeing: physical functioning; role limitations due to personal or emotional problems; emotional well-being; bodily pain; social functioning; energy/fatigue; and general health.
- Participants' responses to the SF-36 questions have been scored according to the RAND Scoring Rules; firstly each individual response is scored on a range of 0 – 100 using a RAND scoring key[2]. Scores for questions which relate to the same health and wellbeing dimension are averaged together to create a score for each dimension. Questions are aligned to a given health and wellbeing dimension in accordance with the RAND guidance[3].
- This analysis produces a participant score out of 100 for each of the eight health domains. A higher score indicates a more favourable health status. The mean of the scores for each domain across all five localities was taken to give the programme average. We have

[2] http://www.rand.org/health/surveys_tools/mos/mos_core_36item_scoring.html

[3] Ibid

combined all first surveys completed by participants (either at scoping or interim stage) to produce a baseline profile of participant characteristics both for each locality and for GGT overall.

1.4.2.1.1 Survey response rates

- 33% (2071 out of 6229)[4] of high and low level participants engaging across GGT programme completed the initial participant survey. The survey response across the five localities varies from 16% to 64% (Table 1.1), with Age UK LS&R having the highest response rate. While the response rate at the programme level generates a statistically valid sample, the low response rate for the majority of localities suggests the profile may not be representative of all GGT participants. Nonetheless, the profile derived from analysis of the surveys presents a useful insight into the characteristics of some of the older people participating in the programme. The baseline participant profile reported is derived from the surveys completed by participants when they joined the programme (round one surveys). Follow on surveys have also been collected by each locality. Each participant's surveys were categorised by wave of survey (baseline, follow up wave one, follow up wave two etc.) and sorted by duration from the date of the first survey. The time categories used were:
  - Up to three months from the date of the first survey (excluding those completed within two weeks);
  - Between three and six months from the date of the first survey;
  - Between six months and one year of the date of the first survey;
  - Between one and two years of the date of the first survey;
  - More than two years since the date of the first survey.

Table 1.1 shows the number of surveys collected and then used in the impact assessment across the programme.

Table 1.1 Number of individuals completing surveys and number of surveys completed as at June 2016

	Number of individuals completing surveys in total	Number of surveys completed in total	Number of individuals included after data cleaning	Number of surveys included after data cleaning	Number of individuals used in impact assessment	Number of surveys used in impact assessment
Cheshire	247	325	218	281	55	119
Coventry	343	917	342	800	277	735
LS&R	757	1,178	646	976	277	607
Oldham	355	584	325	532	144	351
South Tyneside	431	530	379	456	73	150
Total	2,133	3,534	1,910	3,045	826	1,962

The data cleaning process started by removing duplicate entries from individuals from the data set and then involved scoring the survey responses to the SF-36 survey. This was done according to RAND Europe guidance, who developed the survey.

Not all survey responses included answers to all questions. Where a respondent had answered fewer than ten of the SF-36 questions, the survey was removed from the analysis.

Some of the individuals only completed a baseline survey, and therefore could not be used in the analysis of impact. A total of 1,084 individuals completed only one survey, with 527 completing two surveys, 388 completing three surveys and 11 individuals completing four surveys.

Statistical analysis of the difference between round one and follow-on surveys has been undertaken using the above time categories to assess changes in participants' health and wellbeing. The analysis has been conducted using a 5% margin of error and 95% confidence level. The margin of error tells us the size of the error which surrounds the survey findings; the smaller the margin of error, the greater confidence we can have in the survey results. The confidence level tells us how sure we can be of the margin of error. (Common standards used by researchers are 90%, 95%, and 99%).

1.5 Structure of this report

The remainder of this report is structured as follows:

- Chapter 2 presents a summary of programme activity and delivery;
- Chapter 3 gives a high-level overview of the profile of participants involved in GGT;
- Chapter 4 presents a summary of programme outcomes for participants, volunteers and the wider system;
- Chapter 5 presents costs of GGT at a programme level;
- Chapter 6 explores sustainability of GGT and draws together learning for both national Age UK and localities.

The following annexes are also included:

- Annex 1 – list of stakeholders interviewed across all five localities.
- Annex 2 - topic guides used for the stakeholder, volunteer and participant interviews.
- Annex 3 - GGT logic model and theory of change.
- Annex 4 – programme data analysis for SF-36 scoring and healthcare utilisation.

2 Programme Activity and delivery

This chapter examines programme delivery and activity over the last 11 quarters (33 months) of GGT before considering enablers and barriers to success. It draws on analysis of QMR performance data submitted by local Age UKs to national Age UK as well as qualitative research undertaken with local partners, stakeholders, GGT participants and volunteers.

2.1 High and low level activity

2.1.1 GGT supports older people with LTCs to take part in a range of physical activities

The GGT programme aims to help older people to lead more active lives through delivery of a range of exercise based interventions tailored to the needs of the older population.

Activities range from one-to-one support provided in the home to group classes delivered in community settings.

Low level activities:

- Aim to support older people with less intensive needs.
- Activities can be delivered by non-specialist staff and volunteers.
- Referrals are typically received through a broad range of routes including self-referral, community organisations and other Age UK services.
- Examples include bowls, walking football, seated exercise, dance classes and yoga.

High level activities:

- Aim to support older people requiring more specialist support.
- Activities most often delivered by qualified instructors and trained staff and volunteers.
- Referrals are primarily through health professionals such as GPs and hospital teams.
- Examples include balance and stability classes, dementia support, falls prevention and home exercise with recovery buddies.

2.1.2 The programme has already exceeded high level targets and is on track to meet the low level activity targets

As of the end of June 2016, (33 months into the programme), GGT has reached an estimated 6,229 older people through high and low level activities (Table 2.1).

Table 2.1 Delivery progress at quarter 11 (33 months into the programme – June 2016) against programme targets[5]

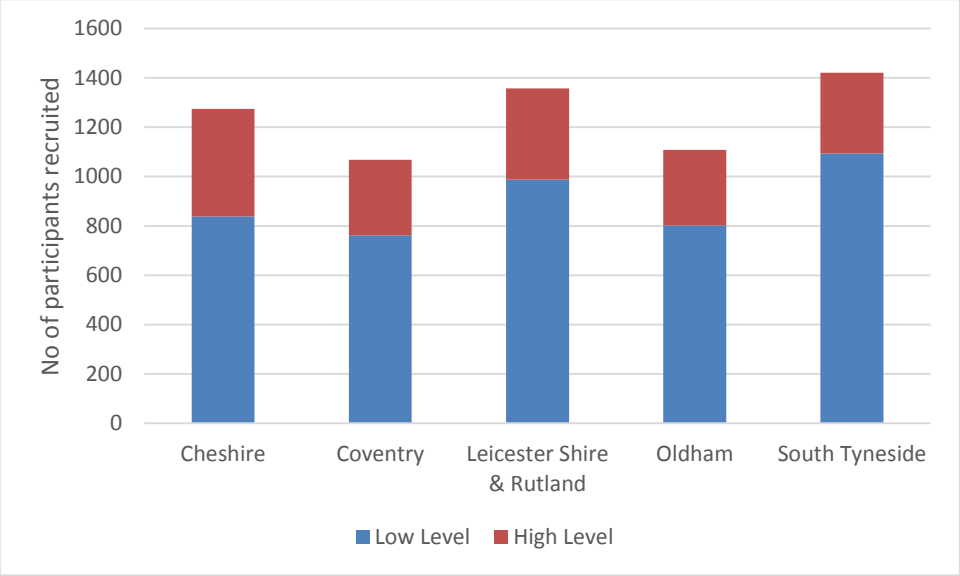
Activity	Q11 cumulative total	Forecast recruitment at Q11	Q11 progress against three year target	Cumulative 3 year target
High level	1,745	1,485	108%	1620
Low level	4,484	4,125	99.6%	4500
Total	6,229	5,610	102%	6,120

[5] All targets are expected to be met by the end of the programme

Recruitment numbers for both high and low level activities have exceeded Q11 forecasts. The number of high level participants recruited has already exceeded the target to be achieved by the end of the programme and is on track to meet its three year target for low level activities.

There is variation in recruitment between each of the five localities reflecting the different emphases local Age UKs have placed on low and high level activities since the inception of GGT as well as the geographical spread of each locality's target population.

Figure 2.1 Cumulative total of participants recruited to low and high level activities by locality up to June 2016 (Q11) [6]



2.1.3 A focus on high level recruitment has resulted in a big increase in numbers while low level recruitment continues to be strong

Supported by national Age UK, local Age UKs have focused on a number of different ways of improving the recruitment rate of low and high level participants;

- Through building on existing, and developing new relationships with local health and social care organisations establishing new referral routes which target older people that could most benefit from high level activities (see section 2.2 for further information); and
- Increasing capacity to support the delivery of high level activities through upskilling volunteers and Age UK staff and redesigning delivery models (see section 2.3 for further information).
- Raising awareness of GGT through effective information and advice activity, targeted to the older population (see section 2.4 for more on this).

At the interim stage of the evaluation, localities had recruited a lower than expected number of participants to high level activities. High level activities often took the form of one to one support, which is more resource intensive and requires more specialised skills than those needed to deliver low level activities. Local Age UKs reported that recruitment to these activities was more challenging as it was more difficult to source both appropriate participants and instructors. In addition, local Age UKs had a greater dependency on referral of suitable participants from health and social care services; developing and establishing

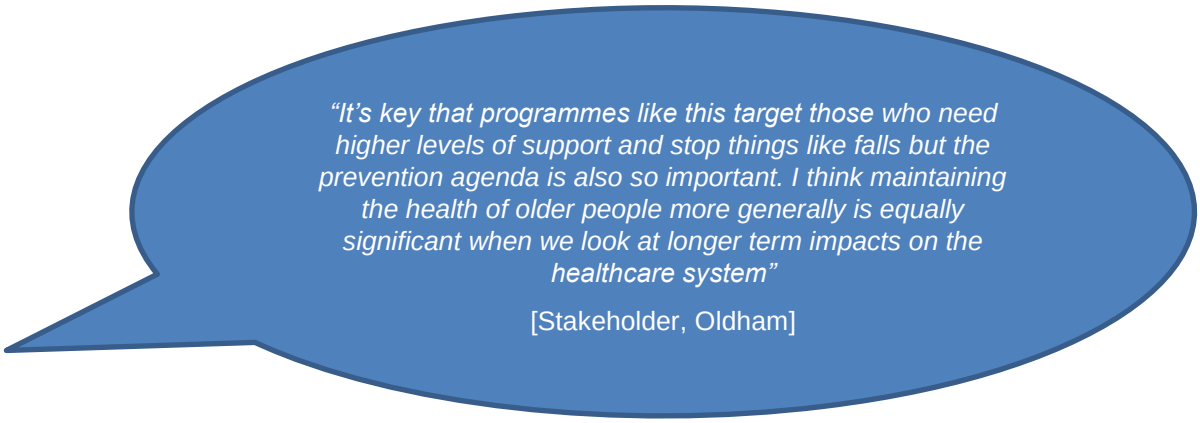
[6] This figure reflects numbers from the first 11 quarters (just under three years) of the programme as at June 2016. GGT is due to end in September 2016 when final Q12 numbers will be reported.

relationships with such organisations takes time and so recruitment of older people with higher levels of need had taken longer to embed.

Stakeholders considered that this group could potentially receive the greatest benefit from GGT as they were most at risk of deterioration in health, for example those who have experienced falls. Stakeholders highlighted that this group were more likely to present in primary or secondary care and have a higher utilisation of healthcare resource, which strengthens the potential impact of GGT on both participants and the healthcare system more widely.

Local Age UKs have increased their focus on high level recruitment over the course of the last 5 quarters and worked hard to increase recruitment rates. This is reflected in the numbers with an additional 1021 participants recruited to high level activities between Q6 and Q11.

Although local Age UKs have placed increasing attention on the recruitment of high level participants, they have continued to expand low level activities and recruit new participants. Between Q6 and Q11, local Age UKs recruited an additional 2,180 older people to take part in low level activities. While stakeholders acknowledged that this group are less likely to be dependent on healthcare resource, many highlighted the importance of programmes such as GGT for all older people. Preventing crises such as falls or rapid deterioration in health is important, however stakeholders commented that the role that GGT can play in supporting older people with lower needs to maintain or improve their health and wellbeing should not be underestimated.



2.2 GGT referral pathways

Local Age UKs have established a variety of formal and informal referral routes from external health and social care services including hospitals and GPs as well as internally from other Age UK initiatives

Over the course of the last three years, local Age UKs have developed and strengthened networks with key health and care stakeholders to establish both formal and informal referral routes. Establishing referral routes was one of the first steps taken by localities at the start of GGT and local partners have worked to embed these over the remaining years of the programme.

As well as supporting the recruitment of participants, the development of referral pathways also has strategic benefits:

- Developing pathways has facilitated the **strengthening of professional relationships and partnership working** between local GGT teams and other health and social care professionals/teams (including for example primary care, and integrated care teams) and other community and third sector providers.

- The establishment and development of relationships has assisted with **improvements in the integration of local services aimed at bettering the health and wellbeing of older people**, as well for those people whose needs can be supported by existing activities provided by other organisations, for example third sector organisations. These improvements in the integration of local services has helped older people to better navigate those services available. As a result, this has supported older people to increase and sustain their involvement in physical activity, both those as part of, and outside GGT.

Local Age UKs have autonomy to design and deliver projects in a way that is tailored to their local context, but there are common features across most in terms of referral routes:

Links with health and social care services

Local partners have worked hard to expand their networks and develop relationships with key health and care stakeholders to support the embedding of both formal and informal routes of referral. This has been particularly successful in helping local Age UKs to recruit participants who require higher levels of support.

Across all five localities, there have been multiple examples of ways in which GGT classes have become embedded in health and care pathways:

- Age UK Cheshire has received referrals to its cardiac rehabilitation classes from GP practices and the local Cardiac Rehabilitation Unit. The team have also developed and maintained links with hospitals in Chester and Crewe with presence in their units.
- Age UK Coventry has established GGT within a formal respiratory care pathway in which community respiratory nurses refer patients to take part in high level GGT activities. In addition, the GGT team refer patients out of GGT; a formal ward referral route from GGT into existing pulmonary rehabilitation services was established early on in the project. The team has worked closely with the local hospital - University Hospital Coventry & Warwickshire receiving referrals from a clinic for people with COPD, aiming to improve their physical wellbeing through exercise.
- Through GGT, Age UK Coventry has also developed a strong relationship with the Community Physiotherapy service. Not only has this been a good source of referrals for Age UK Coventry; this referral route also led to the team making a connection with the wider Coventry and Warwickshire Partnership Trust's Physiotherapy service who have also now referred into the project.
- Age UK LS&R benefits from a GP Exercise Referral Scheme Co-ordinator who has an on-going relationship with the Rehabilitation Department of Leicester General Hospital. The Co-ordinator delivers talks to patients attending the Falls Prevention Programme with the in-clinic team also distributing GGT materials to their patients.
- More recently, the LS&R team have delivered a presentation about the benefits of GGT to Leicester Community Mental Health Team City East & West. This was very well received and feedback suggests that the project will start to receive referrals from the Mental Health Team going forward.
- In Oldham, the GGT Falls Prevention class is integrated into the falls pathway delivered by the NHS falls prevention service. The Age UK Oldham team have worked to ensure that the class is accessible to people with dementia and sensory impairment, providing support for these people to attend. This required the team to strengthen close links with the community physiotherapy team, with GPs and other health professionals providing referrals to the service.
- Additionally, the Age UK Oldham team has stepped in to fill gaps in provision left by the dissolution of local health services. For example, they have taken over the running of health walks following the cessation of provision by Pennine Care NHS Foundation Trust.
- In South Tyneside, the GGT team work closely with NHS teams to support referrals into the project. The project receives weekly referrals from the physiotherapy

department at South Tyneside Hospital and has more recently started to receive referrals from the Cardiac Rehabilitation team and Respiratory Clinic.
- The team has also engaged local GPs with the project, delivering presentations at practice manager meetings and a GP Education Forum. This was effective with GPs now increasingly referring patients to GGT activities.

Partnerships with community organisations

As well as establishing relationships with key health and social care partners, local Age UKs have created and built upon connections with organisations in the community.

- Age UK Cheshire has worked closely with a large social enterprise leisure and physical activity provider 'Brio' to support the delivery of a number of low level activities.
- In Coventry, a key referral route to GGT is through a partnership with Atrium Health, a not-for profit enterprise delivering cardiac and pulmonary rehabilitation services locally. This relationship works both ways; Atrium Health refer older people who are not yet at the level to attend their classes to GGT; the intention being that GGT will work with these people in their home and build up their confidence so that they can then be referred back to Atrium Health to participate in their services outside of the house.
- The project team also works closely with local care homes and the Coventry City Council Healthy Lifestyle team to recruit older people to GGT activities.
- Age UK LS&R recruits participants through a number of different routes made possible by the development of relationships locally. The project receives referrals from Community Engagement Officers as well as a Care Navigator team at Leicester City Council. The team has also built links with third sector organisations such as the Alzheimer's Society and independent living complexes more recently.
- The team in Oldham have established relationships with a number of local organisations including the Stroke Association, Dr Kershaw's day centre for cancer patients and community day centres. These partnerships have been key to recruiting high level participants to GGT activities. More recently, Age UK Oldham has been working to develop referral pathways with Making Space, an organisation which offers one to one support for people living with dementia to access activities.
- Age UK Oldham's long standing relationship with Oldham Community Leisure has been of great benefit to the GGT team. Particularly in the early stages of the project, the team worked closely with Oldham Community Leisure to deliver a variety of activities for older people in the community. This partnership is on-going with GGT recently part funding specialist stroke training of one of Oldham Community Leisure's staff members. This will support the longer term delivery of specialised classes for participants who have suffered a stroke.
- In South Tyneside, the team has made a number of connections with other local organisations to support the success of GGT, including Public Health, who included GGT on their 'Change for Life' website. The project has benefitted from a variety of locations provided free of charge in which to run classes, for example a workshop for Men in Sheds classes. This has been possible due to the development of links in the community.

Self-referrals

Another way in which participants can get involved in GGT is through self-referral to project activities.

All Age UK localities have recruited participants to both high and low level activities through self-referral methods. Information and Advice activities, which are discussed further in

section 2.4, support this as participants are made aware of the project and then choose to take part. Many older people reported hearing about the project through local publicity and taster sessions delivered in locations such as community centres and sheltered accommodation. Participants in localities such as South Tyneside and LS&R have also been signposted to self-refer to classes by healthcare professionals including GPs and practice nurses.

Internal referrals from other Age UK initiatives

Local GGT projects also benefit from other Age UK health and care initiatives – particularly with respect to receiving more targeted high level referrals.

- In Cheshire, GGT has benefited from an Age UK Well Being Co-ordinator located at the Countess of Chester centre for Healthy Ageing within Ellesmere Port Hospital. Since late 2014, the initiative has supported referrals to GGT, in particular to one of three GGT cardiac rehabilitation classes as well as the seated exercise class run at the centre.
- In house referrals from other Age UK initiatives have formed one of the largest referral routes into GGT services for Age UK Coventry. In particular, their Contact & Connect partnership referral service, which provides information to older people and refers them into appropriate local services and Age UK Friendship groups, aimed at improving social networks of older people through small groups that meet regularly.
- GGT in Oldham has been boosted by several other Age UK services. The Promoting Independent People (PIP) service has people based in GP clusters. These employees work with older people with long term conditions who have replied to a letter from their GP inviting them to access the PIP service. When older people are referred to the PIP service they receive information about GGT from a PIP worker, all of whom have received GGT inductions to ensure they understand the project's 'offer'.
- In addition, Age UK Oldham's Dementia Information service is promoting GGT activities at their post-diagnostic dementia groups, which individuals and their carers attend for information following a diagnosis of dementia. This service also promotes GGT to those who do not have a formal diagnosis of dementia.
- Age UK South Tyneside has worked with another Age UK project transporting isolated, older people who are not accessing health care services to their GP surgeries. An Age UK Care Navigator located in GP surgeries is then able to meet with these people and inform them of GGT activities that they could access, enabling the team to be put in contact with harder to reach older people who could benefit from the classes on offer. Age UK South Tyneside has also changed the format of their internal referral system, which has made it easier for other Age UK staff to understand their GGT sessions. Clients are now given a single point of contact, which has enabled them to receive more appropriate referrals for their needs.

Localities are still working to develop new relationships with local stakeholders to support referrals. For example, Age UK LS&R is still exploring how GGT can be linked with the wider social prescribing agenda, Age UK Oldham is making new connections with the local BME communities and Age UK Cheshire is developing a partnership with local organisations VIVO and Brio to help build the sustainability of GGT activities.

In terms of ensuring sustainability of GGT in the longer term, stakeholders interviewed noted that the integration of GGT with local services is key. Integration between local services was considered critical for ensuring that older people are able to better navigate a landscape of disjointed services and have an improved experience of local health and social care. The referral pathways described all support the integration of GGT with health and well-being services.

2.3 Models of delivery

Each locality had the autonomy to design and deliver activities for their community in a way best suited to their locality. In order to meet the varying needs of participants involved in GGT, local Age UKs have adapted and refined their models of delivery over time to fit their local contexts. For example, Age UK Coventry developed a new model involving freelance tutors who would be better placed and have more flexibility to focus on growing demand locally for high level activities.

Models are becoming increasingly volunteer led supporting longer term sustainability

At the interim stage of the evaluation, stakeholders noted that volunteers would be invaluable in supporting the sustainability of GGT. The involvement of volunteers in class delivery can not only help to reduce delivery costs but also create and maintain skills in the community. A number of localities are moving toward an increasingly volunteer led model of delivery. For example, in Age UK South Tyneside a number of classes including Fitsteps and Zumba are primarily volunteer led enabling Age UK staff to step back and hand over control to volunteers. This has also increased the flexibility with which classes can be delivered as volunteers are able to offer classes over a wider range of days and times, something which staff may not have been able to provide. In Coventry, the GGT team are working with volunteers through Age UK's 'Inspire and Include' project where volunteers are trained to become qualified instructors who can then assist and take exercise classes. Volunteers in LS&R and Oldham run a number of classes such as walking football as well as supporting paid instructors to deliver activities.

The introduction of costs supports the delivery of activities

Over the course of the last three years, all localities have introduced a small charge for classes to cover the costs of activity delivery. This in turn will help to support the longer term sustainability of the project. Charges have been introduced in a number of ways; in some cases, a course of sessions have been provided free or at a reduced cost to encourage older people to attend with the charge then introduced or increased as the number of participants rise, in others, participants are invited to pay a set fee or to make a 'contribution' above or below this cost.

The prices of each class are regularly monitored by local Age UK teams to ensure that there are appropriate cost models in place, balancing the need for affordability against the need to cover expense. The review of cost models has been important to help localities to plan for the longer term sustainability of classes; the introduction of new, or amendment to existing, charges are both being considered to ensure viability of activities once project funding ends.

The use of a reliable tutor base has helped expand the number and range of activities delivered

Several localities have used a number of external, freelance tutors to support the delivery of activities in their communities. Age UK Coventry recruited three freelance tutors who concentrate solely on delivery of activities for those with higher levels of need. This enables the team to respond flexibly to peaks and troughs in demand. The use of this model has helped to ensure that the project has the capacity to support a greater number of high level participants. The model also enables the team to respond flexibly to changes in demand more cost effectively, with tutors paid on an hourly basis. This model has also been used in Oldham where the team have a number of freelance tutors who deliver seated and gentle exercise in a variety of locations including sheltered housing. Tutor expenses are covered by the costs of classes and give Age UK Oldham further resource to deliver these classes for other older people.

