Independent Evaluation of Local Area Coordination on the Isle of Wight

February 2018

Evaluation team
Philippa Darnton, Evaluation Lead, Wessex AHSN
Joe Sladen, Evaluation Programme Manager, Wessex AHSN
Andrew Liles, Evaluation Advisor, Consilium Partners
Andrew Sibley, Evaluation Programme Manager, Wessex AHSN
Sydney Anstee, Consultant Researcher, Wessex AHSN
Cindy Brooks, Senior Research Assistant, Centre for Implementation Science, Wessex AHSN
Tim Benson, Director, R-Outcomes

Correspondence
Philippa Darnton, Evaluation Lead, Wessex Academic Health Science Network Limited, Innovation Centre, 2 Venture Road, Chilworth, Southampton, SO16 7NP

Disclaimer
The findings of this independent evaluation are those of the authors and do not necessarily represent the views of the Local Area Coordination Team.

Acknowledgements
We would like to thank the Local Area Coordination Team and the people supported by them for their participation in this evaluation.

Contents

Executive Summary

Local Area Coordination (LAC) is an integral part of the Isle of Wight's My Life a Full Life model of care. The LAC model is a person-centered approach focused on prevention and co-production to help individuals lead lives with greater control and independence. The LAC model moves away from traditional approaches to providing support in a time-generous, patient centered, empowering and flexible way.

People R-Outcomes surveys found statistically significant improvements in health status, health confidence and personal wellbeing for those receiving LAC support. These strong findings indicate LAC work is strongly welcomed and effective at changing people's general health status, health confidence and personal wellbeing.

Staff R-Outcomes surveys found very high levels of satisfaction with their work, "what I do in my job is worthwhile" being scored 100 out of 100 points. Scores over 80 points are considered "high", and only four questions fell below 80 points, suggesting there is room for service development. These areas were: "I can manage my work" (72 points), "I am involved in decision that affect me" (72 points), "I am fully aware of what other relevant services do" (74 points), and "I always considering involving other service when care planning" (77 points).

A comprehensive qualitative evaluation included four components: LAC staff interviews, interviews with people receiving LAC support, case studies provided by LAC staff, and a survey of other health professionals regularly involved with LAC. All the qualitative data was collected between February and July 2017. At the end of the data collection period, 8 staff interviews, 7 people interviews, 22 case studies and 23 surveys had been obtained. Ten themes were identified from the synthesis. Five of the themes were related to factors that supported the processes of LAC work. Another five themes were related to the perceived effects of LAC work on people, staff, and wider system. A number of challenges to operationalising LAC work were also identified.

Considering the combined findings of 4 qualitative elements and the R-Outcomes surveys in the evaluation, the following conclusions can be drawn.

The nature of LAC work was to be true to its aims and approach and it was widely reported that staff enacted LAC work based on its principles. It was also considered to have been enacted at the right intervention level, the "dose" so to speak was appropriate. The service supported people in a person centred way to the depth and time required.

Importantly, a number of ingredients were important to enacting LAC work and these were evidenced by the five themes (report section 2.2). LAC work benefited from a positive working environment within their core team, strong recruitment practices, support to maintain their core principles, and from collaborative environments with other services.

The extent of LAC work can best be seen in its various reported impacts. Compared to other services, the unrestricted nature of LAC support (time and type of person introduced) was considered one of the most important strengths of the programme. Subsequently, LACs affected a wide range of impacts (report section 2.3).

The impact of LAC work was seen in a number of areas, for people, staff and the wider system (explored in detail in section 2.3). Importantly, people overwhelmingly welcomed the LAC support provided and described how it had changed their lives. The nature of their feedback highlighted the long-term focus of LAC work, compared to quick fix approaches taken by other services.

The findings of the people R-Outcomes synthesised well with the qualitative findings and once again highlights the strong support from people for LAC.

Staff R-Outcomes findings similarly found LAC staff largely satisfied with their work, which synthesised with the qualitative findings about staff valuing the LAC role.

One staff R-Outcome finding about being 'fully aware of what other relevant services do' was lower than expected, however, collaborative working relationships were at the center of LAC work and they acknowledged they could be improved (see report section 2.4 for reported challenges).

Despite the perceived impacts, choosing and measuring the most appropriate long-term impacts of LAC work has yet to be determined. There was considerable concern from staff about whether hospital-based metrics about admissions were 'the right metrics' to assess LAC work.

Reflections on the broader aims of MLaFL model of care were also made. There was good evidence LAC work is meeting 3 of the 4 MLaFL aims. The fourth aim, 'Changing the way we provide better quality care, with the money and people we have available' was difficult to assess qualitatively and is currently being investigated by Solent University through activity analyses and econometric analyses. Solent University will report their findings separately to this report.

The qualitative synthesis and a follow-up discussion with LAC staff generated an important list of active ingredients of LAC work. These are reported in section 6 of the report. Some are about how to get a LAC service going and others about how to 'do' LAC work as an individual and within groups. Identifying these active ingredients will support existing LAC services to understand their impacts and also inform future plans to start a LAC service in other areas.