Training has enabled Age UK staff to improve the cost effectiveness of delivery

Localities have provided a variety of training courses for volunteers and staff across the course of the programme, which supports a reduction in costs over the longer term. Age UK Cheshire has extended training across the team to ensure that multiple members of staff are qualified to deliver a variety of GGT activities to optimise the cost effectiveness of its team structure.

In Oldham, 11 staff and volunteers have recently been trained in the YMCA Level 2 Award in Delivering Chair-Based Exercise (QCF). . This has enabled Age UK Oldham to deliver chair based exercises to a wider range of people within the community, including new sheltered housing complexes. The newly qualified instructors give Age UK Oldham further resource with which to deliver classes in the community at a cheaper cost to the project.

Both Age UK South Tyneside and Coventry have become Central YMCA Qualification registered centres. This has enabled their teams to deliver level 2 seated exercise courses in-house with South Tyneside GGT staff also gaining qualifications as Assessors and IQAs. Age UK South Tyneside recently provided Level 2 training to Age UK Oldham staff.

This will reduce the costs of future training for GGT and creates a pool of tutors for these localities. In addition, it has provided a funding stream through the provision of training to other organisations/people from which the income can support projects going forward. For example, in South Tyneside, the team was contacted by 'Sight Service', a local organisation working with people who are visually impaired, to train a team of their staff in chair based exercise.

2.4 Information and advice activity

Between November 2013 and June 2016 over 485,429 contacts were made through the distribution of information & advice (I&A) resources. At the interim stage of the evaluation, GGT had already exceeded the three year programme target for information and advice

Localities have used a variety of I&A techniques to market GGT classes

Local Age UK partners have utilised a variety of methods to raise awareness of GGT activities within their communities. These methods include target mailing, attendance and presentations at local events, leaflet distribution, and the use of print and social media including Facebook and Twitter.

Local teams considered newspaper articles and attendance at community events to be some of the most effective ways of targeting and attracting participants to low level activities. Local partners reported that these techniques were often the least time intensive yet most effective at conveying the aims and benefits of GGT.

Stakeholders interviewed reflected that the materials used were effective at engaging not just older people but volunteers too and were targeted appropriately. In particular, stakeholders shared that the information was helpful to participants who were able to see that GGT offers a wide variety of activities not just those more traditionally associated with the older generation.

'The materials have been fantastic, they've helped get lots of volunteers involved as well as participants who were able to see the selection of things on offer' [Stakeholder, Oldham]

The evidence of how awareness raising has converted into participation in classes is limited

Anecdotal feedback suggests that the programme's information and advice activity has been successful in recruiting older people to GGT activities. The majority of participants interviewed recalled hearing about the projects through Age UK, namely seeing leaflets and articles in their local community, which prompted them to try to find out more. The majority of survey respondents also reported hearing about the programme from Age UK. However, the evidence available does not allow for differentiation to be made between participants hearing about GGT from promotional material or directly from Age UK contacts. As a result, it has not been possible to assess the extent to which the I&A activity 'converts' to participation overall.

Focus on the provision of health and wellbeing materials could be stronger in keeping with one aim of the programme overall

While the main focus of the activity to date has been awareness raising, to a lesser extent materials have been valuable in promoting the benefits of physical exercise more generally. Stakeholders considered that materials which included information on physical health and exercises, which older people could do at home were effective at educating and supporting participants. Stakeholders conveyed that these methods were particularly effective as they enabled older people to take the information away and refer to later on.

Despite this, several stakeholders expressed that there could have been greater emphasis on promoting the benefits of physical exercise more widely to older people. One stakeholder commented that older people were brought up in a culture which focused much less on wellbeing and fitness and so to engage this group, the narrative supporting GGT needed to be strong. Several stakeholders commented that GGT could have concentrated more on refining and embedding this narrative from the outset to support the recruitment and maintained involvement of participants.

2.5 Volunteer involvement in GGT

Volunteers provide invaluable community assets to support the delivery of GGT

In total, 160 volunteers have been recruited across the five localities between November 2013 and June 2016. The ways in which volunteers have been involved in GGT varies across each locality, however all local teams reflect that their support has been invaluable.

Volunteers have taken on multiple roles to support project delivery

The roles undertaken by volunteers range across each GGT project. Local teams have supported and encouraged volunteers to take up roles which they feel comfortable in and able to do. In some localities, such as Oldham and South Tyneside, volunteers have played a key part in providing transportation for older people to access activities, acting as drivers. Several participants interviewed during the evaluation reflected the invaluable role that volunteers played in transporting them to classes, which for these participants would otherwise not have been possible. Another key task undertaken by a number of volunteers has been providing administrative support to the GGT team including the co-ordination of fellow volunteers, participant survey inputting and taking a register at classes.

Over time, the role of volunteers has evolved in all localities with many now taking responsibility for running classes for participants. This has not only enabled volunteers to gain new skills and confidence, but has also supported the longer term sustainability of individual activities. For example, in LS&R, one volunteer delivers Wii console sessions at a Day Centre for people living with dementia and in Cheshire, volunteers run walking football sessions. As discussed in section 2.3, the role played by volunteers in project delivery is a central way in which localities are beginning to achieve sustainability for individual classes.

Volunteers found the process to become involved fairly straightforward however delays were often experienced

Volunteers interviewed reflected that the process to become a volunteer for GGT projects was relatively straightforward and the level of information needed by teams was appropriate for the roles they played. The recruitment process differed slightly across localities, however broadly involved application forms, background checks and a relatively informal induction procedure.

While most volunteers were satisfied with the process undertaken to get involved with GGT, several volunteers from across a number of localities indicated a degree of frustration with the time taken to complete the process of recruitment. Part of this delay was attributed to the formal background checks needed to allow volunteers to work with older people. However, volunteers also considered that there had been a number of delays in co-ordinating and managing their information, which held their applications up. Several commented that having staff in place in each locality assigned to oversee the volunteer process from start to end would be worthwhile.

Volunteers have brought a wealth of experience which benefitted GGT classes and this is one way in which commissioners may be drawn to the project

Although local Age UK partners have shared that finding volunteers with 'appropriate' skills to support GGT has been difficult at times, local teams have benefited significantly from those volunteers who have been involved. There has been a variety in demographic profile exhibited in the volunteer portfolio available to GGT, which has also been reflected in a range of skills mix. Volunteers have brought a vast range of experience on which GGT projects have been able to draw. For example, in Oldham, one volunteer who is completing a sports degree has been able to use his knowledge to run walking football classes for older people. In South Tyneside, another volunteer with a love of dance has channelled this into providing a range of gentle dance classes for participants in the community.

Stakeholders interviewed highlighted the value of volunteers in supporting the sustainability of GGT (as described in section 2.3) and the key role they have to play in creating longevity once project funding ceases. Linked to this, several stakeholders reflected that the use of volunteers in supporting the projects provided a unique selling point to commissioners and may give a competitive advantage when seeking additional funding. Furthermore, the involvement of volunteers may be appealing at a cost saving level with the potential to reduce the costs of mainstream commissioning of GGT activities.

Several stakeholders considered that volunteers could also effectively support the engagement of those who are traditionally harder to reach such as ethnic minority groups, more so than health and social care services. This may be of particular interest to localities such as Oldham and LS&R who have focused on targeting BME communities.

Age UK staff, stakeholders and volunteers have identified a number of factors, across the programme's lifetime, which have both facilitated and presented challenges to success. Here we examine these factors in detail.

2.6 Enablers for success

GGT aligns well with local priorities

All stakeholders interviewed considered that GGT both fits with, and complements, local strategic health and wellbeing priorities. This was perceived as a particular strength of the programme overall; both in supporting the establishment of projects locally and in future, when seeking future funding. Stakeholders emphasised that the twofold appeal of the programme was central to success as local projects focused not only on the physical and emotional wellbeing of older people but also on addressing social isolation.

The view of strong alignment between GGT and local priorities was echoed across all localities. For example, in South Tyneside, the focus of GGT in bringing older people together in groups and reducing social isolation is one of four key areas identified by the Health and Wellbeing Board in their strategy for improving health and wellbeing across the borough. Stakeholders from LS&R highlighted that GGT aligned well with LS&R's local health and social care strategy - 'Better Care Together', which is a programme of work transforming the health and social care system locally by 2019. This strategy emphasises current pressures and associated costs from a system that is reactive rather than proactive, the prevention agenda and bringing care into the community. One stakeholder reported that GGT 'slots perfectly' into two of the eight Better Care Together work streams; those focused on frail, older people and long term conditions.

> *"'GGT is a huge, huge part of the prevention agenda as it helps people with their physical and mental wellbeing which in turn helps prevent them from developing more serious conditions. It is these kind of things we need to be looking to fund over the next few years"* [Stakeholder, LS&R]

At a national level, GGT fits well with the increasing focus on prevention and the need to move to a more holistic model of health and social care that is less dependent on traditional health care services and more reliant on community and third sector support. Activities within GGT feed directly into this agenda; all localities provide a variety of low level activities which support older people to participate in physical exercise and in turn, potentially improve or maintain health levels. High level participants receive more intense support from GGT, for example through Falls Prevention classes. Underlying this support is the aim of maintaining and improving the functionality of participants and preventing further deterioration. Anecdotal feedback from both participants and stakeholders suggests that this support has been very effective. In South Tyneside, four participants interviewed were referred to a GGT falls class following admission to hospital. All participants reported that since involvement in these classes, they had not had any further contact with, or admissions to, hospital. This reflects the role that GGT has started to play at

> *"'Things like GGT make the [health and social care] system more affordable"* [Stakeholder, LS&R]

> *"'It's like having a monitoring system in the community, rather than waiting until that patient has a fall and are taken into hospital, when Nicola sees they are deteriorating, we can get them back and act as a safeguard.'* [Stakeholder, South Tyneside]

a local level, with one stakeholder describing the project as '*an extension of the health service'*.

GGT addresses gaps in existing health and wellbeing services

As well as aligning well with local priorities, stakeholders considered that classes provided through GGT are much more focused on health and wellbeing than other projects available locally; in particular the activities were viewed as better tailored to the needs of the older generation. Several stakeholders reported that a key impact of GGT 'on the ground' has been to make activities accessible to older people with higher level needs. In this respect, they considered that GGT had really filled a gap in existing provision rather than duplicating what is already offered within the community. For example, in Oldham GGT has made group activities accessible for older people with dementia who would previously have struggled to attend classes without further support. The focus on targeting those who are typically 'harder to reach' such as those within the BME community, those who are socially isolated and those with long term conditions was valued. Stakeholders considered that this focus should help GGT gain traction in local health and social care systems.

> *"'if this would go, then we would have nothing as exercise on prescription is not set up for that type of patient, they don't do groups, it's literally just go to the gym and they write you a little programme and anyone over 65 would find that difficult.'* [Stakeholder, South Tyneside]

That GGT both fills local gaps in provision and aligns with national and local priorities was seen as important for making inroads with commissioners and encouraging engagement with the programme as a whole.

Projects are run by Age UK which is well known and respected

Several stakeholders reported that GGT being an Age UK project had helped localities develop and embed activities more easily. Stakeholders considered Age UK to be a well-known and trusted organisation for older people, which a number stated enabled other third sector and health and social care organisations to refer into the project with confidence.

> *"'The fact is, that when you know it's an Age UK run class, you can relax, it's a trusted organisation and that helps"* [Stakeholder, Coventry]

The projects have been delivered by enthusiastic and dedicated teams

Age UK staff employed and assigned to deliver GGT in their communities have worked hard to ensure the success of activities for older people. All stakeholders across the five localities shared positive views about the roles that the teams played in making their projects work effectively. Stakeholders gave examples of how individuals had gone 'above and beyond' what was expected in their roles to ensure that the participants were well supported and enjoyed attending GGT activities. For example, in Oldham and South Tyneside, staff carry out free walking stick checks and adjustments for participants, which avoids the need to attend at a hospital to get this completed.

"'All of the staff have just done so much more than was required. You can tell they're really passionate about it, it shines through and I think that's what has pushed it forward and made it work"
[Stakeholder, Oldham]

'People with LTC are the ones who otherwise tend to deteriorate in terms of their physical wellbeing and tend to develop further needs in future so if we can find a way of supporting and encouraging these people to take part in activities then that's an important approach to take" [Stakeholder, LS&R]

2.7 Challenges to success

Finding local resources to enable projects to run activities within budget has sometimes presented challenges

Local Age UK partners, GGT participants and stakeholders interviewed highlighted the importance of the availability of safe and reliable transportation for older people and the impact that this can have on participation in GGT. Localities reported that many participants had found it difficult to find transportation that is affordable, convenient and dependable; this has been a particular issue for those older people requiring higher levels of support.

Older people interviewed used a variety of methods of transportation to attend GGT classes. Independent of support from Age UK, reliance on family members and taxis were the most frequently cited means by which participants got to and from classes. Due to expense and availability, these methods were not considered to be sustainable over the long term and several participants reported that this may become a deciding factor for their involvement in GGT in future.

All localities have worked to improve the transportation options for participants in their communities. Age UK Cheshire received short-term funding for a driving scheme and reported that class attendance increased 'dramatically' when the scheme was in place. In South Tyneside and Oldham, volunteer drivers have supported participants to attend a number of classes and across localities staff have also stepped in to fill this role. Age UK staff and stakeholders alike emphasised the significance of transport for supporting access

to GGT activities, with several suggesting that there could be benefit in local Age UKs providing transport or establishing links with others who could help to address the gap.

Linked to this, local partners have reported problems finding venues to run GGT activities, which are both conveniently located and affordable. Classes have been held in a variety of venues including church halls, community centres and rooms in sheltered accommodation. A number of localities have also been able to use rooms within GP surgeries and health centres. GGT teams have worked to identify potential venues for activities based on proximity to where participants live and good transport links but this has remained a problem throughout the lifetime of the programme.

Developing relationships with local key players

Creating and maintaining relationships with key local organisations to support the development and delivery of GGT was critical for each project's success. However, a number of stakeholders gave feedback that local Age UK partners would have benefitted from stronger identification and cultivation of relationships with stakeholders critical to sustaining GGT. Stakeholders suggested that this could have been approached more strategically and so was felt to have led to missed opportunities to embed projects fully in the local landscape. This reflects feedback from several Age UK staff across differing localities who reported that engaging with commissioners had been challenging.

Local teams reported that GPs in particular are often 'bombarded' by information from many different health and wellbeing initiatives which are often short-lived, and as a result GP engagement is difficult. Nonetheless, as noted previously, local Age UKs are making inroads with GP practices, with the majority of local GGT teams now 'joining-up' with them.

Encouraging participants to progress from high to low level activities

Feedback from Age UK staff, volunteers and participants indicates that fewer participants than expected have transitioned from high to low level activities. This finding is supported by programme management information collected by local Age UKs. Local partners have highlighted that some participants find progression difficult physically but also psychologically particularly when they have established relationships with the instructor and other class members. Local Age UKs have adopted different approaches to try to overcome this; for example Age UKs Oldham and South Tyneside have identified gaps in provision between high and low level activities and have developed classes to cater for people who are ready to progress from Falls Prevention classes but are not 'ready' to take part in low level activities.

3 Overview of the profile of GGT participants

This chapter provides an insight into the baseline profile of older people participating in high and low level GGT activities. This has been informed by an analysis of participants' responses to the survey completed when they first join GGT activities (i.e. round one survey). Given the variation in response rate across all five localities, it is difficult to assess whether survey respondents are representative of GGT participants at the programme level. It is possible that the profile is skewed to a degree as a result of the large response received from LS&R. Nonetheless, the profile derived from analysis of the surveys presents a useful insight into the characteristics of some of the older people participating in the programme and how this may compare with what was initially expected.

3.1 Profile of GGT participants[7]

The profile of round one survey respondents suggests that GGT is supporting older people who often at least one long-term condition yet largely feel in control of their health

- 33% response rate (2071/6229)
- The mean age is 76
- 72% (1460/2018) are female
- 49% (800/1618) live alone
- 78% (1317/1691) have one or more than one long term health condition
- 32% (511/1575) had experienced a fall or loss of balance in the last month
- 77% (1320/1705) feel in control of their health
- An average respondent has 0.48 days of unplanned visits to their GP in the last month and one long term condition
- Arthritis was the most frequently reported long term condition (725 respondents reported having this LTC).

More than three quarters, 78% (1317/1691) of survey respondents reported a long-term condition. Arthritis, heart conditions, diabetes and respiratory conditions are the most common conditions reported respectively. However, this is self-reported and participants also reported a diverse range of other conditions including dementia, cancer, Parkinson's disease and underactive thyroid. Self-perception of health is strong with 77% (1320/1705) feeling in control of their health. Despite this, around a third of respondents had experienced a fall or loss of balance within the last month.

3.2 SF-36 profile of participants

Participants have relatively high emotional wellbeing and low physical wellbeing

The participant survey includes the SF-36 questionnaire. Responses to these questions are scored and analysed across eight dimensions of health and wellbeing:

- **Emotional wellbeing**: emotional well-being, social functioning, energy/fatigue and role limitations due to emotional health.

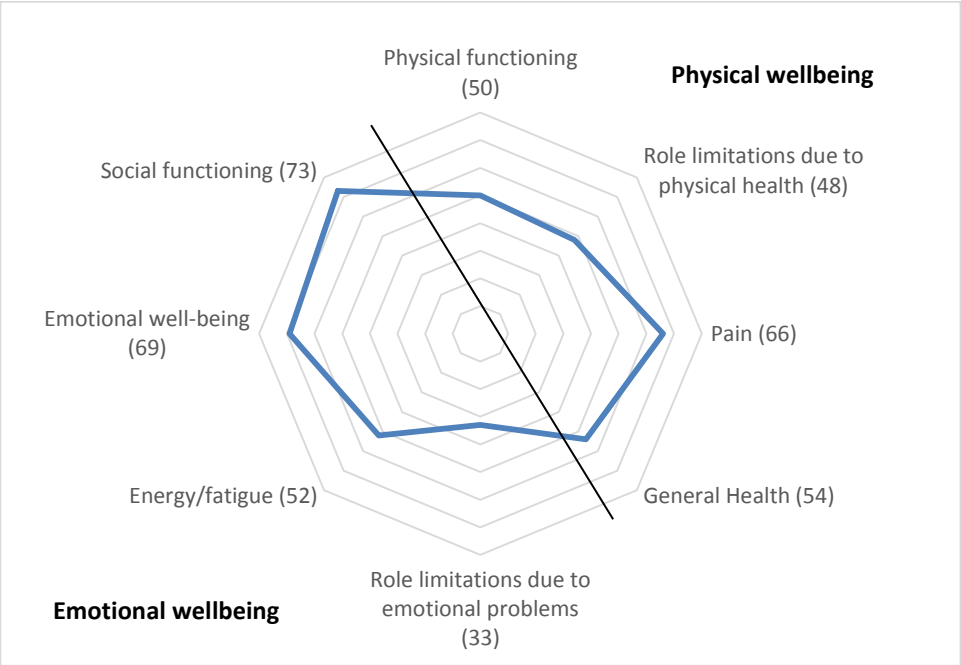
[7] This profile is derived from the surveys competed by participants when they join the programme (round one surveys). Follow-on surveys (second round surveys) from participants have been excluded from this analysis to provide a baseline profile of participants.

- **Physical wellbeing**: general health, pain, physical functioning, and role limitations due to physical health.

Survey responses are converted to a score out of 100 for each of the eight domains. A high score denotes a more favourable health stage.

Figure 3.1 illustrates the baseline average scores for each of the eight domains at the programme level.

Figure 3.1 SF-36 domain profile of GGT survey respondents



SF-36 scores are illustrated in brackets – the higher the score the more favourable the health status. Please see introduction for scoring rules.

Survey respondents scored on average more highly across the dimensions of emotional wellbeing. However, the lowest score overall was in relation to a participant's role limitations due to emotional problems. The higher score in relation to emotional wellbeing is reflective of qualitative interviews which suggested that participants could more readily share social and emotional outcomes compared to ones related to physical health.

In line with findings at the interim stage of the evaluation, participants scored less well across the dimensions of physical wellbeing, particularly with respect to physical functioning, general health and role limitations due to physical health. Levels of pain appeared to be relatively manageable across the programme. The profile remains similar to that reported at the scoping and interim stages of the evaluation which reported physical functioning and role limitations due to physical health are low for participants.

3.3 Motivations for participating in GGT

- One of the final questions of the participant survey asks participants to report what they wanted to achieve from taking part in GGT activities. Despite some expected variation in response, some common themes emerged in relation to motivation for participating in GGT. The motivations shared by participants are all consistent with the intended aims and expected outcomes of the programme reflected in the programme's logic model in annex 3. Frequently cited themes included:
  - to improve balance and stability;
  - to retain or regain independence in day to day life;

- to maintain or increase mobility and physical fitness; and
- to meet new people, make friends and have fun.

3.4 Summary of the typical GGT participant

A 'typical GGT participant':

- Is female;
- 76 years old;
- Lives with another;
- Heard about GGT through their local Age UK branch;
- Wanted to join GGT to meet people and improve their fitness;
- Suffers from arthritis;
- Feels in control of their health;
- Reports having one long term condition;
- Has visited their GP unplanned 0.48 days in the last month;
- Has (relatively) low levels of physical wellbeing with the exception of pain;
- Has slightly higher levels of emotional wellbeing compared with physical wellbeing although limitations of role due to emotional problems was an issue for participants.

4 Qualitative outcomes and impact

The programme logic model[8] , in Annex 3, describes a number of intended outcomes and impacts for the GGT programme. The flexibility of the programme, allowing local targeting and tailoring of activities, ongoing support for participants to continue attendance (for example through the use of volunteer buddies and peer health mentors), and the regular assessment of older peoples' needs were all expected to maximise the impact of GGT on the health and wellbeing of participants.

Interviews with local Age UK teams including project and senior staff, stakeholders, volunteers and older people explored how and if GGT was delivering change and achieving the desired outcomes set out in the GGT logic model. These interviews provide qualitative evidence of outcomes consistent with the programme's theory of change and are discussed in this chapter. This chapter also sets out the programme level analysis of changes in participants' physical and emotional wellbeing, and health care utilisation.

4.1 Outcomes for participants

4.1.1 GGT has improved access to health and wellbeing activities, which are suitable for older people and tailored to their needs

GGT has brought a range of community-based accessible activities, which appeal to a wide variety of older people. A number of stakeholders commented on a decline in local authority funding and the availability of activities suitable for older people, particularly those with long term conditions or higher levels of need.

> *"There's not a lot like this out there for us, not where you get this kind of support and help from friendly faces. I feel like I can get involved in exercise again"* [Participant, Oldham]

Local Age UK partners have worked to identify potential venues for activities based in proximity to where participants live and with good transport links. Classes have been held in a range of venues including church halls, community centres and rooms in sheltered accommodation. The choice of venues to run classes has been an important factor for participation for a number of older people who 'feel more comfortable' in places which are familiar to them and aren't intimidating. A number of participants interviewed suggested that they have taken part in GGT over and above any other form of physical activity as they find gyms, sports halls and more typical locations for physical exercise 'daunting'.

Stakeholders felt that GGT has significantly improved access to physical activity for participants with high level needs in particular. Several commented on the value of the programme in enabling older people with higher levels of need to take part in exercise. For example, providing physical activities for people with dementia or who are blind requires a higher level of support than is often available with the majority of community activities.

In addition, stakeholders reflected that increased integration between local services is increasingly supporting older people to better navigate a landscape of disjointed services and in turn, improve access and the quality of their experiences. As a result, this has supported older people to increase and sustain their involvement in physical activity, both those inside of, and external to, GGT.

[8] The GGT logic model underpins the evaluation framework for the evaluation of the programme. It sets out the programme's inputs, activities/outputs, short-term and longer term outcomes, the programme's Theory of Change provides further narrative for the logic model and sets out the presumed mechanisms by which GGT is expected to deliver outcomes and impact.

4.1.2 GGT is increasing the participation of older people with LTCs in exercise

Between November 2013 and June 2016, GGT has reached a total of 6,229 older people through high and low level exercise classes. As of the end of quarter 11, 48% of low level participants and 42% of high level participants were still taking part.

Multiple interviews with participants, volunteers and Age UK staff undertaken during the final evaluation suggest that GGT is, in the main, not duplicating existing physical activities available to older people within each locality. This was considered to be particularly true for participants with higher levels of need, including those with dementia or who have recently had a stroke. Furthermore, feedback indicates that in the absence of GGT, a significant number of older people would not have taken part in other physical exercise; this was emphasised for high level participants in particular. Stakeholders stressed the appropriateness of sessions for the older population, something which the majority considered is not covered through other local activities, including those funded by Public Health.

> *"I don't know what I'd do without this, I'm not well enough to go to a gym or somewhere on my own but here they take the time to help me"* [Participant, South Tyneside]

Older people interviewed also reported that through GGT, they have increased the amount of exercise they are taking part in. Participants interviewed noted that GGT had increased their desire to do some form of physical activity as they found the sessions enjoyable. In addition, the majority suggested that Age UK staff members, the style and the content of classes had encouraged them to take up more than one activity, increasing the level of physical activity undertaken.

4.1.3 Through GGT older people are creating and strengthening social networks, helping to reduce social isolation

The majority of older people interviewed reported that one of the key benefits of attending GGT classes was the opportunity to meet new people and build friendships, which without the classes was considered very difficult.

Participants emphasised both the risk, and significance, of feeling isolated from the community in later years. Most stressed the importance of GGT for helping them to meet people with similar interests and give them a reason to leave their house or flat. As a result of attending GGT classes, participants noted improvements in the levels of interaction with people on a weekly basis which afforded a sense of belonging.

> *"People who have lost their partners who come here now have a support group, we have that support network of friends, it's more than just a fitness thing. It means a lot of things to a lot of different people…you could say it treats the person holistically."* [Participant, Coventry]

In addition, participants often shared their joy at being able to meet others and make friends with people who lived only a street or two away - yet they had never met before. This has reduced the feeling of social isolation for these participants, creating the sense of having a newly created social network close by. Many older people interviewed noted that having a network of people to draw on had become more important as they aged, particularly as it can be '*easy to become socially isolated*'.

Social interaction with new friends was not limited to GGT classes. Several reported developing new friendships outside of GGT classes, with examples of groups of friends going out shopping, for meals and even on holiday.

The interactions and opportunities to make new friends has not only supported a reduction in feelings of loneliness and isolation but also encouraged higher levels of participation in

activities. Participants emphasised that the chance to see new friends and Age UK staff, who made them feel welcome, gave them an incentive to return to sessions week after week. Stakeholders also considered that having friendly faces who 'expect' a participant to return every week improves the participation and retention rate of older people in GGT, particularly those needing higher level support.

4.1.4 Participation in GGT is helping to improve the confidence and self-esteem of older people

Older people reported that taking part in classes as part of GGT has improved their confidence and self-esteem, both in relation to undertaking physical exercise generally as well as with everyday functioning. For example, several participants reported great improvements in their self-belief of being able to independently get up from a chair and walk small distances more confidently following balance and stability classes. They report that this has been key to them feeling that they have regained a sense of independence.

> *"I feel more confident at home, and generally in life. I already know the walks we go on but I wouldn't feel confident doing them on my own"*
> [Participant, Oldham]

A number of participants who had received high level support through GGT felt able to move from one to one support to attend group exercise classes, reporting an increase in confidence in relation to their physical health.

As well as increasing the confidence and self-esteem of older people, stakeholders, volunteers and participants have reported an increase in the self-worth of those taking part in GGT. Several described the valuable role older people would have played in life when younger and feel that GGT is a great way to re-introduce them to the community and emphasise that they are still valuable members of society.

4.1.5 Qualitative evidence of improved physical and mental wellbeing is emerging

Interviews with older people provide qualitative evidence of improvements in both the mental and physical wellbeing of GGT participants. Participants had varying levels of health prior to involvement with GGT activities and so changes to emotional and physical wellbeing looks different across this population.

A number of older people reported that taking part in exercise with the support of Age UK staff has led to a reduction in joint pains and increased functionality. Several pointed to changes in their ability to take part in the entirety of a class as evidence of improvements in fitness. A few participants interviewed report being able to stand again unassisted and move their arms and legs more easily, with one now able to walk without a split following a sustained period of involved with GGT balance classes.

> *"I feel so much healthier now from taking part in these classes, my legs ache less and I've had no winter 'nasties' this year."*
> [Participant, Coventry]

Numerous participants shared experiences of improved mental wellbeing including feeling happier within themselves, feeling valued again and one participant who described feeling comfortable and confident enough to come off her anti-depressants following a period of engagement with GGT.

> *"The walking football project has been the primary reason for my weight loss, together with my new healthy diet and stopping smoking."*
> [Participant, Oldham]

Three people interviewed reported that the exercises and techniques learned during GGT classes had enabled them to react better to incidences such as loss of balance and falls. Several participants also reported a reduction in the number of falls experienced and in turn, the number of contacts with the hospital. Age UK staff also reported that older people felt healthier and this seemed to have knock on effects to GP attendances; some staff noted that older people were visiting GPs less and required less support as they were becoming increasingly able to look after themselves.

For some participants, involvement in Get Going Together activities has been instrumental for maintaining existing levels of health and wellbeing, thereby preventing longer term deterioration of their physical conditions.

Age UK South Tyneside has collected quantitative data to help assess the impact of GGT, in addition to the participant survey. The findings suggest that participants have experienced improvements in their mobility and physical functioning following involvement in GGT.

Data was collected by the local hospital based physiotherapy team, which worked in partnership with Age UK South Tyneside to deliver its falls prevention classes. The team assessed *Balance, Gait and Functional* score ratings before and after attendance at classes. Results from 25 participants reveals significant improvements in all three scores:

- 50.2% improvement in Balance Score
- 58.2% improvement in Gait Score
- 43.9% improvement in Functional Score

Interviews with participants' supports this, with interviewees reflecting that taking part in physical exercise seemed to have an impact on their mobility and flexibility.

> *"The classes help me to keep fit as possible especially my joints and also keeps my brain working. I can play with my grandchildren again now"* [Participant, LS&R]

4.2 Outcomes for volunteers

4.2.1 Volunteering for GGT has provided a sense of wellbeing and purpose for those involved

A number of volunteers interviewed reported that volunteering has made a big difference to their mental wellbeing. They reflected that supporting GGT has led to a positive increase in mood. In particular, all volunteers highlighted that the opportunity to help the older generation and feel as though they are giving back to the community has improved their self-worth and gave them a good sense of wellbeing. Several volunteers who were retired reported that GGT had made them feel valued and useful again, giving them the opportunity to continue to contribute to society.

> *"'It gives me a good sense of wellbeing knowing that I'm helping people, there have been times in my life where I've needed help so I'm trying to pay a little back. I consider these people to be my friends"* [Volunteer, Oldham]

> *"'I really enjoy it, you get to know different people and you feel as if you are giving something back to the community, it shows life doesn't end at 60 "* [Volunteer, South Tyneside]

4.2.2 Volunteers have gained a range of new skills through GGT

Volunteers reported that GGT has given them the opportunity to learn a variety of new skills as well as utilise existing ones. For example, volunteers across projects have received a variety of training opportunities including chair based exercise training and dementia training. This has supported the increase of skills in the local community.

> *"'I feel this has given me a second chance, I've learnt a lot. I've been able to give something back and improve my prospects at the same time"* [Volunteer, Oldham]

Several retired volunteers noted that GGT has enabled them to retain skills gained during employment and keep their 'brain active'.

A number of volunteers of a variety of ages reported that having the chance to interact with the older generation regularly through GGT has enabled them to learn from them. The sharing of both skills and stories was appreciated by volunteers who felt that the cross-generational relationships that are built through the programme have been invaluable for both participants and volunteers alike.

4.2.3 Volunteering is offering unemployed people the opportunity to gain work experience and build their confidence

> *'It's given me a lot more confidence. When you've been out of work a little while you lose your confidence and feel like you can't do things…now I feel confident in applying for jobs and going to job interviews.'* [Volunteer, LS&R]

A few volunteers expressed that being involved in GGT has given them the opportunity to develop a new skill set which will be valuable for supporting future employment prospects. Volunteers have gained experience in people facing roles and learn '*the ability to deal with people'* through engaging and communicating with older people but also with the GGT team and wider Age UK staff. Volunteers felt this had improved their social skills, which could then be drawn on as an example on CVs and at job interviews.

For three volunteers, GGT has not only impacted on the employability of volunteers but it has also introduced them to the possibility of working in the social care industry, giving them the experience to make this step.

4.3 Outcomes for stakeholders and the wider health and social care system

4.3.1 GGT has helped to integrate Age UK with health and wellbeing services and improved partnerships with other local organisations

> *'Our aim is for people to stay active for life and not just for the 6 months that we see them…GGT offers older people continued provision'* [Stakeholder, LS&R]

Local partners have developed relationships with key health and care stakeholders to help integrate GGT with health and care services – including creating referral routes from primary, community and acute care. All localities have been successful, to varying degrees, in establishing relationships and integrating with new and existing services.

There are multiple examples across localities of ways in which GGT has become embedded in health and care pathways. In Coventry and South Tyneside, GGT has become formally established within respiratory care, physiotherapy and falls pathways. In Cheshire, the team receive referrals to its cardiac rehabilitation classes from both GP practices and the local Cardiac Rehabilitation Unit as well as maintaining a presence in local hospitals. Age UK LS&R benefits from a GP Exercise Referral Scheme Co-ordinator who has an on-going relationship with the Rehabilitation Department of Leicester

> *"Thanks to Age UK we are meeting the NICE guidelines which is the most important thing, the NHS is in no financial situation to keep people on for 30 weeks nor is it medically necessary but it stops the cycle of falls then hospital, discharge, then fall again. The consultants completely back this, they think it's so important what we're doing'* [Stakeholder ?] [Stakeholder, South Tyneside]

General Hospital. In Oldham the GGT Falls Prevention class is integrated into the falls pathway delivered by the NHS falls prevention service.

Localities have also created and maintained links with local organisations such as other third sector groups, local councils and housing providers. These relationships have supported local Age UK partners to recruit participants, deliver activities and support the project more generally. The development and strengthening of these local partnerships has not only been beneficial for GGT but they can also be sustained going forward.

4.3.2 Qualitative evidence suggests that GGT has reduced unplanned demand on healthcare services

Feedback from older people, volunteers and Age UK staff suggests that through more regular involvement in activities, participants have felt healthier and in turn, less reliant on healthcare services. Age UK staff report that their regular participants are describing a reduction in the number of times they visit their GP or nurse. A number of participants noted improvements in their balance and stability, which they feel have led to a reduction in the number of falls/near-falls they have had or better equipped them to deal with the after effects of one. A few participants compared their frequency of unplanned hospital contact before and after their involvement in falls prevention classes, describing a 100% reduction in attendance.

> *"People are telling us they're not going to the doctors as often and feel a lot healthier than they have done in the past."* [Staff member, Coventry]

A perceived reduction in unplanned demand on healthcare services is potentially associated with additional factors besides participation in physical exercise. Local Age UK partners have supported participants in a number of other ways over the course of GGT; staff have performed a variety of tasks including adjusting walking sticks and frames removing the need for participants to attend their GP or hospital to have this done. In addition, teams have signposted older people to support in the community, which a number of participants reported they previously would have approached their GP for. Two participants also reported that the regular contact with Age UK staff and participants had reduced the frequency with which they attended the GP to 'feel like someone is there and listening'.

4.4 Impact of GGT on the emotional and physical health of participants – changes in participants' SF-36 profile

The impact of GGT on the emotional and physical wellbeing of participants was assessed using the participant survey analysing baseline vs follow up responses. The baseline reported is derived from the surveys competed by participants when they joined the programme (round one surveys). Follow on surveys were also collected by each locality.

Each participant's surveys were categorised by wave of survey (baseline, follow up wave one, follow up wave two etc.) and sorted by duration from the date of the first survey[9]. The time categories used were:

- Up to three months from the date of the first survey (excluding those completed within two weeks);
- Between three and six months from the date of the first survey;
- Between six months and one year of the date of the first survey;

[9] The impact analysis presented below is based on 826 surveys. Please see annex 4 for a detailed methodology of the survey analysis and complete set of findings. The participant profile of the surveys used in the statistical analysis was reviewed to get a greater understanding of the representativeness of the surveys used in the analysis. The results show that, on the whole, the profile of participants is broadly similar to the profile presented in chapter 3, with comparable figures for age, gender balance and percentage of respondents with long term conditions. Respondents used in the statistical analysis were slightly less likely to live alone.

- Between one and two years of the date of the first survey;
- More than two years since the date of the first survey.

The outcomes below are presented by time category.

The evaluation has taken place over a three year period, over which a deterioration in health and functioning of the older population would be expected, particularly for those with long term conditions - a focus of GGT. Long term conditions, by nature, may worsen over time. The results of the analysis below should be considered in light of this. While only a number of changes in score were statistically significant, even maintenance or small improvements could suggest that GGT has supported the preservation, or prevented a sharper deterioration, in an older person's health.

4.4.1.1 *The findings show that involvement in GGT has improved participants' energy, social functioning and levels of pain but ability to deal with day to day life as a result of emotional problems has decreased*

Table 4.1 below shows the domains in which an increase in participant SF-36 scores were observed across each time category. A higher score denotes a more favourable health state and so an increase in score suggests an improvement in wellbeing.

There have been statistically significant improvements in scores at multiple points in time, for the following domains (Figure 4.1)[10]:

- Energy/fatigue
- Social functioning and
- Pain

These findings indicate that involvement in GGT has had a positive impact on participants' experience of pain, energy and social functioning, which is consistent with qualitative findings. In contrast, role limitations due to emotional problems showed scores over time that were significantly lower than the baseline score. Reasons for this are not clear but are unlikely to be due to factors within the control of the GGT programme. .

Table 4.1 SF-36 domains which showed an increase in participant score across time categories

Up to 3 months	Up to 6 months	Up to 1 year	Up to 2 years	>2years
Physical function	Energy	Energy	Energy	Non-significant increases for all categories
Role limitations due to physical health	Emotional wellbeing	Social functioning	Pain	
Role limitations due to emotional problems	Social functioning	Emotional wellbeing	Physical function	
Energy	Pain	Pain	Role limitations due to physical health	
Pain	Physical function		Emotional wellbeing	
			Social functioning	

Cells shaded blue indicate a statistically significant change at a 95% confidence level

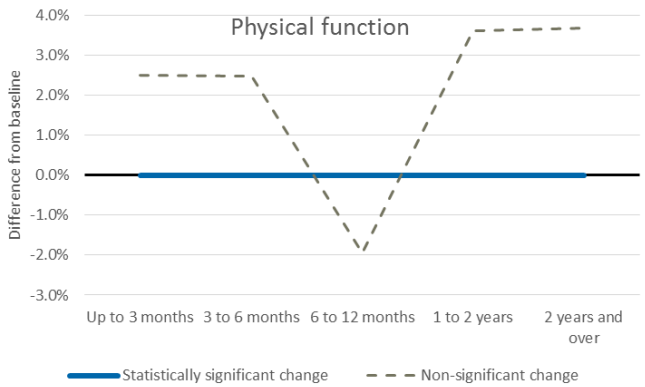
[10] The figure presents the change in SF-36 scores over time. It is important to note that the scores are not from exactly the same individuals for all periods, therefore the charts present an indication of change rather than the changes for a group of individuals.

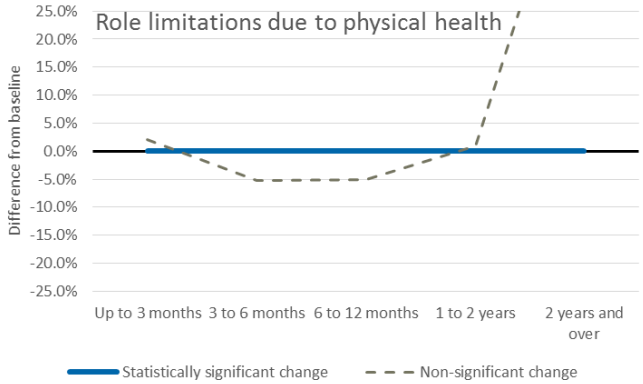
There was a slight increase in the scores for physical function, role limitations due to physical health and emotional problems, energy and pain in the comparator group up to three months from the baseline measure. However, none of these increases in score were statistically significant. The change in SF-36 scores for participants between three months and six months from the baseline survey showed more statistically significant results than for the group up to six months. In this category there were statistically significant increases in the SF-36 scores for energy, emotional wellbeing, social function and pain, but the small increase in score for physical function was not statistically significant. **There were statistically significant increases in SF-36 scores for participants who completed a survey between six months and one year (energy and social functioning) and between one and two years (energy and pain) from completing the baseline survey.** There were also a number of non-significant increases across domains. The change in SF-36 scores for participants who completed a survey over two years following the completion of the baseline survey shows no statistically significant changes in SF-36 scores. This should be expected due to the small sample size. There were non-significant increases for all SF-36 categories in this time category.

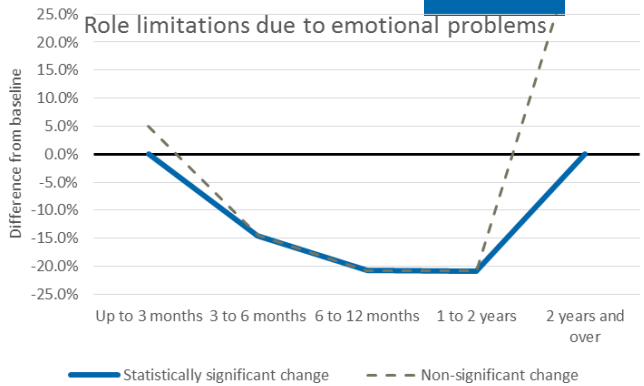
Findings from the survey reflect qualitative findings of the benefits for older people from participating in GGT activities. Survey results show that GGT has contributed to improvements across a number of areas of emotional and physical wellbeing for participants. Statistically significant improvements have been observed for pain, social functioning, and emotional wellbeing suggesting that these have been the areas of greatest impact. A number of improvements in scores were also seen across other domains but these were not found to be statistically significant.

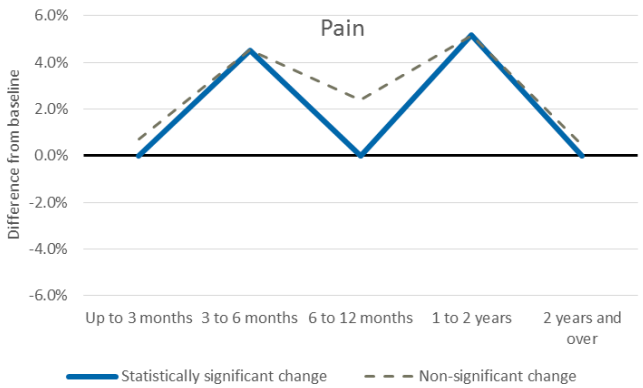
Given the age of participants, some degeneration of health and social functioning might be expected over the time period covered by the survey. **Results show that scores across a number of domains (excluding role limitations due to emotional problems) have either increased or remained stable. This indicates that the programme has also contributed to preventing decline and maintaining health and social well-being.**

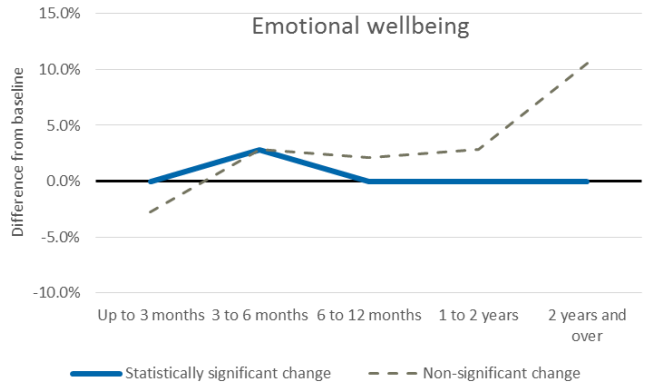
Figure 4.1 Change in SF-36 scores over time – overall impact

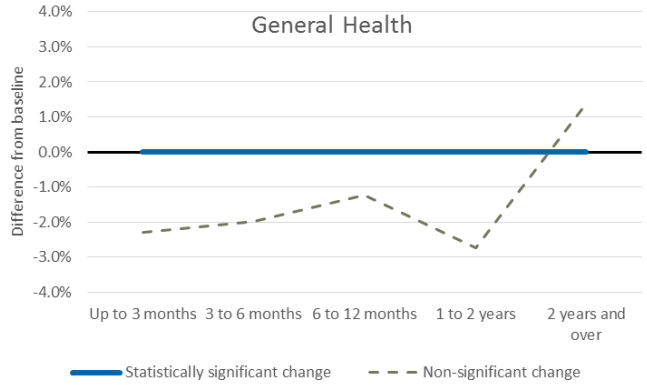


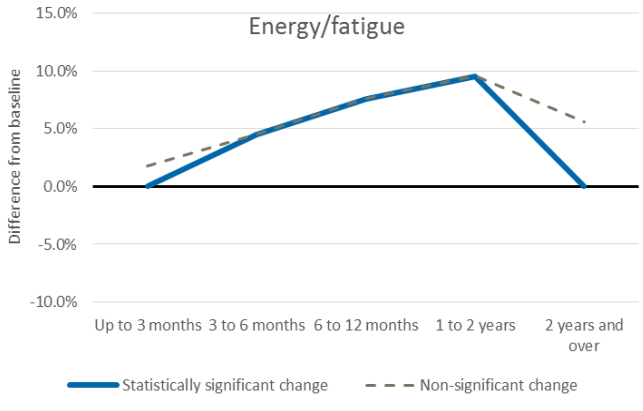


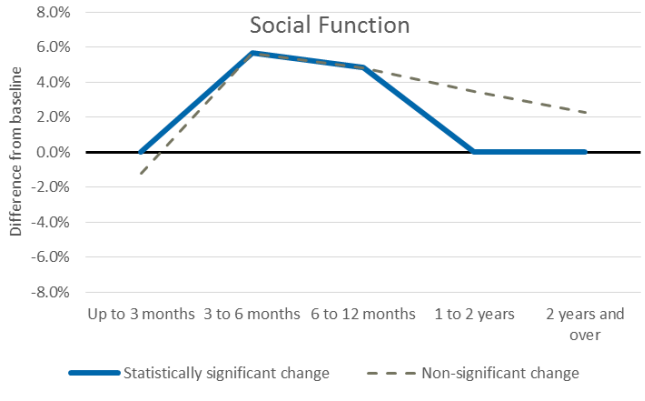






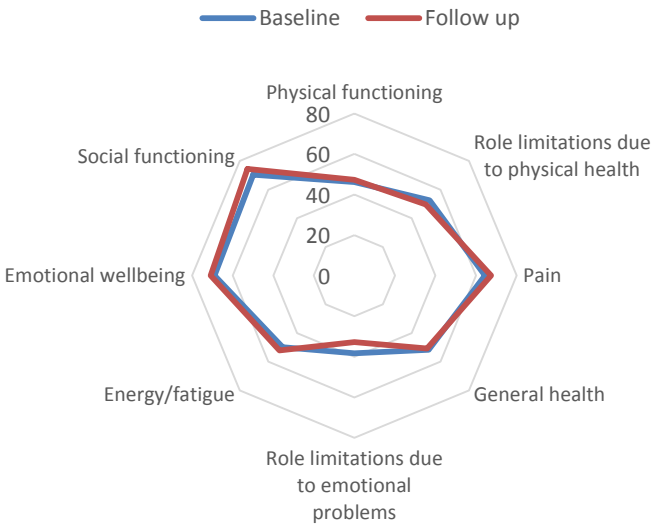






4.4.1.2 *The greatest difference is observable for participants responding between three to six months from their baseline survey*

	Total	
	Base	6 months
Sample size	366	
Physical function	46.21	47.36
Role limitations due to physical health	52.51	49.77
Role limitations due to emotional problems	38.25	32.71
Energy/fatigue	49.88	52.13
Emotional wellbeing	68.95	70.90
Social function	70.52	74.52
Pain	64.45	67.37
General health	51.80	50.78



Cells shaded blue indicate a statistically significant change at a 95% confidence level[11]

The change in SF-36 scores for participants up to six months showed the greatest number of statistically significant results across the programme. In particular, the change in SF-36 scores for participants between three months and six months from the baseline survey showed more statistically significant results than for the group up to six months. These findings suggest that maximum benefit of participating in GGT is experienced between three and six months, where the most significant improvements were observed, although small sample sizes have limited the assessment of impact over longer periods of time.

There were statistically significant increases in the SF-36 scores for energy, emotional wellbeing, social functioning and pain, and a statistically non-significant increase for physical function. There was a statistically significant decrease in the score for role limitations due to emotional problems, and an insignificant decrease in the scores for role limitations due to physical health and general health. This suggests that participants involved in GGT for a period of up to six months have experienced an increase in their energy, pain levels, emotional wellbeing and social functioning. The findings also suggest that GGT has had less of an effect on physical or general health of participants although this may be expected for a cohort of participants for which some degeneration of health and social functioning might be expected over the time period covered by the survey.

4.4.1.3 *There has been a change in demand for unplanned health appointments for GGT participants*

Over time, there has been a change in demand for unplanned health appointments (Figure 4.2 and Table 4.2).

[11] While some changes may be statistically significant, the magnitude of change in some instances is very small, which may mean they have little practical value for individuals. For example, a 1.95 point change in emotional wellbeing, while statistically significant, may mean little in practice for respondents.

For the first two time periods (up to six months), **the number of unplanned GP appointments per person is significantly lower than at the baseline, and between three and six months the number of unplanned hospital appointments per person was significantly lower than at the baseline.** For participants involved in GGT for up to six months from their baseline survey, **the number of unplanned GP appointments, hospital appointments and other health appointments all decreased**, with the change in the number of GP and hospital appointments statistically significant. This change indicates a decrease of 70 GP appointments, 62 hospital appointments and 17 other health appointments. If these changes are applied to the total population who completed at least six months on Get Going Together (741), then the change in appointments is 142, 126 and 34 respectively.

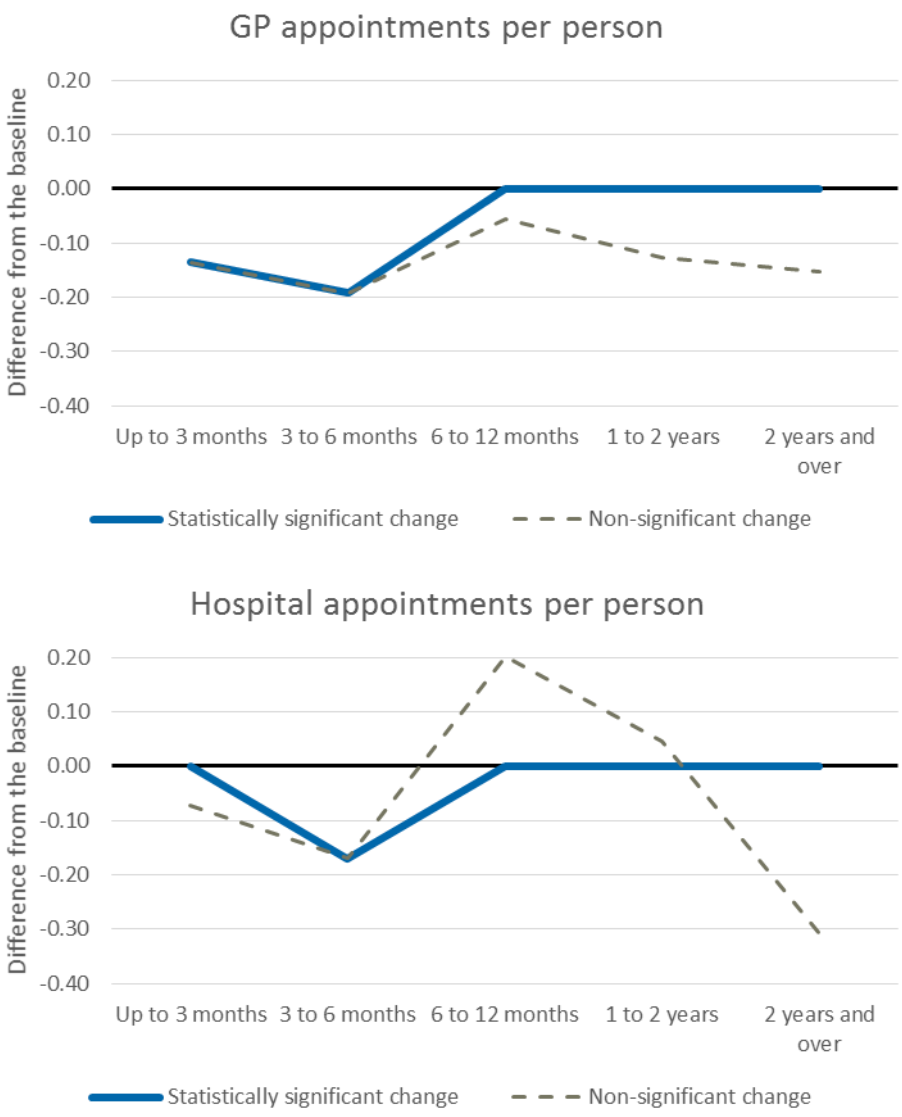
Table 4.2 Number of unplanned appointments at baseline and each time point (in days)

	Base	3 months	Base	6 months	Base	1 year	Base	2 years	Base	> 2 years
Unplanned GP appointments	0.24	0.1	0.31	0.12	0.39	0.34	0.38	0.26	0.15	0
Unplanned hospital	0.2	0.13	0.3	0.13	0.19	0.39	0.15	0.2	0.38	0.08

Cells shaded blue indicate a statistically significant change at a 95% confidence level

This finding indicates that there has been a reduction in the number of unplanned health appointments for participants involved in GGT for up to six months following their baseline survey. However it has not been possible to assess if the changes in health appointments are directly caused by GGT or by other factors.

Figure 4.2 Change in unplanned health appointments



After six months, there are no statistically significant changes in healthcare demand from the baseline. It would be expected that in the target age group the number of GP, hospital and other health appointments would increase over time as individuals get older. Therefore if the number of health service appointments did not change from the baseline, this could show that the programme has supported the maintenance of good health, as the number of health appointments had not increased.

4.5 Case Studies

The following case studies provide qualitative, illustrative examples of how GGT has promoted better health and well-being amongst participants.

Case study 1: Mr and Mrs Q

Mr and Mrs Q are husband and wife and both attend the seated exercise class at the Healthy Ageing Centre at Ellesmere Port Hospital. Mrs Q, who has Alzheimer's, was referred to the Centre in April 2016 after passing out and being taken to A&E. She was given a *'full MOT' by the staff at the Centre*' which Mr Q describes as '*brilliant… they checked out everything, organised a scan for a problem she was having and bought in social services… they also gave me an assessment and [name of well-being coordinator] invited us both to attend the seated exercise class'.* Mr Q explains how the class has helped them both '*It's helping me as much as it's helping Mrs Q. I've got a vascular problem with reduced circulation in my legs and problems with my back… what happens in this chair is terrific, it does something to me that is amazing, I just feel like a different person when I've finished the session'.* Mr Q explains that he feels physically better since attending the sessions and that they provide an opportunity for Mrs Q to get out of the house see other people.

Case study 2: Mr J

Mr J is 76 years old and lives in Coventry. He suffers from knee pain and has been told by his doctor that he needs to lose weight.

Mr J initially heard about the sessions after seeing a poster in the doctor's surgery. He started off having one-to-one sessions with GGT and was given an exercise regime that he does at home almost every day. Mr J also attends the group bowling class every week.

The sessions have improved Mr J's knee pain: "it's helped my knees enormously, just doing the exercises and coming here…I've got too much weight putting pressure on them [his knees]…I get a tremendous amount out of coming here…doing the bowling has helped with just the ability to even stand up and get out of the chair more easily…it's excellent".

Case study 3: Mr D and Mrs I

Mr D is 74 years old and is married to Mrs I who is 73 years old. They live in Leicester. Mr D suffered a stroke over 6 months ago and he has very impaired balance and cannot walk unaided. He also became very stiff and inflexible.

Both Mr D and Mrs I have been attending the seated exercise classes for 6 weeks because their stroke consultant recommended regular exercise for Mr D.

Attending the class has improved the physical mobility of Mr D and he can do far more than he could before he joined the class: 'It's improved my flexibility and walking and also balance and movement.'

Mrs I explained that she can see the benefits that the class has had on her husband far more than he can: 'it's improved him getting in and out of bed and putting his own shoes on, his own trousers… and reaching and stretching generally…I see the benefits more so than he does I think'. Mrs I attends the classes because of her husband but was glad that she joined because 'I'm feeling a lot better for it too because exercise is bound to be good for you…and it's one of those things that you don't have to keep up with everyone, you can take it at your own pace… and we're glad to have found it'.

Case study 4: Mrs H

Mrs H recently had a stroke, which affected her mobility and communication. She attended a stroke group at which the Oldham GGT team delivered a number of taster sessions.

Mrs H really enjoyed the activities and so enquired if there were other things she could take part in. She then started to attend chair based exercise classes.

The classes have really improved Mrs H's confidence and she has made a significant effort to progress. She has recently been introduced to Easyline gym equipment by the chair based exercise instructor and following several sessions in this gym, has been supported to use a treadmill for the first time since her stroke in the mainstream gym.

Mrs H has been encouraged to get an Active Card, which entitles her to access to the mainstream gym at a reduced price. She is now an Active Card holder and feels ready to attend mainstream gym sessions with the support of instructors.

Case study 5: Mrs B

Mrs B is 85 and lives in Jarrow, South Tyneside. She suffers from a range of long term health conditions including arthritis and is unsteady on her feet.

Mrs B heard about the GGT Balance and Stability classes and decided to give it a go as she had started feeling nervous when out and about. She has been attending the classes for over 6 months.

Since participating in Balance and Stability classes, Mrs B has felt much more confident in going out on her own and feels less nervous about falling as she is steadier on her feet. Before attending the classes, Mrs B was worried about going out alone but now has even been able to catch a bus to the shops independently.

The team also put her in contact with Age UK's falls preventions team who offer assessments to make homes safer for older people. The team fitted a bannister and grab rails, which now help Mrs B when she needs to get up during the night.

5 Economic analysis

This chapter provides an analysis of the costs associated with GGT and value of change in healthcare demand. The cost analysis has been informed by expenditure data collected from each GGT locality. The monetary value of the change in demand for health services has been informed by both the participant survey and external unit costs of health and social care.

5.1 Analysis of programme costs

Data was collected for the expenditure in each area on the GGT programme. There were a wide range of inputs into the programme, including staff time, venue hire, overhead costs and volunteer contributions. Table 5.1 presents the total expenditure by site and type of expenditure. The largest item of expenditure was staff costs, followed by venue hire, equipment and tutors for classes. The total expenditure for the programme was over £1 million. These costs are all direct payments made for the delivery of the GGT programme, taken from the programme budget.

Table 5.1 Expenditure by category and area for entire programme[12]

	Leicester (£)	Coventry (£)	Oldham (£)	South Tyneside (£)	Cheshire (£)	Total (£)
Expenditure						
Salary costs and recruitment	66,020	108,258	121,150	124,096	91,592	511,116
Staff training		6,122	3,104	9,212	2,283	20,721
Volunteer recruitment, training, costs	33,859		6,665	11,100	1,086	52,710
Staff travel		5,113	5,668	6,942	3,872	21,595
Venue hire, tutors, transport and equipment	61,283	27,007	25,517	9,836	91,007	214,650
Promotion	5,141	1,185	520		4,631	11,477
Overheads	18,477	3,275	5,130	23,727	50,408	101,017
Management	21,174			20,627		41,801
Evaluation	1,280					1,280
Other		38,763	23,694			62,457
Total expenditure	207,234	189,723	191,448	205,540	244,879	1,038,824
In-kind costs						
Volunteer hours	1,200	800	3,500	4,800	6,900	17,200

[12] All budgets are expected to be spent by the end of the project

	Leicester (£)	Coventry (£)	Oldham (£)	South Tyneside (£)	Cheshire (£)	Total (£)
Volunteer cost	£10,400	£6,000	£27,300	£39,400	£58,300	£141,500
Venues	£23,400	£18,700	£15,100	£46,800	£20,600	£124,500
Transport	£0	£0	£3,600	£9,600	£0	£13,200
Financial contribution	£0	£13,500	£2,000	£2,000	£36,036	£53,536
Total in-kind	£33,800	£38,200	£48,000	£97,800	£114,936	£332,736
Total overall	£241,034	£227,923	£239,448	£303,340	£359,815	£1,371,560

5.1.2 Expenditure

Expenditure varied across each locality; however the largest spend in each was on staff costs and recruitment as may be expected for a programme such as this. Age UK South Tyneside recorded the greatest expenditure on staff recruitment and salaries; this is likely to reflect their team composition and model of delivery, which was reliant on trained Age UK staff members at the outset, particularly for higher level classes. Age UK LS&R has the lowest expenditure on staff costs, again reflective of the team in place, which was largely co-ordinated and run by one staff member with volunteer support. This is complemented by management costs, which are not recorded in a number of other localities.

Age UK Cheshire spent the most on venue hire, tutors, transport and equipment as well as on overheads. This is likely to reflect the large quantity of community venues used by the team. In addition, Age UK Cheshire covers a wide and somewhat rural area, in which transport is likely to be of greater need and expense.

Age UKs Oldham and Coventry recorded the lowest expenditure of all localities.

5.1.3 In-kind costs[13]

The total value of the in-kind contribution was over £330,000. The two largest components of the in-kind contribution were volunteer costs and venue hire. Cheshire had the largest in-kind contribution as a result of recording the highest total of volunteer time across all localities. Age UK Cheshire used volunteers nearly 2000 hours more than the locality with the next highest total. . Age UK Cheshire has had a higher degree of staff turnover, particularly at a management level, than other localities and so the use of a consistent volunteer base has supported a stable portfolio of activities.

[13] The Management Information collected provided details of the number of volunteer hours used by the programme, venues provided free of charge for programme activities, transport costs and the financial contributions of participants. The approach from the Volunteer Investment and Value Audit (VIVA) from the Institute for Volunteering Research (IVR) has been used to estimate the value of volunteers' time.

This approach multiplies the number of volunteer hours by an appropriate wage rate. The hourly wage rate has been taken from the Annual Survey for Hours and Earnings (ASHE) for each area, and the 25th percentile value of earnings has been used. The wage rate was multiplied by the total number of volunteer hours provided for the programme.

The management information provided information on venues provided free of charge. Where no information was provided about the number of activities provided free of charge, it was assumed that each activity had a duration of one hour, and there were an average of fifteen activities delivered per week. The value of hiring a venue for one hour was estimated using information on the cost of hiring community spaces in the local areas (www.hallshire.com).

5.2 Analysis of monetary value of change in healthcare demand

As explored in section 4.4.1.3, the average number of unplanned hospital and GP appointments has changed over time.

The decrease in demand for health services is difficult to monetise as the exact nature of the health care appointments is unknown. The monetary value per appointment has been estimated using the following assumptions:

- The cost of a standard GP appointment, lasting 11.7 minutes. This cost is estimated to be £37[14];
- The cost of an unplanned hospital appointment is assumed to be an emergency admission. The cost of an emergency admission is estimated as the cost of a non-elective inpatient stay, and is estimated to be £1,566[15]; and
- The cost of an appointment with another healthcare professional is assumed to be with a GP nurse, and last 15 minutes. The cost is estimated to be £12[16].

Figure 4.2 showed the change in demand for unplanned health appointments over time. **For the first two time periods (up to six months), the number of unplanned GP appointments per person is significantly lower than recorded in baseline surveys, and between three and six months the number of unplanned hospital appointments per person was significantly lower** than was recorded by participants in their baseline surveys.

The monetary value of the change in healthcare demand for the statistically significant changes from the baseline survey are presented in Table 5.2. **This shows that the total value of the change in demand for healthcare is over £200,000**, and all of the change is concentrated in the first six months after the baseline survey was completed by participants.

Table 5.2 Monetary value of change in healthcare demand from the baseline using statistically significant results

	Up to three months (£)	Three to six months (£)	Total (£)
GP appointments	4,200	5,300	9,400
Hospital appointments	0	196,600	196,600
Other appointments	0	0	0
Total	**4,200**	**201,800**	**206,000**

Between three and six months, the monetary value of the change in demand for health services is estimated to be nearly £100,000 less than at the baseline for the population surveyed and over £200,000 less than at the baseline for the population who completed a survey beyond three months from the baseline (Table A4.7).

Individuals who have taken part in GGT for over two years use £6,400 less healthcare resource than they did at the time of the baseline measure. However, this impact is not significant (Table A4.13).

Table A4.15 presents the overall monetary value of the change in healthcare demand including the statistically insignificant changes from the baseline survey. **This shows that the total value of the change in demand for unplanned healthcare appointments is**

[14] Personal Social Services Research Unit (2015) Unit Costs of Health and Social Care 2015. Average cost of a GP appointment (duration 11.7 minutes) – excluding qualification costs, including direct care staff costs: £37. Cost inflated to 2015-16 prices using GDP deflators

[15] Department of Health (2015) NHS Reference Costs 2014 to 2015. Average cost of a non-elective inpatient admission (£1,565) inflated to 2015-16 prices using GDP deflators

[16] Personal Social Services Research Unit (2015) Unit Costs of Health and Social Care 2015. Average cost of a GP nurse appointment. Cost of face to face contact time is £47 per hour (excluding qualification costs); cost divided by four to estimate cost of individual appointment. Cost inflated to 2015-16 prices using GDP deflators

slightly lower than the results using only the statistically significant results at £124,000. This is due to the increase in demand for healthcare appointments after six months, particularly hospital appointments.

These findings could point to a correlation between participation in GGT and use of healthcare resource, although it is not possible to assess whether the changes in appointments are caused by the GGT or by other factors. This is due to a lack of a comparator group to assess the impact of the programme against. The change in use of healthcare resource could be due to changes in the way health conditions are monitored by health professionals, or the number of appointments returning to their natural level following a period of high demand. As it has not been possible to assess these other potential impacts, it is not possible to attribute the change in healthcare resource to the GGT programme.

It should also be noted that a reduction in the use of health resource in the short term is not necessarily a cost saving to the health service in the longer term. If individuals do not visit a health professional when they first realise symptoms (and inappropriately attempt to self-manage the condition) it can lead to more costly treatments being needed in the future. It is important that the use of healthcare resources is appropriate, rather than at a lower level. However, from the results of the survey it is not possible to assess if the use of healthcare resources has become more or less appropriate over the course4 of the GGT programme.

5.3 Comparing costs and impacts achieved

As can be seen from the analysis above, it has not been possible to capture the net impact of the programme. This is because there is no suitable comparator group to measure the progress of the programme against. It would be expected that in the target age group the number of GP, hospital and other health appointments would increase over time as individuals get older. Therefore if the number of health service appointments did not change from the baseline, this could show that the programme had an impact, as the number of health appointments had not increased. However, without a comparator group it is not possible to assess this impact.

In order to assess the effectiveness of the programme, the impact on participants demand for health services has been compared to other programmes. Both programmes focused on providing a range of activities and interventions for older people, however, targeted a variety of different groups compared with GGT. Fit as a Fiddle targeted 'all older people' with individual projects focusing on more specific groups including BME communities and faith groups. Silver Dreams supported a range of older people including the bereaved, faith communities, older men and those with a particular disability. **While there are similarities between the projects in relation to age of participants, GGT targeted older people with long term conditions and so likely to have higher levels of need and poorer health than in the other programmes described. The comparisons made here should be viewed in light of this.** The Silver Dreams programme[17] reported that demand for hospital appointments, GP appointments and nurse appointments all decreased among participants (Emergency hospital appointments decreased by 12%, GP appointments by 20% and nurse appointments by 11%). This is a much smaller decrease than the decrease in health service demand among participants of the GGT programme at six months (a decrease of over 60% for GP appointments, 57% for hospital appointments, both of which were statistically significant). However, the GGT analysis focusses on unplanned GP appointments, whereas the Silver Dreams analysis focusses on any GP appointments. Additionally, the target age

[17] A Big Lottery Fund programme in association with the Daily Mail aiming to address gaps in provision by challenging organisations to develop an innovative project that would pioneer ways to help vulnerable older people deal more effectively with life-changing events. *Big Lottery Fund (2014) Silver Dreams Fund Learning and Evaluation Contract: Final Report*

group for Silver Dreams was slightly broader than for GGT as it targeted anyone over 50 years.

Similarly, the Fit as a Fiddle project[18] reported that for a project in the South West of England, the number of GP appointments decreased by 0.3 appointments per participant over a three month period. This is a larger change in health service demand as seen in GGT (at three months, the same period as Fit as a Fiddle example, the change for GGT participants was 0.1 appointments per participant).

The impact of the programme on participants SF-36 score cannot be measured for the same reason. As people become older, their general health and physical function (and other SF-36 indicators) will decline, therefore even keeping the score the same as the baseline measure could be seen as the programme having an impact.

It has been difficult to measure the value for money of the programme. This is due to the difficulty in identifying the additional impact of the programme due to the lack of a suitable comparator group. This means it has not been possible to conduct a Cost Benefit Analysis or a Social Return on Investment calculation, or measure the cost per outcome achieved. Additionally, it is difficult to measure the cost per output achieved, as it is not possible to analyse how many activities each individual took part in. Therefore, in order to assess the value for money, the cost per participant has been calculated, and the change in outcome measures over time have been collected. These indicators have been compared to similar indicators from evaluations of programmes with similar aims, to estimate the performance and value of the programme.

However, the number of individuals in each area is known, as is the total expenditure in each area. This is presented in Table 5.3. The average cost per participant across the programme is £220, with the highest cost per participant in Cheshire at just over £280.

Table 5.3 Average cost per participant

	Number of participants	Total spend (£)	Average spend per participant (£)
Leicester	1357	241,034	177
Coventry	1068	227,923	213
Oldham	1108	239,448	216
South Tyneside	1421	303,340	213
Cheshire	1275	359,815	282
Total	6,229	1,371,560	220

Overall, the findings are positive and reflect effective use of community assets including volunteers, venues and transportation. Programme results indicate that involvement in GGT has had a positive impact on participants' experience of pain, energy and social functioning, with statistically significant improvements in all three scores at multiple points of time. This has been at an average cost per participant of £220. In addition, the analysis showed statistically significant reductions in the number of GP appointments per person (up to six months) compared to baseline and statistically significantly lower numbers of unplanned hospital appointments per person between three and six months, with a total change in demand for healthcare of over £200,000. Considering the outcomes at a programme level in light of the overall investment made suggests that the programme has been cost effective.

[18] An Age UK Big Lottery Fund person-centred programme with the overall objective of supporting physical health and mental well-being. *Ecorys UK (2013), Fit as a Fiddle Final evaluation report.*

6 Conclusion and learning

The final evaluation provides evidence that the GGT programme has progressed well in meeting its aims and objectives with a number of important outcomes emerging and plans for longer term sustainability starting to materialise. This chapter focuses on the strategies to promote sustainability being developed by local projects before summarising key learning for both national and local Age UKs.

Local Age UKs have made significant progress developing and establishing GGT projects within their local contexts. Local partners have tailored delivery models and their portfolios of activities in light of their local context and demand of the older population within this. The final 12 months of the programme in particular has seen an increased focus on establishing relationships with key stakeholders locally to support the embedding of the project within health, care and community pathways.

Furthermore, stakeholders interviewed were in strong agreement that GGT aligns well with a variety of strategic priorities both at national, and local levels. On the whole, most stakeholders reflected that GGT 'fills a gap' in community provision rather than duplicating what is already out there. Many reflected that GGT activities are more appropriate for older people than the majority of existing services, particularly for those with a higher level of need.

The final part of the programme finishes in November 2016, from which point local projects (in part or in whole) may be sustained or built on. Local partners have been exploring a number of mechanisms to do this including mainstream commissioning by CCGs or local authorities, or through seeking alternative funding routes. Partners have also already taken a variety of other actions to help secure sustainability of part, or all of, their projects. These actions have been referenced throughout this report and are explored in detail in each of the local GGT partner reports.

To support the implementation of actions to promote sustainability, we have highlighted the key elements below:

Key ways to support sustainability:

- **Explore and seek out new funding streams to support delivery costs**

  Local partners have used their remaining GGT funding to support sustainability, for example by purchasing equipment needed to continue activities and providing training for staff and volunteers.

  Alongside this, partners have been exploring new opportunities for further funding. Project teams have applied for an assortment of grants, for example in Oldham the team has worked with some groups to successfully apply for funding to support their Caribbean group. Seeking out and securing funding to support activities longer term will be important in ensuring a smooth transition to self-sufficiency for classes, which are not yet wholly self-sustainable, as well as affording the opportunity of growth for others.

- **Introduce charges for classes, where appropriate**

  Localities have been undertaking frequent reviews of the cost models of their GGT classes to assess the financial viability of each session conducted and introduce a small charge, where needed. Classes have been priced differently based on their model of delivery and content. For example, classes which require instructors to have considerable amounts of training or venues that are more expensive can have a higher charge attached. The use of an effective cost model is vital to establishing classes

within the community and ensuring that delivery associated outgoings are met over the longer term.

- **Focus on models of delivery, which are less reliant on Age UK staff for support**

  As discussed in chapter 2, localities have developed a number of different delivery models to support the provision of GGT activities. A number of localities are moving toward an increasingly volunteer led model of delivery. For example, in Age UK Cheshire a number of classes including Walking Football are primarily volunteer led enabling Age UK staff to step back and hand control to volunteers. The involvement of volunteers in class delivery can not only help to reduce costs but also create and maintain skills in the community. Teams have worked hard to utilise the enthusiasm and skills of their volunteers to ensure that key roles across projects can be filled including administrative support, drivers and activity instructors. A range of training has been provided to support volunteers to fulfil these roles effectively including chair based exercise instructor tuition. Another model has included the use of independent tutors; Age UK Coventry has developed a model involving freelance tutors who are better placed and have more flexibility to focus on growing demand locally for high level activities. This removes the reliance on Age UK staff to support these participants and enables tutors to take responsibility for delivery.

- **Utilise community resource**

  Linked to the development of delivery models that can exist externally of GGT, is the importance of effectively utilising community resources. In Cheshire, the GGT team, are working with a local organisation, Brio, to deliver a number of classes. Taking advantage of assets within local communities as well as the enthusiasm and support of volunteers is key to delivering GGT over the longer term. Localities have started to do this to good effect, for example, developing relationships with local venues to secure sites at a reduced cost and delivering classes in sheltered housing. Reviewing what already exists in the community such as volunteer drivers and transport providers will ensure that projects can successfully link with existing resources and potentially identify solutions to challenges that localities have faced to date. Drawing on community assets in such a way helps to embed GGT within localities and has the potential to increase the cost effectiveness of delivering activities in the longer term.

- **Evidence outcomes**

  Stakeholders emphasised the importance of evidencing 'hard' outcomes from GGT for older people and the health and care system to support applications for continuation funding, or to be taken up in mainstream commissioning. Generating robust but proportionate evidence of the value and impact of GGT is essential for gaining support and funding in the longer term and localities should ensure that this is communicated effectively. The GGT participant survey is the primary means by which 'hard' outcomes can be demonstrated but the value of this varies across localities. Several local teams have also collected evidence, which will be useful for supporting outcomes. For example, in South Tyneside, the local physiotherapy team have collected Balance, Gait and Functional score ratings before and after attendance at high level support classes, which show significant levels of improvement for participants and can be used to apply for continuation funding.

- **Share a narrative of how GGT aligns with local health and care priorities and offers something unique**

  Each locality differs, as do local health and social care strategies leading to differences in funding priorities. Identifying gaps in provision of services as well as understanding the priorities at a local level will help local teams to make it explicit to stakeholders how GGT can help support these. Several localities have started to do this, for example Age UKs Oldham and South Tyneside have identified local gaps in provision for those

ready to progress from Falls Prevention classes but who are not 'ready to be left back in the community'.

In addition, communicating a shared narrative around what sets GGT apart from other health and wellbeing initiatives is key to securing the interest of commissioners. More generally, alignment with increasingly prominent social prescribing and prevention agendas will support local teams to position GGT accordingly.

- **Build networks to advocate and secure sustainability**

  It is important to continue to raise awareness of GGT and engage with partners and stakeholders that are critical to sustaining GGT, for example further developing relationships with commissioners who can help secure mainstream funding. In Coventry, one stakeholder reported that strong relationships with the CCG and Public Health could potentially lead to more formal partnerships when Public Health is recommissioned meaning GGT would be well-placed for future funding opportunities.. LS&R has a project steering group, which comprises representatives from the local authority, the CCG and adult social care, in addition to senior management from Age UK LS&R. The local team have recently managed to secure funding from the local city council for a number of classes for 12 months. In order to secure the support of key stakeholders locally, local teams need to raise awareness about the outcomes achieved through GGT to date, and how it aligns with similar national and local priorities / initiatives.

- **Continue to integrate GGT with local services and embed in pathways**

  Over the course of the last three years, local Age UKs have made significant progress with establishing links and referral routes with hospitals, GPs, community care, third sector organisations and public health services. Embedding GGT in existing pathways of care and more widely in local community provision offers an effective way of sustaining the project over the longer term by encouraging local stakeholders to consider GGT as part of the mainstream landscape (rather than an 'add-on'). For example, Age UK South Tyneside has successfully developed and embedded GGT in the local health and social care system through extensive work with local GP practices and hospitals. The team receive referrals from both GPs and South Tyneside Hospital, which has supported the integration of GGT into existing pathways of care; establishing their high level classes as '*an extension of local health services'.* In Cheshire, their Chief Executive is represented on the West Cheshire Falls Prevention Strategy Group, which is supporting the forward development of falls prevention activity.

With programme funding drawing to a close, there is a large body of learning for localities, the national programme team and the wider charity. The main learning is set out below.

6.1 Learning for national Age UK

6.1.1 Designing, managing and evaluating a programme

Consider how programme design could be more focused

GGT has developed a broad-based approach. Although the general aims of the programme were clear from the outset, the best ways in which to meet these aims were left open to interpretation and contingent upon local contexts. There has been value in enabling localities to take a flexible approach and this has given rise to an overall programme with a mix of target groups under the umbrella of 'older people', activities, goals and delivery models. Common themes have started to emerge, for example, a focus on falls prevention support. However when developing similar future programmes, Age UK may wish to consider how best to balance local flexibility with a more highly focused and shared

approach that reflects national strategic priorities for older people. It may be worth focusing future programmes more strategically on particular types of activity for which there are gaps in provision (such as high level support) or target priority groups including those that services often fail to reach (for example those within the BME community, older adults within deprived communities or those who smoke). The social aspect of GGT has emerged as critical, playing a major role in reducing isolation and creating social networks for older people. Age UK may wish to consider this as a central aim of further programmes.

An example of how the programme could be more focused is in terms of targeting participants with arthritis. The participant survey shows that arthritis is the most commonly reported long term condition at a programme level, and across all five localities. While an element of this may be a result of older people feeling more comfortable reporting having arthritis or being more aware of this as a condition, this finding still suggests that this is an area in which Age UK could consider focusing in future.

Physical activity is important for people with arthritis as it can help to ease stiffness, improve joint movement, strengthen muscles and support people to remain more independent. Age UK may consider further research and potential investment in provision for older people with the condition, recognising that the type and severity of the condition is wide ranging. Age UK should review the current level of support and services for people with arthritis and explore ways in which this could be complemented or improved, for example through offering classes focused on improving joint function. Age UK could also consider working with other organisations to improve the services available for older people with arthritis, such as Arthritis Research UK, Arthritis Care and Arthritis Action.

Consider how best to provide guidance and support for project level monitoring

Each locality has successfully submitted a number of project updates every quarter, however the content and quality of these have been variable. Completing these updates was left open to local interpretation reflecting the flexible approach taken to meeting high and low level targets. In future, clearer guidance on recording monitoring information would be useful in enabling better monitoring and evaluation. There has been a degree of variability in the ways in which projects individually record figures such as low and high level participation, transfers from high to low level activities and even what constitutes high or low level support. Ensuring that this is clear from the outset will support the submission of more accurate and consistent information across all five localities. One example of this is the different ways in which local partners have recorded the reach of their information and advice activities, which has made comparison at a programme level difficult.

Clearly understand and define the programme's target group

GGT aimed to help older people with long term conditions (LTC) to lead a more active life, enabling them to take part in physical activity tailored to meet their needs and interests. Results from the participant survey indicate that the programme was successful in targeting a significant number of older people with long term conditions, supporting them to take part in a range of exercise opportunities, with 78% reporting one or more long term condition. However, 22% of participants who completed the survey reported having no long term conditions at all, despite the initial aim of the programme centring on this group. There are several reasons why this may be the case, which are discussed below.

The participant survey was the only tool by which details on an individual's long term condition(s) were collected. All responses are thus, by nature, self-reported. This has three potential implications for the assortment of long term conditions described:

a) Participants may not have felt comfortable sharing the range or nature of their long term conditions through the survey and so not reported any. Feedback from a small number of participants suggested caution around how results would be used and who would be able to access them.

b) Participants may not identify with having a 'long term condition' or identify with having any of those listed on the survey and so not completed the question.
c) Many survey responses were partially complete and so this question may have been missed or disregarded.

In addition, it is likely that local GGT projects attracted a wider variety of older people than was the initial aim, particularly in light of the focus on health and wellbeing. It is possible that older people with higher levels of emotional and physical wellbeing engaged with the range of activities on offer and may not have a long term condition to report. This is to be expected given that projects aimed to make low level activities inclusive rather than excluding people on the basis of prescribed criteria for inclusion.

This provides several points of learning for national Age UK. It is important to ensure that time is invested at the beginning of a project to ensure that the group that the programme aims to support is thoroughly defined and understood at the outset. Nonetheless, this may need to be balanced by a pragmatic approach to inclusion to activities that a broad range of older people may benefit from. Age UK could also consider introducing a way to more closely monitor the ways in which local Age UKs ensure that they meet the aims of the overall programme, for example supporting localities to specifically focus on the target group. In addition, this learning highlights the need to ensure that appropriate tools are chosen to capture the information needed, a point which is discussed further below.

Prioritise and focus monitoring and evaluation on a number of measures that are meaningful

Evaluating a programme of this scale can be challenging. The GGT participant survey has been the primary tool by which change has been measured and 'hard' outcomes demonstrated at both programme and locality level. It is important to ensure that there is a robust method in place by which to monitor and assess change and it is key that the methodology chosen is appropriate. The participant survey includes the RAND SF-36 survey instrument which allows responses to be scored and analysed in eight dimensions of health and wellbeing. In addition to this, the survey contains a large number of more general questions on participant demographics, motivations for taking part in GGT and healthcare utilisation. Although the choice of a validated survey tool is an appropriate way to support the generalisability of programme results, the tool was not designed to be used specifically with the older population, particularly those with higher levels of need. As one of the aims of the programme is to support older people with long term conditions, with an added focus on those requiring specialist support, this survey instrument has not proved wholly suitable. Furthermore, in light of the cohort of participants, maintenance or a deterioration in health may be expected (rather than improvements) and the survey is not designed to capture this effectively.

Over the lifetime of the programme evaluation, participants, volunteers and Age UK staff have reported a number of challenges with administering the participant surveys;

- Participants and staff considered the survey to be too long to complete. This was viewed to be both off putting and difficult for older people to complete in full which has affected the completion rate of the survey overall as well as the consistency with which questions were answered.
- The language and style of the questionnaire was considered unsuitable for the older population, particularly those with visual impairments, learning difficulties and those for whom English is a second language. In addition, several questions within the survey were considered ambiguous.
- As a result of the length and perceived difficulty of the survey, Age UK staff, volunteers and participants all reported the need for extra support to complete them to be provided. This often led to surveys not being completed at all, not completed in full or questions being misunderstood. This is reflected in the number of surveys appropriate for use in the impact assessment.

In light of this, in future, Age UK should consider working alongside the evaluation team, to clearly identify and prioritise which intended programme outcomes to evidence from and focus on these when designing evaluation tools. Taking time to reflect upon what information is needed to evidence the processes and outcomes of most significance will help to ensure that all monitoring and evaluation tools are fit for purpose. For example, one of the intended aims of the programme was to understand how information and advice activity 'translates' into participation. However, the design of the survey question intended to collect this information does not allow this analysis to be undertaken.

Furthermore, once a tool or measures had been decided upon, it would be good practice to undertake cognitive testing and pilot the survey instrument with a sample population to ensure that questions are valid and reliable.

Honing the focus and testing the acceptability of the evaluation tool would help to increase the response rate, improve the quality of responses overall and reduce the burden of support for completion required from project teams and volunteers.

Be realistic about what evidence can be expected to emerge

When commissioning an evaluation focused on a population of this type, it is important to be realistic about the scale and size of outcomes to be expected. The evaluation has run over a three year period, over which time a deterioration in health status of the older population may be expected. It is essential therefore that Age UK and sponsors are realistic about the degree of change that would likely be seen within this cohort. It may be that maintaining or preventing a sharp deterioration in health is as important for this population as evidencing an improvement in mental or physical wellbeing as reflected in chapter 4. This should be made explicit from the outset to allow for the development of pragmatic expectations.

6.1.2 Working collectively

When designing and supporting the delivery of programmes, greater attention might be given to the way in which the programme operates as a cohesive whole rather than five distinct projects. Establishing formal mechanisms for localities to share learning and develop local plans that support a more consistent approach to delivery may facilitate this approach. There have been a number of workshops over the course of the evaluation encouraging the sharing of progress and lessons learned, however a more formal way to share developments and enable project leads to benefit from the experiences of others would be valuable. The development of workshops mirroring the programme's lifecycle might be useful, for example, practical workshops focused on implementation support, developing relationships with commissioners and securing exit plans.

6.2 Learning for localities

Distinguish between roles for project delivery and strategic oversight

Project teams have played a pivotal role in the successful delivery of GGT over the last three years. Their work has supported the successful implementation of a variety of high and low level activities for participants in their localities. During the first eighteen months of the programme, the majority of project teams were rightly focused on implementation and delivery rather than sustainability and delivery and co-ordination has proved their key strength. Providing strategic oversight and focus on engaging with partners and stakeholders that are critical to sustaining GGT has been less of a focus for most front-line staff and this role has been filled variably by senior AUK staff across localities. . Ensuring there is someone who can fill the role between senior management and the team on the ground would be useful for making sure there is no disconnect between day to day project delivery and fulfilment of a longer term strategic vision.

Invest time in developing relationships with key local stakeholders

Safeguarding time to invest in developing relationships with important local stakeholders has emerged as a significant piece of learning from the programme. Local Age UKs have made progress with establishing links and referral routes with hospitals, GPs, community care, and public health services. This is crucial for embedding activities in such a way that it is difficult for people to envisage the local health and care system without GGT , rather than something to signpost to or an 'added extra'. Achieving this takes time, commitment and the '*right people to be in the room'*. A number of localities have successfully made inroads with key local stakeholders including local city councils, Public Health and hospitals. One example of how investing time to develop local relationships can lead to success is in South Tyneside. Age UK South Tyneside has successfully developed and embedded its presence in the local health and social care system through extensive work with local GP practices and hospitals, engaging both senior staff and those on the ground and showing a willingness to work in partnership. The team receive referrals from local hospitals with links established with Respiratory, Cardiac Rehabilitation and Hip and Knee Clinics in South Tyneside Hospital as well as the community physiotherapy team. GGT staff regularly deliver classes in a South Tyneside Hospital either independently or in partnership with NHS staff, establishing themselves as equals to healthcare professionals. This has supported the integration of GGT into existing pathways of care; establishing high level classes as a mainstream service rather than an 'add on'. Referrals work both ways with Age UK South Tyneside able to refer back in to the physiotherapy team if they feel participants need this support again. Stakeholders conveyed that this is key for both ensuring older people remain safe and well but also supporting earlier intervention, which can save a potential squeeze on healthcare resources.

Decide what is important and focus on doing this well

The findings presented throughout this final report identify shared approaches to targeting and recruiting older people who could benefit from GGT. These include establishing referral pathways with falls prevention, cardiac rehabilitation and physiotherapy services, targeting specific LTC groups and promoting GGT through other Age UK initiatives. However, the findings also suggest that local Age UKs are targeting different cohorts of older people. While there is a trend of higher emotional wellbeing and lower physical wellbeing across survey respondents from all five GGT localities; the survey findings also suggest that a number of local Age UKs are recruiting participants with lower levels of physical and emotional wellbeing compared with other localities. Across the five localities, there is also variation in the proportion of participants who self-report a LTC, the LTCs reported, and /or health care utilisation. This in part, reflects the differing extent to which local Age UK partners have focused on high level activities, relative to low level activities.

Over time, all five projects have increased the emphasis on specifically targeting older people with LTCs and those who may benefit 'most' from GGT. However, it would have been valuable for local Age UKs to consider their target cohort and priority areas to focus upon earlier on within the projects. Stakeholders have reflected that a number of localities have taken a 'scattergun' approach to recruiting older people to GGT; primarily focusing on promoting low level activities and '*seeing who turns up'* then focusing more specifically on particular groups such as people with dementia or BME communities. Although this is useful for maximising the appeal of GGT, at times, staff have reported that this has made project delivery more difficult. Local partners have struck a balance between focusing on participants with lower levels of need and supporting those with greater levels of need, who require a more intensive level of resource.

Considering pathways to maximise impact from the outset and the relative merits of focusing on supporting older people with high needs compared with those with relatively good health and wellbeing currently should have been given greater priority. It is difficult to assess the relative value of focusing on those older people most in need of improvements to health and wellbeing in the short-term compared with supporting the maintenance of good health and wellbeing where this already exists. It is possible that supporting the former group could

generate more measurable impact in the short-term – and therefore more visible benefits for older people and the wider health and care system. However, this is more resource intensive, requiring higher levels of support from staff. In addition, the cohort of participants is likely to be smaller impacting on the potential financial viability of providing this support over the long term, even with charges attached. In contrast, the maintenance of good health and wellbeing could well bring greater long-term benefits and also links with the national prevention agenda. The cohort of older people with relatively good health and wellbeing currently are likely to be easier to attract to GGT activities. This group are also likely easier to support financially over the long term both in terms of higher participant numbers and lower levels of resource required.

From a sustainability perspective, it is highly likely that health and care commissioners will necessarily prioritise interventions that reduce demand on services, as well as improve outcomes for older people in the short-term. However, further consideration from localities at the outset of GGT of which cohort of older people to support and how, would have enabled a more strategic and focused approach to implementation and delivery to be taken. This would have been valuable for both the directing of resources but also enabled localities to focus more closely on monitoring and evaluating outcomes which matter most to them. At present, localities split both resource and attention on participants with both low and high levels of need, which has made it more difficult to evidence outcomes for either cohort.

This also presents learning for national Age UK when developing programmes of this kind in future. Localities have necessarily had to split their time between participants with low and high levels of need to meet programme targets. In future, it may be more beneficial to allow localities to concentrate their resource on one specific cohort and as one stakeholder commented, '*do this brilliantly rather than trying to do everything well'*.

Complement and build on existing provision

The majority of stakeholders interviewed considered that GGT has added value at a local level through filling gaps, rather than duplicating, existing provision. However a number felt that a more strategic approach to mapping current provision and more formally developing links within the community would have ensured that each project was maximising local resource. A number of stakeholders commented that there have been a number of missed opportunities at a local level to fully complement and build on community assets. Several considered that GGT has overlooked the chance to fully understand from the outset what is out there for older people and how to work alongside this rather than taking a scattergun approach to provide 'more of the same'. In Cheshire for example, one stakeholder reflected that working alongside community organisations would have ensured that the best is made of existing built facilities and that provision is dovetailed, targeting those most in need of support where appropriate.

A number of stakeholders suggested that Age UK localities might consider increased partnership with nursing homes. Stakeholders emphasised that residents can be frequent fallers and are often poorly served in receiving support for this because they cannot attend group exercise classes outside of the care home. Some residents may attend NHS falls clinics but may find it difficult to do so due to transport and the additional support they need in order to attend. The costs of falls to public services can be high as a result of the number of days spent in hospital following a fall and so focus on this area could be of particular benefit to both older people and the system. Providing falls prevention classes in care homes could be increased through links to services like GGT and this should be explored further in each locality.

Be organic and responsive to local contexts

The design of the programme has enabled each local Age UK to tailor projects to best fit their local contexts. This has afforded each local team a degree of flexibility to introduce and try out a variety of activities for their older population. This approach has been valuable in providing learning for each locality about what works and what best fits the needs of their

older participants. It is important that localities learn from implementation and are not afraid to be responsive and adapt when things do not work. For example, all localities have introduced a variety of both traditional and novel activities to try to establish what appeals to their local population. Each local Age UK has responded to feedback from participants and monitored attendance figures making adjustments to their activity portfolios accordingly. This is key for supporting the longer term viability of projects.

Make plans for sustainability from the outset

Considering sustainability of projects from the outset is crucial. While initial focus is often largely focused on implementation and delivery, it is important to reflect upon how plans for sustainability can be built in from the beginning to avoid missed opportunities. Building relationships from inception that are critical to support the embedding of GGT within the local community is one such way to do this.

Local Age UKs have made great progress through a number of approaches with embedding and adapting delivery to support sustainability of projects over the longer term. For example, the development of referral routes from acute, community and primary care and public health services all serve to embed GGT within local health and care systems. However, for a number of the localities, more strategic conversations with commissioners exploring opportunities for mainstream commissioning or funding at the end of the programme were left to the end of the project lifecycle to take place. Plans to raise awareness of GGT and make approaches to commissioners, funders and key stakeholders in the local community should be incorporated in the project from the beginning. When developing a project of this kind in future, it is recommended that the team identify key local strategic stakeholders at the outset and develop relationships with them early on. Involving these stakeholders throughout the lifetime of the project, such as in design, and delivery of classes is important for securing 'buy in' locally and help the longevity of the project in turn. One such way to do this would be to create a strategic partnership to drive the project from the beginning, inviting commissioners and/or Public Health to sit on steering groups and giving them a real role to play in project development.

At a practical level, reflecting on ways to make projects sustainable early on ensures that appropriate support is put in place to make sustainability possible. For example, the recruitment and use of volunteers with a varied skills mix supports the delivery of GGT activities over the longer term. In addition, recruiting a volunteer co-ordinator to provide support and guidance for volunteers is a role which has worked well in a number of localities to ensure that volunteers are used effectively and classes are consistently supported. By considering what support is necessary from the onset, local teams ensure smooth transitions to self-sufficient models of delivery and confirm that the necessary steps have been established and embedded before project funding ceases.

6.3 Conclusion

GGT has proved a successful programme over the course of the last three years. The programme has recruited over 6,000 older people encouraging them to lead more active lives through supported access to a range of high and low level exercise opportunities. The programme has targeted a range of older people in a diverse number of ways from one-to-one support in the home to group classes in a community setting enabling participants of all levels of need to take part.

The programme has benefitted from a number of enablers for success including drawing on wider community assets including volunteers and strong relationships with local partners in health and social care.

A range of outcomes have emerged from the programme including statistically significant improvements in pain, social functioning and energy/fatigue scores following participation in GGT activities. Qualitative feedback from participants, stakeholders and volunteers also demonstrates valuable social, health and wellbeing outcomes for participants. The final

evaluation provides evidence that the GGT programme has progressed well in meeting its aims and objectives with a number of important outcomes emerging and plans for longer term sustainability emerging. It has proved cost effective with statistically significant reductions in the number of GP appointments per person (up to six months) compared to baseline and statistically significant lower numbers of unplanned hospital appointments per person between three and six months, with a total change in demand for healthcare of over £200,000.

The final part of the programme finishes in November 2016, from which point local projects (in part or in whole) will have strong bases from which to sustain and build on programme successes.

Annex 1 Stakeholders interviewed

We would like to thank the following people for giving their time to speak with us:

Table A1.1 List of stakeholders interviewed

Locality	Name	Role
Cheshire	Lydia Orford	Health Improvement Practitioner
Cheshire	Emma Brunes	Communication Support Coordinator – Stroke Association
Cheshire	Annette Todd	Arthritis Champions Project Co-ordinator
Cheshire	Tracy Weigh	Wellbeing Coordinator (at Ellesmere Port hospital)
Cheshire	Dora	Exercise coordinator
Cheshire	Ellie McFarn	Managing Director Brio Leisure
Cheshire	Volunteer 1	Walking football
Cheshire	Volunteer 2	Walking football
Cheshire	Participant 1	Seated exercise
Cheshire	Participant 2	Seated exercise
Cheshire	Participant 3	Walking football
Coventry	Naomi Brooke	Project Manager of the Lifestyle project – Coventry Public Health
Coventry	Gaye Warwick	Community Physiotherapist, Falls Clinic
Coventry	Jim McCabe	Service development manager for Age UK Coventry
Coventry	Debbie Sharples	Services manager for community development team
Coventry	Paul Dodd	Community Respiratory Team
Coventry	Hannah Wade	Community physiotherapist
Coventry	Participant 1	
Coventry	Participant 2	
Coventry	Participant 3	
Coventry	Participant 4	
Coventry	Volunteer 1	
Coventry	Volunteer 2	
Leicester Shire & Rutland	Anita Clarke	Leicester City Community Engagement Officer
Leicester Shire & Rutland	Mark Pearce	Strategy and Implementation Manager
Leicester Shire & Rutland	Cathy Carter	Commissioning manager
Leicester Shire & Rutland	Ben Smith	Policy Development Officer
Leicester Shire & Rutland	Cheryl Clegg	Head of I & A
Leicester Shire & Rutland	Jane Newstead	Clinical team lead, NHS falls clinic
Leicester Shire & Rutland	Troy Young	Assistant Director, Age UK

Leicester Shire & Rutland	Carla Broadbent	Physical activity officer, Leicester City Council
Leicester Shire & Rutland	Volunteer 1	
Leicester Shire & Rutland	Volunteer 2	
Leicester Shire & Rutland	Participant 1	
Leicester Shire & Rutland	Participant 2	
Leicester Shire & Rutland	Participant 3	
Leicester Shire & Rutland	Participant 4	
Leicester Shire & Rutland	Participant 5	
Leicester Shire & Rutland	Participant 6	
Leicester Shire & Rutland	Participant 7	
Leicester Shire & Rutland	Participant 8	
Oldham	Jackie Hanley	Senior Health and Physical Activity Development Officer, Oldham Community Leisure
Oldham	Barry Cassidy	Oldham Diabetes Voluntary Support Group Chairperson
Oldham	Peter Lane	Making Space
Oldham	Marion Shannon	Freelance tutor
Oldham	Sam Al Shafei	Freelance tutor
Oldham	Julie Eastham	Quality Improvement Nurse, Oldham Clinical Commissioning Group
Oldham	Chris Wilson	Community Development Officer, Oldham Council
Oldham	Dana Murphy	Villages Housing
Oldham	Nicola Martin	The Link Centre, Independent living centre employee
Oldham	Ron Tench	Shaw Wednesday club
Oldham	Nicola Shore	Age UK Oldham
Oldham	Yvonne Lee	Age UK Oldham
Oldham	Volunteer 1	
Oldham	Volunteer 2	
Oldham	Volunteer 3	
Oldham	Volunteer 4	
Oldham	Volunteer 5	
Oldham	Participant 1	
Oldham	Participant 2	
Oldham	Participant 3	
Oldham	Participant 4	
Oldham	Participant 5	
South Tyneside	Marianne Hudson	Senior Physiotherapist
South Tyneside	Jackie Jamieson	Age UK South Tyneside
South Tyneside	Clare Allom	Diabetes UK employee
South Tyneside	Victoria Meston	South Tyneside homes employee

South Tyneside	Jim Holloway	Sports development officer
South Tyneside	Paula Culley	South Tyneside hospital employee
South Tyneside	Tom Relph	South Tyneside Libraries employee
South Tyneside	Volunteer 1	
South Tyneside	Volunteer 2	
South Tyneside	Participant 1	
South Tyneside	Participant 2	
South Tyneside	Participant 3	
South Tyneside	Participant 4	
South Tyneside	Participant 5	
South Tyneside	Participant 6	
South Tyneside	Participant 7	

Annex 2 Topic guides

A2.1 Interviews with older people

Get Going Together programme summary

GGT is a three-year programme of physical activity interventions for older people with long term conditions. It aims to deliver physical, mental and social outcomes through providing low level (large groups for people with lower needs) and high level (1-1/small group support for higher needs) classes.

Interview needs to capture information about

- Physical/mental condition before the intervention
- Use of health care resources (GP and Hospital – including planned and unplanned)
- Motivations for joining GGT
- Whether they have been involved in similar classes (before GGT and during)
- How they were referred in /became aware of GGT
- Quality and appropriateness of intervention – activities, tutors, volunteers, other participants
- What difference involvement in GGT has made – physical, mental, social and impact on use of health care
- Whether and why they continue to participate in GGT
- Whether and how participants are supported to progress within and beyond GGT
- What would they do in the absence of GGT

Questions

"We would like you to tell us about your experience of Get Going Together. Start wherever you like and please take as much time as you need. We will listen to your story, and when you have finished we may ask you some questions to find out more about things you have mentioned."

Prompts:

- How did you hear about it?
- Why did you want to get involved?
- How often do you attend classes?
- Over what time period have you been attending GGT classes?
- What difference has it made to you?
  - Confidence in getting out / exercising
  - Meeting new people / socialising / social isolation
  - Improved physical fitness and physical functioning
  - Health benefits – medication, visits to healthcare services
  - Intention to do new things
- Any detailed examples of difference GGT has made over time – e.g. can make independent shopping trips now, can now do gardening, visit family etc. – anything which draws out a change over time?
- What would you do if you couldn't come to these classes?
- Are these type of activities available elsewhere? Would they be accessible?
- Any benefits from the wider organisation e.g. signposted to services, benefit checks – so financial benefits, home checks, found out about other classes.
- Is there anything you would change about your Get Going Together classes?
  - Try and steer away from very specific information e.g. "I don't like the second song they use in Fitsteps"

- If you could give one message to the people running the Get Going Together services, what would it be?

Test findings – so we can attribute any changes to Get Going Together.

To finish:

- Is there anything else you would like to mention which we haven't already covered?

A2.2 Interviews with volunteers

Get Going Together programme summary

GGT is a three-year programme of physical activity interventions for older people with long term conditions. It aims to deliver physical, mental and social outcomes through providing low level (large groups for people with lower needs) and high level (1-1/small group support for higher needs) classes.

The interview needs to cover:

- Previous experience of volunteering (AUK and more broadly)
- Rationale for volunteering to GGT
- Nature and extent of volunteering on GGT
- Support received – Inc. any training
- Quality of the experience – becoming a volunteer; support; overall satisfaction
- Outcomes: confidence, knowledge, skills, physical, mental, social, economic
- Their views on outcomes for participants (why?)
- Attribution point

Please note: we are aiming to speak with different volunteers to our last fieldwork visit. However if this is not possible and ICF have interviewed them before, please tailor the topic guide accordingly e.g. skip questions 2-4 and focus on further support received, further impacts of volunteering, further outcomes they have seen for participants. It will still be important to explore question 1 in case they have developed new roles or responsibilities.

Your Age UK staff lead will be able to inform you if we have spoken with them previously.

Previous experience and getting involved in GGT

Aim: to understand reasons for involvement and baseline experience in volunteering

1. What are your roles and responsibilities as a GGT volunteer?
   - Have these changed over time?
   - How long have you been volunteering?
   - How much do you typically volunteer in a typical month?
   - Do you volunteer anywhere else?

2. What previous experience do you have of volunteering?
   - For Age UK, and more generally
   - Has any of this experience related to physical activity programmes for older people, or similar?

3. Why did you decide to volunteer for GGT?
   - New skills and knowledge
   - Improve physical and/or mental health and wellbeing
   - Social outcomes – meeting new people
   - Give something back to the community
   - To help in finding employment

4. How easy was the process to become a volunteer?

- How did you hear about it?
- How challenging was the application process?

Volunteering experience

Aim: to determine participants' views on the quality of their experience

5. What support have you received in your role as a volunteer?
- General induction
- Training in: needs assessment, buddying, IT, admin, health conditions, physical activities
- Information and communication
- Emotional support – talking, listening

6. How useful was this support? How could it be improved?
- Probe against each type of support mentioned

Outcomes

Aim: to determine the outcomes achieved for volunteers – and their views on how participants have benefited

7. What difference has volunteering on GGT made to you?
- Knowledge and skills
- Sense of wellbeing from contributing to the community
- Physical and mental health benefits
- Employment benefits

8. What about your involvement in GGT has helped to bring about these outcomes?
- Training provided
- Nature/extent of activities involved with
- Opportunities to socialise

9. Has there been anything which has prevented you from benefiting more?
- Lack of training
- Lack of variety of activities / not enough exposure
- Insufficient opportunities to socialise

10. How do you think the participants you have worked with have benefited?
- Knowledge and skills
- Physical and mental health benefits
- Employment benefits
- Explore the barriers and enablers to achieving these outcomes

11. What do you think you would have done in the absence of GGT?
- Volunteered elsewhere
- Not volunteered

11. What are your future plans related to volunteering or GGT? Would you like to continue?

12. What would you like to see for the future of GGT?

Do you have any further comments or questions?

Aim: to allow the interviewee to make any further points not already covered, and ask any questions about the programme of research

Thank interviewee for their time

A2.3 Stakeholder interviews

This is the topic guide for the final round of stakeholder interviews. These interviews aim to take the informed external stakeholder view of the projects – how they fit into the local context of provision, important outcomes and sustainability of the project following the end of the Programme in September 2016.

In preparing for the interviews please refer to the following:

- Scoping and interim interview write-ups (check whether we have interviewed them before);
- The detailed scoping report and summary slidepack of key findings to date;
- The interim report summary; and,
- The summary findings for this particular GGT project.

The interview needs to cover:

- Their knowledge and understanding of GGT, and how they have been involved;
- Fit of GGT with strategic priorities locally;
- How GGT adds value to existing provision of health and wellbeing services;
- Extent to which recruitment is targeting those most in need ;
- Effectiveness of referral pathways / clarity of referral guidelines;
- Outcomes for participants: physical, mental, social;
- Outcomes for the wider health economy: improved integration/partnership working, reduced use of public resources;
- Opportunities for improvement – what works well and what could be improved;
- What are the barriers and how can they be overcome; and
- How to secure sustainability.

Get Going Together programme summary

GGT is a three-year programme of physical activity interventions for older people with long term conditions. It aims to deliver physical, mental and social outcomes through providing low level (large groups for people with lower needs) and high level (1-1/small group support for higher needs) classes.

Introduction

Aim: to determine role of interviewee and current or potential involvement with GGT

1. Please tell me about your current role and responsibilities.

2. How does your work relate to the health and wellbeing of older people in the area?

3. What formal and informal relationships have you had with:
- the partner Age UK;
- the GGT project; and
- other similar projects or services.

Context and rationale

Aim: to understand project fit with strategic priorities and with supply and demand

4. How does GGT fit with local strategic priorities for health and social care / older people?

5. What services exist in the region to meet this need?
- Refer back to previous findings and ask if there is anything else they are aware of

6. What are the gaps in this provision?
- Particular types of service e.g. mental health, wellbeing, physical activity
- Geographical coverage
- Suitability for this particular target group [older people with LTCs]

Understanding of the project

Aim: to determine participants' current understanding of and involvement in the project; or their potential interest and how they might get involved

7. Please tell me about your understanding of the rationale behind GGT
- Targeting older people with LTCs
- Prevention agenda
- Impacts on health and social care system more widely

8. Please tell me about your experience and understanding of GGT
- If/how have they been involved
- What is your understanding of GGT – target group, aims and objectives, high and low level activities
- Thoughts on cost effectiveness, explore in-kind costs

Outcomes for older people and the health and social care system

Aim: to understand the difference GGT has made locally

Please note that this may not be applicable/appropriate for all stakeholders so tailor accordingly

9. What have been the outcomes for older people?

- Physical
- Mental
- Social and emotional
- If none, why do you think this is?

10. What have been the impacts on the health and social care system?

- Partnerships and referral pathways developed
- Integration of services
- Increased uptake of services through increased awareness among older people of health issues
- Evidence of reduced demand on other parts of the system, e.g. through increased self-management
- If none, why do you think this is?

11. To what extent would these outcomes have been achieved without GGT?

12. What are the facilitators and barriers for achieving these outcomes?

- What has worked well? What could be improved?

What are the issues for the sustainability of the project?

Aim: to take stakeholders' views on the key factors for the sustainability of the project locally

13. How should the project act to ensure it is sustainable?

14. Which partnerships are most important to develop and maintain?

15. What are the key outcome measures to evidence success to clinicians and commissioners?

- What are the challenges associated with collecting these data?

Do you have any further comments or questions?

Aim: to allow the interviewee to make any further points not already covered, and ask any questions about the programme of research

Thank interviewee for their time.

A2.4 Short interviews with I&A stakeholders

Explain that Age UK has passed us their details. We want to find out how the information and advice materials that GGT has distributed are being used and whether they are having an impact.

There are two types of materials for discussion: promotion for the GGT project; and health messages on the benefits of physical activity for older people with long term conditions.

We need to capture information on:

- The baseline situation – what is their client profile and their existing I&A provision
- A description of the materials and view on quality
- Impact of materials – do they think it makes a difference to older people, through joining GGT or other activities; or increased their awareness of the benefits of physical exercise.
- What other routes could be taken to disseminate these materials.

Get Going Together programme summary

GGT is a three-year programme of physical activity interventions for older people with long term conditions. It aims to deliver physical, mental and social outcomes through providing low level (large groups for people with lower needs) and high level (1-1/small group support for higher needs) classes.

1. Please tell me a little bit about your organisation and how older people are involved.

2. What information and advice do you already provide?

3. Please tell me about the I&A materials you helped to distribute.

- Views on quality, relevance and appropriateness

4. What has been the uptake of the materials?

- Which materials have been most popular?
- Which groups of people have taken which materials? Are these the right groups?

5. How useful have the materials been for older people?

- Raising awareness and increasing knowledge
- Encouraging uptake of physical activities

6. What suggestions would you make to Age UK to improve the design or distribution of these materials?

7. Do you have any further comments or questions?

Thank interviewee for their time.

A2.5 AUK staff topic guide

We need to capture information on recent progress and their views on the main themes that have come out of the scoping and interim reports. Please refer to these summaries prior to your visit so that you understand the local context of your site. The interview should cover:

- Developments since the last fieldwork – new classes, referral routes, progress in recruiting volunteers, sustainability;
- How participants are progressing within and beyond GGT;
- Key challenges and features of effective practice;
- Key lessons learned from their project to date; and,
- Plans and methods of sustainability.

Get Going Together programme summary

GGT is a three-year programme of physical activity interventions for older people with long term conditions. It aims to deliver physical, mental and social outcomes through providing low level (large groups for people with lower needs) and high level (1-1/small group support for higher needs) classes.

1. What have been the developments over the last six to twelve months?

- New classes
- New referral routes
- Delivery models – probe for effectiveness, changes made
- Volunteer recruitment
- Building partnerships
- Methods of securing sustainability

2. How do you think GGT fits in your current, local health and social care landscape?

3. What other services exist in your local area? Is there a gap for a project such as GGT?

4. How have you been working to secure sustainability of classes/the project after the end of the programme? Explore costs and in-kind costs.

5. Looking back over the last three years, what difference do you think GGT has made for?:
   a) Participants – probe for case study material, good news stories, good examples of difference GGT has made over time
   b) Volunteers
   c) AUK staff
   d) The local health and social care economy

6. What has worked well?

- Referral partners
- Range of activities
- Friendly/effective tutors
- Volunteer support

7. What have been the challenges?

- Transport
- Finding venues

- Appropriate and effective referral routes
- Retention and progression
- Capacity

8. What are the lessons learned you would share with other partners?

9. If you could start over and run the project again, what would you do differently and why?

Annex 3 GGT logic model and theory of change

This annex presents the Get Going Together (GGT) logic model and theory of change.

A3.1 Logic model and mapping the patient pathway

We have adopted a theory-led approach to establishing the evaluation framework. This has been informed by scoping research and a literature review, and has involved developing:

- A logic model summarising the desired outcomes of GGT and the assumptions and presumed mechanisms by which the pathfinder will bring about change (Figure A3.1) The logic model sets out the programme's inputs, activities/outputs, short-term and longer term outcomes; and
- Participant pathways through GGT, identifying factors which could influence the extent to which the outcomes set out in the logic model are delivered.

A3.2 The theory of change: How is Get Going Together expected to make an impact?

Below is a set of propositions implicit in the design of GGT. These propositions relate to the desired outcomes and impacts of the programme, as set out in the logic model; they are presented alongside consideration of mechanisms and causal pathways by which they are expected to be achieved.

A3.3 Expected outcomes

GGT will **improve access to health and wellbeing activities tailored to people's needs**. It will do this through delivering high and low intensity activities that complement existing services available within the locality (for example, by filling existing gaps in the services available for different sub-groups of older people) and providing transport for older people to and from activities.

Assessment of older people's needs upon referral or initial engagement with GGT; ongoing review of participants' progress and changing needs, and feedback from, for example, older people attending taster sessions and wider stakeholders, will enable activities to be tailored and responsive the target population – and different subgroups of older people, including those that are hardest to reach.

GGT will also **improve awareness of the benefits of physical activity**. It will do this through the production and dissemination of information and advice – through, for example, the distribution of leaflets and posters in community settings, newspaper articles, the use of social media and presentations/talks to community groups. These mechanisms for improving awareness of the benefits of physical activity will also promote GGT activities – helping to reach older people who can most benefit from these activities.

Improved awareness of the benefits of physical exercise and access will lead to greater **participation in exercise based physical activities**. Buddy and peer mentor support provided by volunteers will further enhance participation, by making it less daunting for older people to engage with GGT.

Participating in group and one-to-one activities will also provide older people with a means of increasing social interaction and community involvement. GGT is therefore expected to **reduce social isolation and loneliness**.

Short-term participation in GGT activities and reduced social isolation and loneliness will help to **increase confidence and self-esteem**.

All of these benefits are expected to support ongoing participation in exercise based activities. However, older people could disengage with GGT if they consider the activities are unresponsive

to their needs. This could, in turn have a negative effect on confidence and self-esteem, as well as subsequent participation in physical exercise and levels social isolation/loneliness.

Increased participation in physical exercise and reduced social isolation will lead to **increased health and wellbeing for older people**. However, the level of improvements in health and wellbeing will be dependent on:

- The frequency and duration of participation in GGT activities; and
- The baseline levels of participants' health and wellbeing.

Programme flexibility allowing the targeting and tailoring of activities, ongoing support and encouragement for participants to continue attendance (for example through the use of volunteer buddies and peer health mentors), and the consistency and regular assessment of older peoples' needs are all expected to maximise the effects of GGT on participants' health and wellbeing. Furthermore, for some participants, involvement in GGT activities could help to maintain existing levels of health of wellbeing, thereby preventing longer term deterioration of these outcomes.

Ongoing participation in regular exercise, when tailored appropriately, can also increase stability and muscle strength for older people. GGT is therefore expected to **reduce the number of falls** experienced by participating older people.

Improved health and wellbeing, together with peer support and improved confidence and self-esteem, could lead to older people being more actively involved in the **self-management of, and shared decision making** with respect to the management of, their long term conditions. This could include, for example, changing specific aspects of their lifestyles and making shared decisions with health care professionals about reducing dependency on some medications. This in turn could also lead to **improvements in health literacy** more broadly.

In the short term, GGT is also likely to deliver strategic added value as a result of the necessity to develop referral pathways to and from the programme. This could include **strengthening of professional relationships and partnership working** between local GGT teams and other health and social care professionals/teams (including for example primary care, and integrated care teams) and other community and third sector providers. This in turn could lead to **improvements in the integration of local services aimed at improving the health and wellbeing of older people**, as well for those people whose needs can be supported by existing activities provided by other organisations, including other charities. Improvements in the integration of local services are expected to help older people to better navigate services available – this in turn could help to increase and sustain involvement in physical activity, albeit it not necessarily GGT activities.

GGT provides an opportunity for peer and non-peer volunteers to support the delivery of the programme – including providing transport, and mentoring and buddying support for participants, as well as, for example, instructing exercise classes. GGT could therefore **increase participation in volunteering**. Depending on the nature of involvement in GGT volunteers could also experience the same benefits as participants, particularly with respect to improved awareness of the benefits of physical exercise, improved self-esteem and confidence, reduced social isolation and improved health and wellbeing.

Specific training, for example for peer health mentors and buddying could lead to **improved skills and experience for volunteers**. This in turn could lead to **new employment opportunities**, and/or, further participating in volunteering.

A3.4 Expected impacts

Improvements in health and wellbeing, together with reduced social isolation will lead to **improved quality of life**. Together with a reduced number of falls, and improved self-management /shred decision with respect to long term conditions and of wider health, these outcomes are expected to lead to reductions in the demand on primary and secondary care (particularly in an acute setting).

The reduced or maintained demand is expected to deliver **savings to the health and social care system / better use of available resources** ('savings' would imply disinvestment following freed capacity). Targeting of older people with long term conditions who could most benefit from GGT – particularly those that are hard to reach, and their subsequent participation in the programme could help to identify unmet need and **reduce health inequalities**. Furthermore, the preventative focus of GGT, coupled with delivery model that draws on community assets (for example, volunteering and venues), could also improve the resilience of the health and social care system with managing the increase demand for NHS services from the aging population.

Figure A3.1 Logic model for the Get Going Together programme

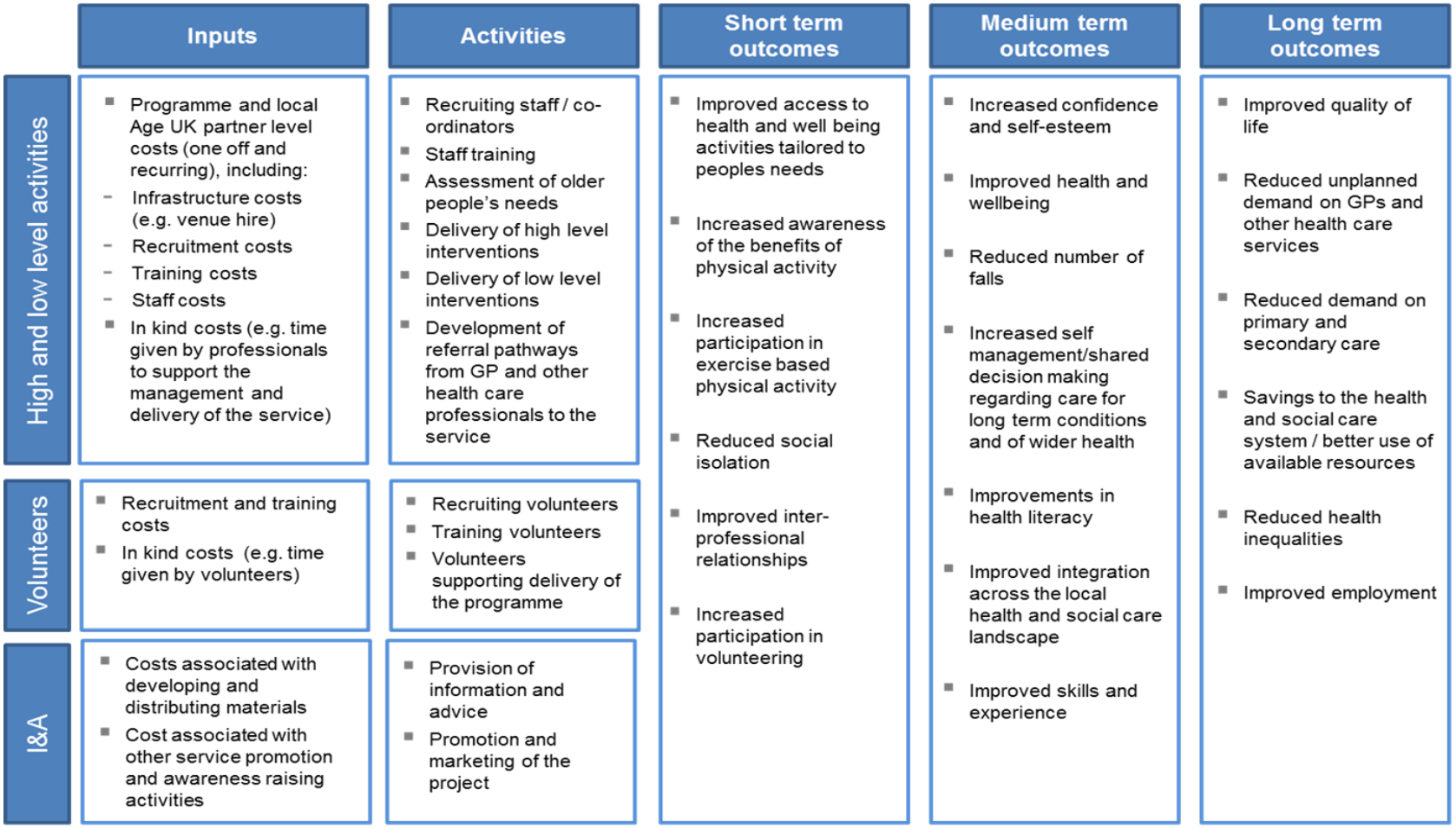
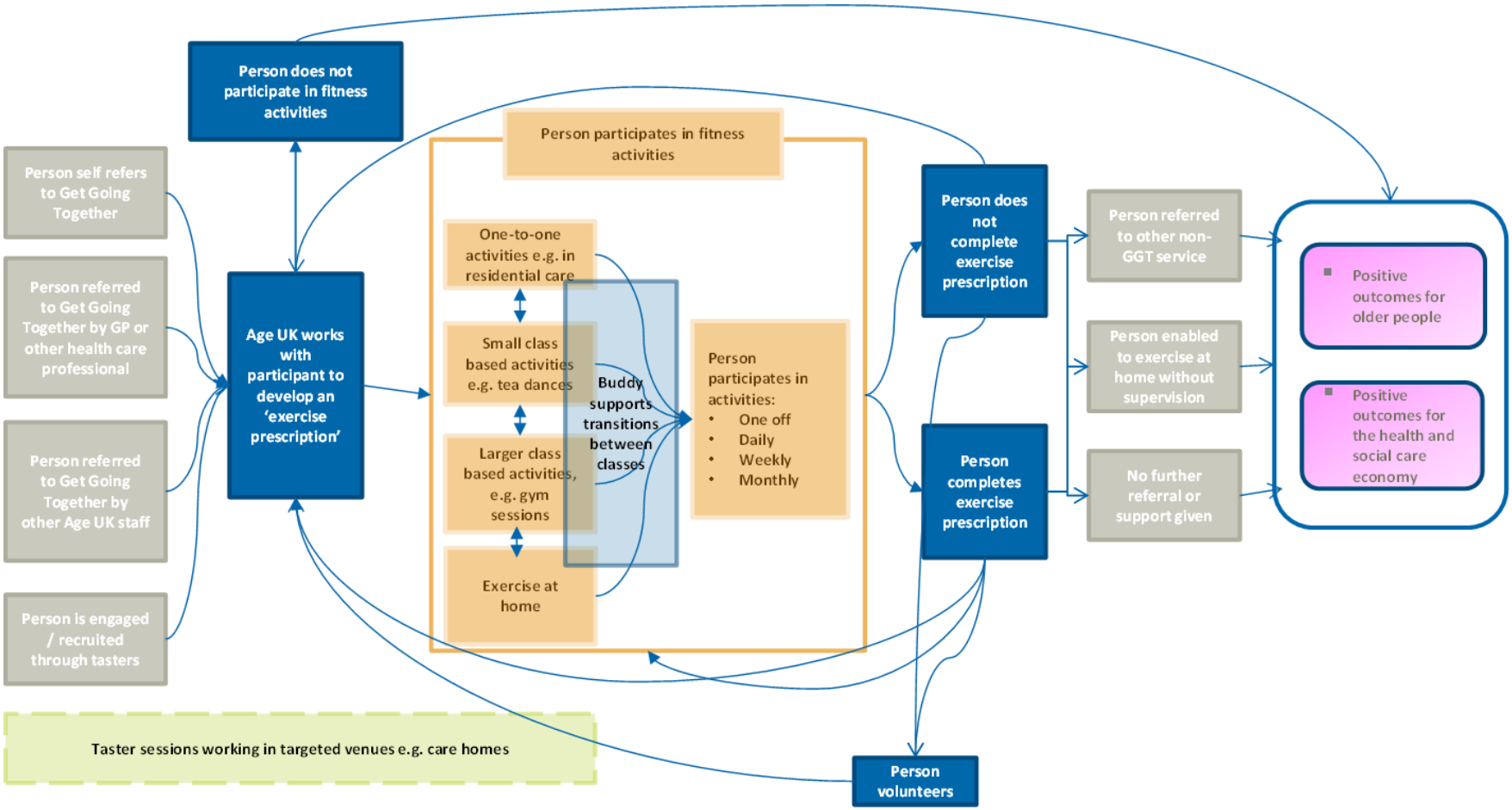


Figure A3.2 Participant pathways through Get Going Together



Annex 4 Methodology and analysis findings

We have carried out a detailed analysis of the participant survey which was carried out throughout the programme. We describe how we cleaned the data and then present the results of the analysis.

A4.1 Data preparation

The data cleaning process started by removing duplicate entries from individuals from the data set. To do this we examined the data for entries where the same person (matching on participant ID, name, initial and year of birth) had multiple entries in a single wave. Following this initial data cleaning exercise, the number of completed surveys was over 3,500 (as shown in Table A4.1).

Table A4.1 Number of individuals completing surveys and number of surveys completed

	Number of individuals	Number of surveys
Leicestershire & Rutland	757	1,178
Coventry	343	917
Oldham	355	584
South Tyneside	431	530
Cheshire	247	325
Total	2,133	3,534

The next stage of the data preparation process involved scoring the survey responses to the SF-36 survey. This was done according to guidance from RAND Europe, who developed the survey. However, not all survey responses included answers to all questions. Where a respondent had answered fewer than ten of the SF-36 questions, the survey was removed from the analysis. Where responses were missing from participants who had completed more than ten questions, the average response score for the survey wave in each location was assigned to the blank response.

We then examined the dates the surveys were completed on. Where there was no date entered, the survey was removed from the analysis. Each participant's surveys were then categorised from waves of survey (baseline, follow up wave one, follow up wave two etc.) and sorted by duration from the date of the first survey. Where a survey was completed within two weeks of the baseline survey, it was excluded from the analysis. The time categories used were:

- Up to three months from the date of the first survey (excluding those completed within two weeks);
- Between three and six months from the date of the first survey;
- Between six months and one year of the date of the first survey;
- Between one and two years of the date of the first survey;
- More than two years since the date of the first survey.

The final stage of the data preparation was to examine if any participants responses fell into the same time category (for example if a participant had completed more than one survey between six months and one year from the date of the first survey). Where the same participant had multiple entries in the same time period, the most recent response was kept, with the other responses removed from the analysis.

Following this data preparation phase, we were left with responses from 1,910 individuals and over 3,000 survey responses (see Table A4.2).

Table A4.2 Number of individuals completing surveys and number of surveys following data cleaning

	Number of individuals	Number of surveys
Leicestershire & Rutland	646	976
Coventry	342	800
Oldham	325	532
South Tyneside	379	456
Cheshire	218	281
Total	1,910	3,045

Some of the individuals only completed a baseline survey, and therefore could not be used in the analysis of impact. These responses were excluded from the impact analysis. Once these responses were excluded, there were 826 individuals who could be used to assess the impact of the programme.

Table A4.3 Number of individuals used in impact assessment

	Number of individuals	Number of surveys
Leicestershire & Rutland	277	607
Coventry	277	735
Oldham	144	351
South Tyneside	73	150
Cheshire	55	119
Total	826	1,962

A4.2 Profile of respondents used in impact analysis

The participant profile of the surveys used in the statistical analysis was reviewed to get a greater understanding of the representativeness of the surveys used in the analysis. The results show that, on the whole, the profile of participants is broadly similar to that presented in chapter 3 with comparable figures for age, gender balance and percentage of respondents with long term conditions. Respondents used in the statistical analysis were slightly less likely to live alone.

A4.3 Impact prior to 3 months

There was a slight increase in the scores for physical function, role limitations due to physical health and emotional problems, energy and pain in the comparator group up to three months from the baseline measure. However, none of these increases in the score were significant. The scores for general health, social function and emotional wellbeing fell, but again these changes were not significant. There were no statistically significant changes in any of the individual programme sites.

The average number of unplanned hospital and GP appointments both decreased for participants up to three months after completing the baseline survey. The change in the number of GP appointments was statistically significant. The changes relate to a decrease of 18 GP appointments and ten hospital appointments. There was a non-significant increase in the number of health appointments with other health professionals (an increase of two appointments).

The decrease in demand for health services is difficult to monetise, as the exact nature of the health care appointments is unknown. The monetary value per appointment has been estimated using the following assumptions:

- The cost of a standard GP appointment, lasting 11.7 minutes. This cost is estimated to be £37[19];
- The cost of an unplanned hospital appointment is assumed to be an emergency admission. The cost of an emergency admission is estimated as the cost of a non-elective inpatient stay, and is estimated to be £1,566[20]; and
- The cost of an appointment with another healthcare professional is assumed to be with a GP nurse, and last 15 minutes. The cost is estimated to be £12[21].

These values were used to estimate the value of the change in health service demand. The change in demand for the sample completing the survey (140), the population surveyed who completed at least one follow-up survey (826) and the population who completed a baseline survey (1,912) is presented in Table A4.5. The largest monetary impact is from hospital appointments, due to the much higher value of an individual admission.

It has not been possible to assess if the changes in health appointments are caused by the get going together programme or by other factors.

[19] Personal Social Services Research Unit (2015) Unit Costs of Health and Social Care 2015. Average cost of a GP appointment (duration 11.7 minutes) – excluding qualification costs, including direct care staff costs: £37. Cost inflated to 2015-16 prices using GDP deflators

[20] Department of Health (2015) NHS Reference Costs 2014 to 2015. Average cost of a non-elective inpatient admission (£1,565) inflated to 2015-16 prices using GDP deflators

[21] Personal Social Services Research Unit (2015) Unit Costs of Health and Social Care 2015. Average cost of a GP nurse appointment. Cost of face to face contact time is £47 per hour (excluding qualification costs); cost divided by four to estimate cost of individual appointment. Cost inflated to 2015-16 prices using GDP deflators

Table A4.4 Baseline and follow up measure, up to three months from baseline

	Leicestershire & Rutland		Coventry		Oldham		South Tyneside		Cheshire		Total	
	Base	3 months	Base	3 months	Base	3 months	Base	3 months	Base	3 months	Base	3 months
Sample size	25		43		33		28		11		140	
Physical function	55.20	54.85	42.67	43.72	56.73	57.87	45.41	46.55	58.62	65.00	50.03	51.28
Role limitations due to physical health	37.01	44.00	53.87	54.65	46.53	49.89	46.01	45.05	47.86	33.40	47.08	48.04
Role limitations due to emotional problems	24.55	27.55	38.76	35.98	22.20	21.11	19.56	21.26	6.93	26.60	25.98	27.29
Energy/fatigue	55.74	57.78	43.91	45.41	56.16	56.97	56.54	56.24	57.22	57.14	52.48	53.43
Emotional wellbeing	64.33	62.56	68.82	68.74	76.44	73.92	78.59	74.63	77.22	73.80	72.43	70.44
Social function	76.55	74.49	66.28	66.88	75.38	76.58	81.03	75.67	81.71	82.91	74.42	73.54
Pain	66.35	66.20	67.15	67.73	66.98	69.32	65.76	62.24	69.63	75.64	66.88	67.36
General health	51.20	49.81	51.16	50.21	52.14	53.06	61.53	57.50	64.03	62.51	54.49	53.23
Unplanned GP	0.40	0.04	0.33	0.05	0.03	0.09	0.11	0.21	0.45	0.18	0.24	0.10
Unplanned hospital	0.12	0.04	0.47	0.19	0.09	0.03	0.04	0.14	0.09	0.36	0.20	0.13
Unplanned other health	0.00	0.00	0.02	0.02	0.00	0.03	0.00	0.00	0.00	0.09	0.01	0.02

ICF analysis; Cells shaded blue indicate a statistically significant change at a 95% confidence level

Table A4.5 Change in the number of health service appointments for individuals up to three months from baseline

	Individuals who completed a survey up to three months after follow up (140)		Individuals who completed any follow up survey (826)		Individuals who completed a baseline survey (1,912)	
	Number	£	Number	£	Number	£
GP appointments	19	700	112	4,200	259	9,600
Hospital appointments	10	15,700	59	92,400	137	213,900
Other appointments	-2	0	-12	-100	-27	-300
Total	27	16,300	159	96,400	369	223,200

ICF calculations; Figures rounded to nearest £100; Cells shaded blue based on results that are statistically significant at a 95% confidence level.

A4.4 Impact up to six months

The change in SF-36 scores for participants between three months and six months from the baseline survey showed more statistically significant results than for the group up to six months. There were statistically significant increases in the SF-36 scores for energy, emotional wellbeing, social function and pain, and a statistically non-significant increase for physical function. There was a statistically significant decrease in the score for role limitations due to emotional problems, and an insignificant decrease in the scores for role limitations due to physical health and general health. There were some statistically significant results in individual areas, particularly in Coventry.

The number of unplanned GP appointments, hospital appointments and other health appointments all decreased, with the change in the number of GP and hospital appointments statistically significant. This change indicates a decrease of 70 GP appointments, 62 hospital appointments and 17 other health appointments. If these changes are applied to the total population who completed at least six months on Get Going Together (741), then the change in appointments is 142, 126 and 34 respectively.

The monetary value of the changes in health service appointments is presented in Table A4.7. The total value of the change in demand for health services is estimated to be nearly £100,000 less than at the baseline for the population surveyed and over £200,000 less than at the baseline for the population who completed a survey beyond three months from the baseline.

It has not been possible to assess if the changes in health appointments are caused by the get going together programme or by other factors.

Table A4.6 Baseline and follow up measure, up to six months from baseline

	Leicestershire & Rutland		Coventry		Oldham		South Tyneside		Cheshire		Total	
	Base	6 months	Base	6 months	Base	6 months	Base	6 months	Base	6 months	Base	6 months
Sample size	81		154		95		28		8		366	
Physical function	46.23	45.76	35.50	37.43	60.08	60.34	54.62	57.46	57.91	65.24	46.21	47.36
Role limitations due to physical health	46.77	44.32	64.11	61.95	40.89	35.96	47.57	44.76	42.56	51.88	52.51	49.77
Role limitations due to emotional problems	33.80	31.91	49.59	39.00	25.40	24.79	35.38	27.08	27.68	33.33	38.25	32.71
Energy/fatigue	56.59	56.96	41.90	45.38	56.68	57.34	50.48	56.67	52.70	55.62	49.88	52.13
Emotional wellbeing	64.67	63.51	66.97	69.65	75.08	78.09	69.33	72.44	76.24	78.87	68.95	70.90
Social function	73.95	78.09	63.12	67.51	77.80	81.78	73.85	77.27	80.10	77.31	70.52	74.52
Pain	67.88	68.24	59.06	62.74	69.83	75.01	63.84	65.32	71.88	64.06	64.45	67.37
General health	52.77	51.51	49.52	48.29	53.33	53.21	54.97	52.77	56.71	55.48	51.80	50.78
Unplanned GP	0.14	0.02	0.47	0.14	0.18	0.12	0.43	0.32	0.25	0.00	0.31	0.12
Unplanned hospital	0.28	0.00	0.52	0.19	0.03	0.06	0.07	0.39	0.13	0.00	0.30	0.13
Unplanned other health	0.06	0.00	0.17	0.08	0.02	0.04	0.00	0.00	0.13	0.00	0.09	0.05

ICF analysis; Cells shaded blue indicate a statistically significant change at a 95% confidence level

Table A4.7 Change in the number of health service appointments for individuals between three months and six months from baseline

	Individuals who completed a survey up to six months after follow up (366)		Individuals who completed any follow up survey beyond three months (741)	
	Number	£	Number	£
GP appointments	70	2,600	142	5,300
Hospital appointments	62	97,100	126	196,600
Other appointments	17	200	34	400
Total	149	99,900	302	202,200

ICF calculations; Figures rounded to nearest £100; Cells shaded blue based on results that are statistically significant at a 95% confidence level.

A4.5 Impact up to one year

The change in SF-36 scores for participants who completed a survey between six months and one year of completing the baseline survey shows a statistically significant increase in the scores for energy and for social functions. There were also non-significant increases for emotional wellbeing and pain. There was a statistically significant decrease in the score for role limitations due to emotional problems, and insignificant decreases in the scores for physical function, role limitations due to physical health and general health. Statistically significant changes in the SF-36 scores were observed in Coventry and Leicester.

The overall results showed that there were statistically insignificant increases in the number of unplanned hospital appointments and other health appointments. These increases would relate to an increase in the number of appointments of 113 (76 hospital appointments and 37 other health appointments), and if this was applied to the population completing a survey between six months and one year from the baseline (519) then 156 additional health appointments would be needed (105 hospital appointments and 51 other health appointments).

In contrast, there was a statistically insignificant decrease in the number of GP appointments. This decrease would relate to a decrease in appointments of 21 for the population completing a survey between six months and a year from the baseline, and if this was applied to the whole population completing any survey after six months from the baseline then 29 fewer appointments would be needed. However, this impact is not significant.

The monetary value of the changes in health service appointments is presented in Table A4.9. The total value of the change in demand for health services is estimated to be an additional £119,000 for the population surveyed and £164,000 for the population who completed a survey beyond six months from the baseline. This impact is not significant.

It has not been possible to assess if the changes in health appointments are caused by the get going together programme or by other factors.

Table A4.8 Baseline and follow up measure, up to one year from baseline

	Leicestershire & Rutland		Coventry		Oldham		South Tyneside		Cheshire		Total	
	Base	1 year	Base	1 year	Base	1 year	Base	1 year	Base	1 year	Base	1 year
Sample size	135		158		52		16		14		375	
Physical function	53.25	47.97	28.79	30.87	65.82	66.15	49.00	52.01	64.44	63.68	44.92	44.05
Role limitations due to physical health	48.17	49.41	71.09	62.70	33.48	36.59	41.50	49.54	53.83	40.23	55.72	52.90
Role limitations due to emotional problems	35.31	31.47	57.65	40.32	24.29	26.67	41.39	30.77	37.25	31.40	43.53	34.50
Energy/fatigue	54.69	55.10	38.17	45.53	57.59	59.36	54.67	55.51	56.07	59.59	48.18	51.84
Emotional wellbeing	62.15	60.21	63.36	67.23	74.33	77.72	76.43	70.76	74.12	79.91	65.41	66.78
Social function	74.06	72.13	54.95	63.48	77.91	80.57	78.47	73.89	79.04	83.46	66.92	70.15
Pain	69.26	65.98	56.75	62.58	67.33	72.60	66.30	57.23	69.01	66.19	63.59	65.10
General health	51.52	51.24	47.46	46.05	53.42	53.17	58.27	56.88	58.55	63.05	50.62	50.01
Unplanned GP	0.27	0.73	0.56	0.08	0.23	0.21	0.25	0.19	0.36	0.14	0.39	0.34
Unplanned hospital	0.05	0.64	0.37	0.17	0.02	0.46	0.06	0.63	0.29	0.00	0.19	0.39
Unplanned other health	0.24	0.40	0.18	0.11	0.04	0.52	0.00	0.00	0.00	0.07	0.17	0.27

ICF analysis; Cells shaded blue indicate a statistically significant change at a 95% confidence level

Table A4.9 Change in the number of health service appointments for individuals between six months and one year from baseline

	Individuals who completed a survey up to one year after follow up (375)		Individuals who completed any follow up survey six months (519)	
	Number	£	Number	£
GP appointments	21	800	29	1,100
Hospital appointments	-76	-119,000	-105	-164,700
Other appointments	-37	-400	-51	-600
Total	-92	-118,700	-127	-164,200

ICF calculations; Figures rounded to nearest £100; Cells shaded blue based on results that are statistically significant at a 95% confidence level.

A4.6 Impact up to two years

Statistically significant increases in the SF-36 scores were observed for Energy and Pain for the overall population who completed a survey between one and two years from the baseline measure. There were also non-significant increases for physical function, role limitations due to physical health, emotional wellbeing and social function. There was a statistically significant decrease in the score for role limitations due to emotional problems, and insignificant decreases in the scores for general health, role limitations due to physical health and general health. Statistically significant changes in the SF-36 scores were observed in Coventry, Oldham and South Tyneside.

The overall results showed that there were statistically insignificant increases in the number of unplanned hospital appointments and other health appointments. These increases would relate to an increase of 19 health service appointments (11 hospital and eight other health appointments) for the 235 individuals who completed a survey between one and two years from the baseline. The increase in hospital appointments remains the same when the changes was applied to the population who completed any survey more than one year from the baseline completing up to two years (243).

In contrast, there was a statistically insignificant decrease in the number of GP appointments. This decrease would relate to an decrease of 30 GP appointments of for those surveyed between one and two years from the baseline, and the change in number of appointments remains the same when the changes was applied to the population who completed any survey more than one year from the baseline completing up to two years. However, this impact is not significant.

The value of the change in demand for health service appointments is presented in Table A4.11. The total value of the change in demand for health services is estimated to be an additional £16,000 for the population surveyed and £17,000 for the population who completed a survey beyond six months from the baseline[22]. This impact is not significant.

It has not been possible to assess if the changes in health appointments are caused by the get going together programme or by other factors.

[22] There is a difference in the monetary values for the population completing a survey between one and two years after the baseline and the population who completed any survey more than one year after the baseline. This is due to the rounding up of values to present in tables.

Table A4.10 Baseline and follow up measure, up to two years from baseline

	Leicestershire & Rutland		Coventry		Oldham		South Tyneside		Cheshire		Total	
	Base	2 years	Base	2 years	Base	2 years	Base	2 years	Base	2 years	Base	2 years
Sample size	85		95		23		5		27		235	
Physical function	53.62	51.88	23.58	28.00	62.38	68.14	58.73	37.00	75.18	79.31	44.89	46.52
Role limitations due to physical health	44.64	48.54	70.20	69.74	33.56	26.28	30.68	56.82	21.94	17.65	51.28	51.73
Role limitations due to emotional problems	31.59	29.45	55.16	36.28	16.53	16.77	20.00	20.00	6.78	19.61	36.74	29.09
Energy/fatigue	53.47	55.81	38.21	45.24	59.55	69.09	60.98	55.86	65.88	66.89	49.30	53.99
Emotional wellbeing	61.82	61.23	66.05	71.12	75.09	84.47	85.04	76.68	82.39	75.35	67.72	69.66
Social function	77.89	76.89	56.11	65.64	85.88	83.78	95.00	80.00	91.76	85.29	71.76	74.25
Pain	69.76	67.37	51.87	61.97	68.48	71.52	75.00	66.36	78.39	72.79	63.39	66.66
General health	51.60	51.72	49.33	45.57	53.55	51.30	60.43	54.00	71.05	72.67	52.96	51.51
Unplanned GP	0.46	0.35	0.51	0.09	0.04	0.04	0.00	1.00	0.12	0.53	0.38	0.26
Unplanned hospital	0.07	0.16	0.29	0.26	0.00	0.09	0.00	0.80	0.12	0.00	0.15	0.20
Unplanned other health	0.11	0.11	0.09	0.18	0.04	0.04	0.00	0.40	0.12	0.00	0.09	0.12

ICF analysis; Cells shaded blue indicate a statistically significant change at a 95% confidence level

Table A4.11 Change in the number of health service appointments for individuals between one and two years from baseline

	Individuals who completed a survey up to two years after follow up (235)		Individuals who completed any follow up survey beyond one year (243)	
	Number	£	Number	£
GP appointments	30	1,100	31	1,100
Hospital appointments	-11	-17,200	11	-17,800
Other appointments	-8	-100	8	-100
Total	11	-16,200	11	-16,800

ICF calculations; Figures rounded to nearest £100; Cells shaded blue based on results that are statistically significant at a 95% confidence level.

A4.7 Impact over two years

The change in SF-36 scores for participants who completed a survey over two years following the completion of the baseline survey shows no statistically significant changes in SF-36 scores. This should be expected due to the small sample size. There were non-significant increases for all SF-36 categories. Statistically significant changes in the SF-36 scores were observed in Coventry for role limitations due to physical health.

The overall results showed that there were statistically insignificant decreases in the number of unplanned GP appointments, hospital appointments and other health appointments. These decreases would relate to a decrease in the number of appointments of two GP appointments, four hospital appointments and one other health professional appointment.

Applying the costs set out in section A4.2 to these changes, the individuals who have taken part in Get Going Together for over two years use £6,400 less healthcare resource than they did at the time of the baseline measure. However, this impact is not significant.

It has not been possible to assess if the changes in health appointments are caused by the get going together programme or by other factors.

Table A4.12 Baseline and follow up measure, more than two years from baseline

	Leicestershire & Rutland		Coventry		Oldham		South Tyneside		Cheshire		Total	
	Base	> 2 years	Base	> 2 years	Base	> 2 years	Base	> 2 years	Base	> 2 years	Base	> 2 years
Sample size	4		6		0		0		3		13	
Physical function	68.75	67.50	26.67	28.33	-	-	-	-	80.45	87.11	52.03	53.95
Role limitations due to physical health	26.11	37.40	25.00	83.33	-	-	-	-	52.65	4.70	31.72	51.05
Role limitations due to emotional problems	28.83	13.86	22.22	61.11	-	-	-	-	16.22	0.00	22.87	32.47
Energy/fatigue	66.26	58.71	45.00	45.83	-	-	-	-	58.33	80.00	54.62	57.68
Emotional wellbeing	61.04	68.00	61.33	64.00	-	-	-	-	74.67	89.36	64.32	71.08
Social function	81.25	89.06	66.01	60.42	-	-	-	-	91.67	100.00	76.62	78.37
Pain	89.75	81.25	60.42	58.33	-	-	-	-	78.97	95.83	73.73	74.04
General health	47.26	53.21	45.44	40.83	-	-	-	-	71.67	76.08	52.05	52.78
Unplanned GP	0.00	0.00	0.00	0.00	-	-	-	-	0.67	0.00	0.15	0.00
Unplanned hospital	0.00	0.25	0.00	0.00	-	-	-	-	1.67	0.00	0.38	0.08
Unplanned other health	0.00	0.00	0.00	0.00					0.33	0.00	0.08	0.00

ICF analysis; Cells shaded blue indicate a statistically significant change at a 95% confidence level

Table A4.13 Change in the number of health service appointments for individuals more than two years from baseline

	Individuals who completed any follow up survey beyond one year (13)	
	Number	£
GP appointments	2	100
Hospital appointments	4	6,300
Other appointments	1	0
Total	7	6,400

ICF calculations; Figures rounded to nearest £100; Cells shaded blue based on results that are statistically significant at a 95% confidence level.

A4.8 Overall impact

Figure 4.1 below presents the change in SF-36 scores over time. It is important to note that the scores are not from exactly the same individuals for all periods, therefore the charts present an indication of change rather than the changes for a group of individuals. The statistically significant changes are presented in blue, with statistically non-significant changes presented in grey.

The figure shows that there were the scores for Energy/fatigue, social function and pain were significantly above the scores at the baseline in multiple time periods, and the score for emotional wellbeing was significantly above the baseline score in one period. Where there were no statistically significant changes from the baseline for these indicators, the insignificant results usually suggested the scores were above the baseline measure. There was only a single indicator which showed the scores over time were significantly lower than the baseline score (role limitations due to emotional problems).

Figure 4.2 shows the change in demand for unplanned health appointments over time. For the first two time periods (up to six months), the number of unplanned GP appointments per person is significantly lower than at the baseline, and between three and six months the number of unplanned hospital appointments per person was significantly lower than for at the baseline. After six months, there are no statistically significant changes in healthcare demand from the baseline, with the insignificant results for GP appointments indicating a decrease in the number of appointments demanded, and mixed results for the demand for hospital and other health appointments.

The monetary value of the change in healthcare demand for the statistically significant changes from the baseline are presented in Table 5.2. This shows that the total value of the change in demand for healthcare is over £200,000, and all of the change is concentrated in the first six months after the baseline measure.

Table A4.15 presents the monetary value of the change in healthcare demand including the statistically insignificant changes from the baseline. This shows that the total value of the change in demand for unplanned healthcare appointments is slightly lower than the results using only the statistically significant results at £124,000. This is due to the increase in demand for healthcare appointments after six months, particularly hospital appointments.

Table A4.14 Monetary value of change in healthcare demand from the baseline using statistically significant results

	Up to three months (£)	Three to six months (£)	Six to 12 months (£)	One to two years (£)	More than two years (£)	Total (£)
GP appointments	4,200	5,300	0	0	0	9,400
Hospital appointments	0	196,600	0	0	0	196,600
Other appointments	0	0	0	0	0	0
Total	**4,200**	**201,800**	**0**	**0**	**0**	**206,000**

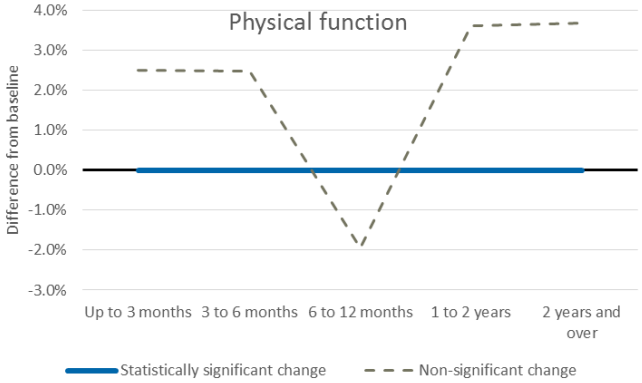
ICF calculations; Figures rounded to nearest £100

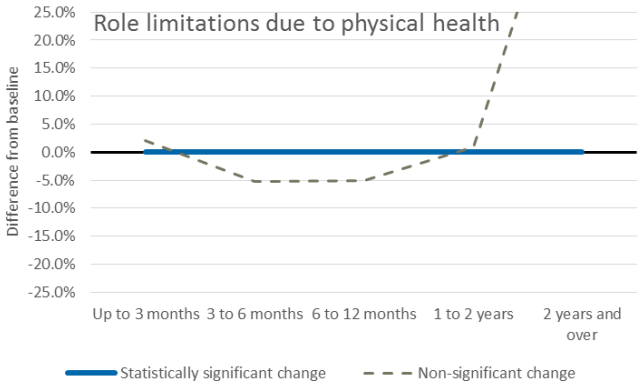
Table A4.15 Monetary value of change in healthcare demand from the baseline using statistically non-significant results

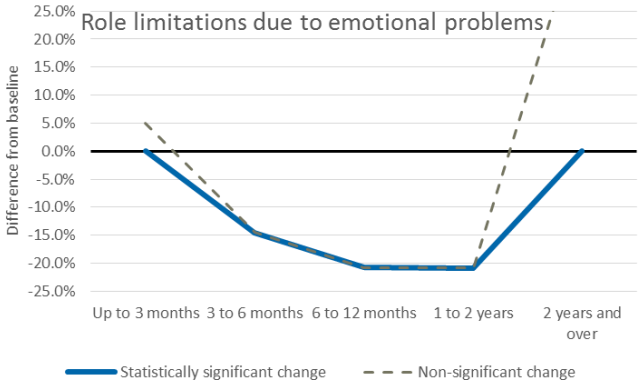
	Up to three months (£)	Three to six months (£)	Six to 12 months (£)	One to two years (£)	More than two years (£)	Total (£)
GP appointments	4,200	5,300	1,100	1,100	100	11,700
Hospital appointments	92,400	196,600	-164,700	-17,800	6,300	112,700
Other appointments	-100	400	-600	-100	0	-400
Total	**96,400**	**202,200**	**-164,200**	**-16,800**	**6,400**	**124,000**

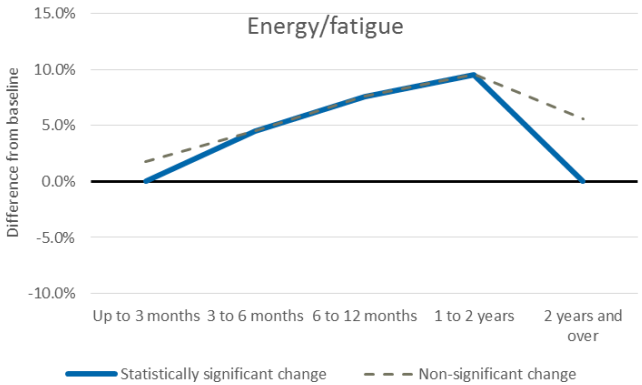
ICF calculations; Figures rounded to nearest £100

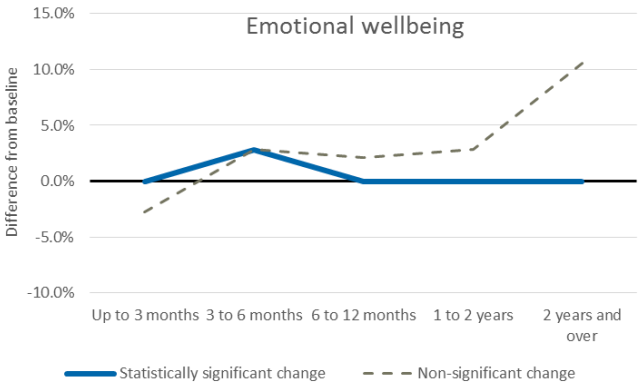
Figure A4.1 Change in SF-36 scores over time

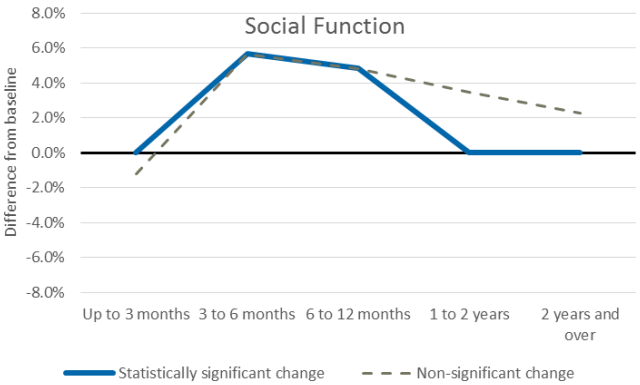


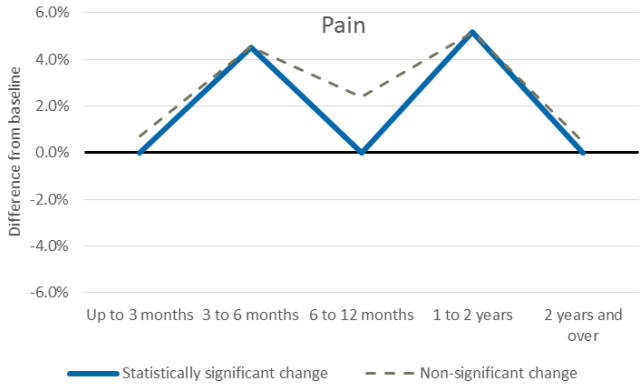












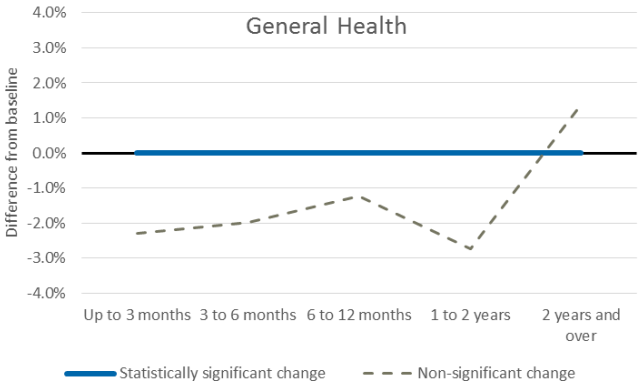
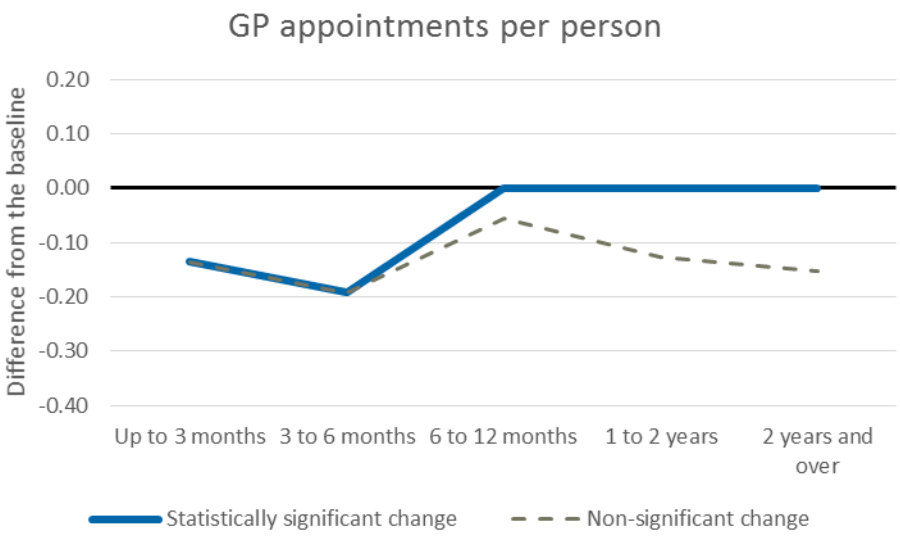
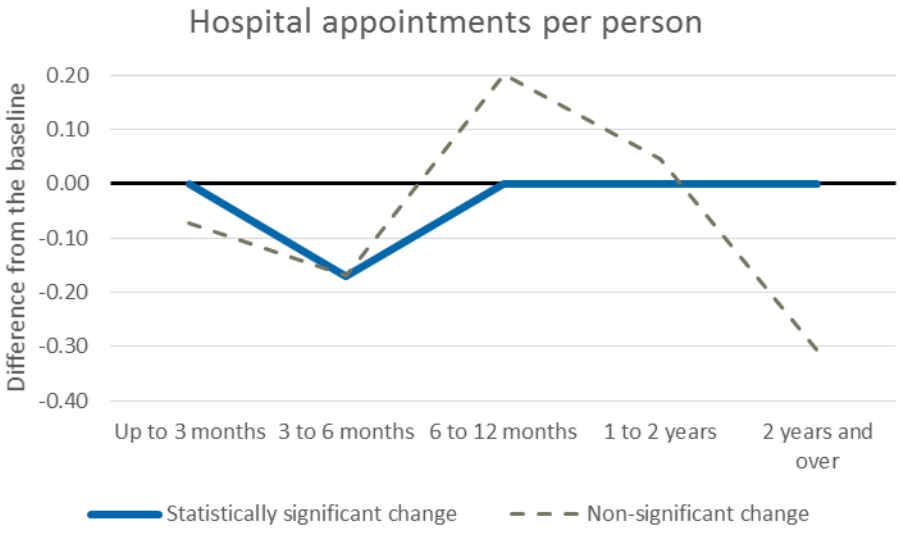
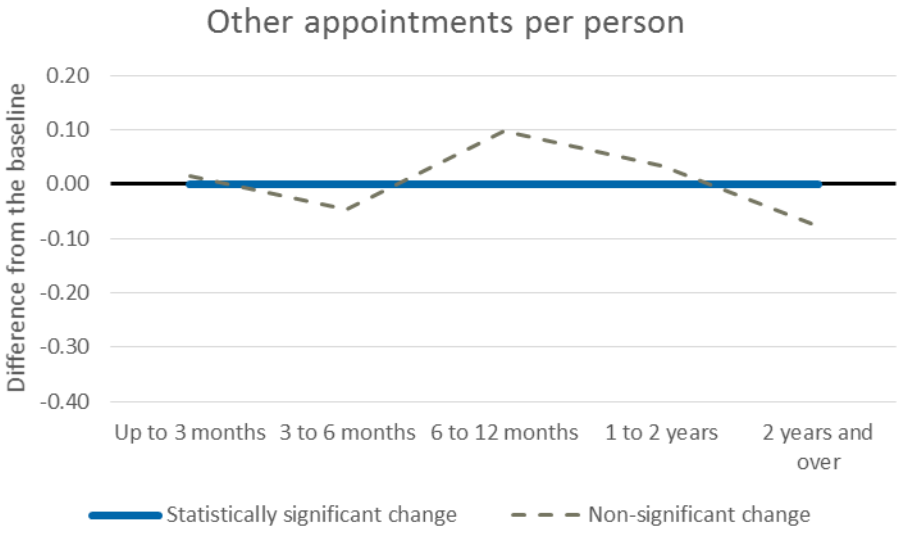


Figure A4.2 Change in unplanned health appointments







A4.9 Analysis of programme costs

Data was collected for the expenditure in each area on the Get Going Together programme. There were a wide range of inputs into the programme, including staff time, venue hire, overhead costs and volunteer contributions. Table A4.16 presents the total expenditure by site and type of expenditure. The largest item of expenditure was staff costs, followed by venue hire, equipment and tutors for classes. The total expenditure for the programme was over £1 million. These costs are all direct payments made for the delivery of the Get Going Together programme, taken from the programme budget.

Table A4.16 Expenditure by category and area for entire programme

	Leicestershire & Rutland (£)	Coventry (£)	Oldham (£)	South Tyneside (£)	Cheshire (£)	Total (£)
Expenditure						
Salary costs and recruitment	66,020	108,258	121,150	124,096	91,592	
Staff training		6,122	3,104	9,212	2,283	
Volunteer recruitment, training, costs	33,859		6,665	11,100	1,086	
Staff travel		5,113	5,668	6,942	3,872	
Venue hire, tutors, transport and equipment	61,283	27,007	25,517	9,836	91,007	
Promotion	5,141	1,185	520		4,631	
Overheads	18,477	3,275	5,130	23,727	50,408	
Management	21,174			20,627		
Evaluation	1,280					
Other		38,763	23,694			
Total expenditure	207,234	189,723	191,448	205,540	244,879	1,038,824
In-kind costs						
Volunteer hours	1,200	800	3,500	4,800	6,900	17,200
Volunteer cost	£10,400	£6,000	£27,300	£39,400	£58,300	£141,500
Venues	£23,400	£18,700	£15,100	£46,800	£20,600	£124,500
Transport	£0	£0	£3,600	£9,600	£0	£13,200
Financial contribution	£0	£13,500	£2,000	£2,000	£36,036	£53,536
Total in-kind	£33,800	£38,200	£48,000	£97,800	£114,936	£332,736
Total overall	£241,034	£227,923	£239,448	£303,340	£359,815	£1,371,560

Management information

A4.10 Comparing costs and impacts achieved

As can be seen from the analysis above, it has not been possible to capture the full impact of the programme. This is because there is no suitable comparator group to measure the progress of the programme against. It would be expected that in the target age group the number of GP, hospital and other health appointments would increase over time as individuals get older. Therefore if the number of health service appointments did not change from the baseline, this could show that the programme had an impact, as the number of health appointments had not increased. However, without a comparator group it is not possible to assess this impact.

In order to assess the effectiveness of the programme, the impact on participants demand for health services has been compared to other programmes. The Silver Dreams programme reported that demand for hospital appointments, GP appointments and nurse appointments all decreased among participants (Emergency hospital appointments decreased by 12%, GP appointments by 20% and nurse appointments by 11%). This is a much smaller decrease than the decrease in health service demand among participants of the Get Going Together programme at six months (a decrease of over 60% for GP appointments, 57% for hospital appointments, both of which were statistically significant). However, the Get Going Together analysis focusses on unplanned GP appointments, whereas the Silver Dreams analysis focusses on any GP appointments. Additionally, the target age group for Silver Dreams was slightly broader than for Get Going Together, as it targeted anyone over 50 years.

Similarly, the Fit as a Fiddle project reported that for a project in the South West of England, the number of GP appointments decreased by 0.3 appointments per participant over a three month period. This is a larger change in health service demand as seen in Get Going Together (at three months, the same period as Fit as a Fiddle example, the change for Get Going Together participants was 0.1 appointments per participant).

The impact of the programme on participants SF-36 score cannot be measured for the same reason. As people become older, their general health and physical function (and other SF-36 indicators) will decline, therefore even keeping the score the same as the baseline measure could be seen as the programme having an impact.

However, the number of individuals in each area is known, as is the total expenditure in each area. This is presented in Table A4.17Table 5.3. This shows that the highest cost per participant was in Cheshire, with an average cost per participant of just over £500.

Table A4.17 Average cost per participant

	Number of participants	Total spend (£)	Average spend per participant (£)
Leicestershire & Rutland	1357	241,034	177
Coventry	1068	227,923	213
Oldham	1108	239,448	216
South Tyneside	1421	303,340	213
Cheshire	1275	359,815	282
Total	6,229	1,371,560	220