1. Introduction

1.1 Background to Local Area Coordination

The population is growing, people are living longer, and people are living with more complex health, yet the total funding of health and care services is reducing. This is putting health and care systems under increasing pressure.

In order to resolve these challenges, the Isle of Wight (IoW) health are care system applied to become an Integrated Primary and Acute Care System (PACS) Vanguard site, and received additional funding to facilitate transformation of services.

A major element of the Vanguard work was focused on developing projects which transform community services by building community and individual resilience, empowering people to choose healthier lifestyles, to facilitate better self-care, and to facilitate better access to appropriate help when people need it. The 'My Life a Full Life' (MLaFL) new model of care is centred on people having greater involvement with family and friends and less reliance on statutory services. It has built on assets within communities and integrated services with the aim of preventing ill health, early intervention when additional support/care is needed and delivering support closer to the person's home. Integral to this approach is the implementation of community focused roles such as Local Area Coordination (LAC). This approach fits well within the broader work of the MLaFL new model of care.

The LAC model has been around for many years and a description of its development and evidence can be viewed in the Local Community Initiatives in Western Bay (2016) formative evaluation report[1]. The LAC model is a person-centered approach focused on prevention and co-production to help individuals lead lives with greater control and independence. The LAC model moves away from traditional approaches to providing support in a number of ways. The key features are:

- The Local Area Coordinator supports people across all service labels and all ages (mental health, older people, carers, physical disabilities)
- Introductions, as opposed to referrals, can derive from anywhere: professionals, community members, and individuals
- An individual is offered an introduction to a Local Area Coordinator. The support can be information and advice or more long term and complex
- No assessment of need. A conversation is had about the person's vision of what a 'Good Life' would look like, focusing on a person's gifts, skills, interests and experiences. This places the person in control, concentrating on their aspirations and desired outcomes. This is a strengths based approach reflecting on what resources the person has to improve their circumstances and make things happen. Local community knowledge services may be part of the solution but only as a last resort and people are supported to access services if appropriate
- Each LAC works within a geographic area with a population of between 10-12,000 people. They get to know the community and build relationships with local people, enabling them to be the first point of contact locally. They create the conditions for community connections and learn about the gifts, skills and activities within the community. LAC

[1] Roderick S, Davies GH, Daniels J, Gregory J. (2016) Local Community Initiatives in Western Bay. Formative Evaluation Summary Report. Swansea University.

works to support the development of inclusive and welcoming communities for people who might be on the margins of society due to mental health difficulties and/or physical disabilities

- LAC supports people to be in control of their lives, and to be contributing citizens instead of passive recipients of services
- LACs work autonomously, identifying key people in their local community who can assist them to build a picture of what is available, what gaps may exist and who are the key people who can help address the gaps and make change happen
- The LAC is based within their community for the vast majority of their time, which can only work well with flexible working and lean management

The LAC service is a key part of the MLaFL new model of care and the service shares the 4 key aims of the model of care:

1. **Preventing ill health.** Provide our residents with information, advice and support to enable them to make the right choices about their lifestyles to help them stay healthy and prevent them from becoming ill in the first place.
2. **Co-ordinated care/collaboration.** Bring all the different health services together so everyone works as a team to support our residents to stay in control over their own health and care. We will share best practice and information better so they will no longer have to constantly repeat their situation to different services. Telling your story once!
3. **Improved access.** Make available the right support at the right time and place, and from the most appropriate service. Bring support closer to home, and even in the home where appropriate, making trips to hospital only when absolutely necessary and only travelling further afield for more specialist help or emergency treatment.
4. **Better Quality services.** Provide the very best level of health and care services we can within the funds we have available.

Based on findings in this report, reflections on these aims are made in the conclusion section.

1.2 Purpose of this report

Wessex AHSN is the independent evaluation partner of the IoW MLaFL Vanguard. The aim of this evaluation study is to answer the evaluation question "*What is the nature, extent and impact of Local Area Coordination as part of the My Life a Full Life new care model?"*

This report presents the findings from the evaluation of the LAC service. The methods used in this study are predominantly qualitative and the findings from each evaluation method have been synthesised together. In addition, this report presents the findings of quantitative person reported outcome measures collected for LAC staff and people who use the service. As requested by Public Health, the scope of this evaluation does not include quantitative or economic evaluation of the service. The IoW Council Public Health Department has commissioned Solent University to undertake this analysis.

2. Synthesised Qualitative Findings

2.1 Introduction

Four qualitative evaluation methodologies have been used as part of this study – these are detailed below. A range of methods has been used to enable this study to evaluate the service through a range of different lenses and each method has a specific purpose.

1. LAC staff interviews – these sought to understand the experiences, challenges, implementation and effects of LAC work.
2. People interviews – these sought to understand people's general experience of receiving LAC support.
3. Case studies provided by LAC staff – these sought to explore situations, processes and outcomes of LAC work.
4. Survey of professionals – these sought to explore the experience, process, implementation, effects, and challenges from the perspective of other professionals who engage with LACs on a regular basis.

The findings from all four components have been brought together as synthesised qualitative findings. The results of this synthesis are presented in this chapter.

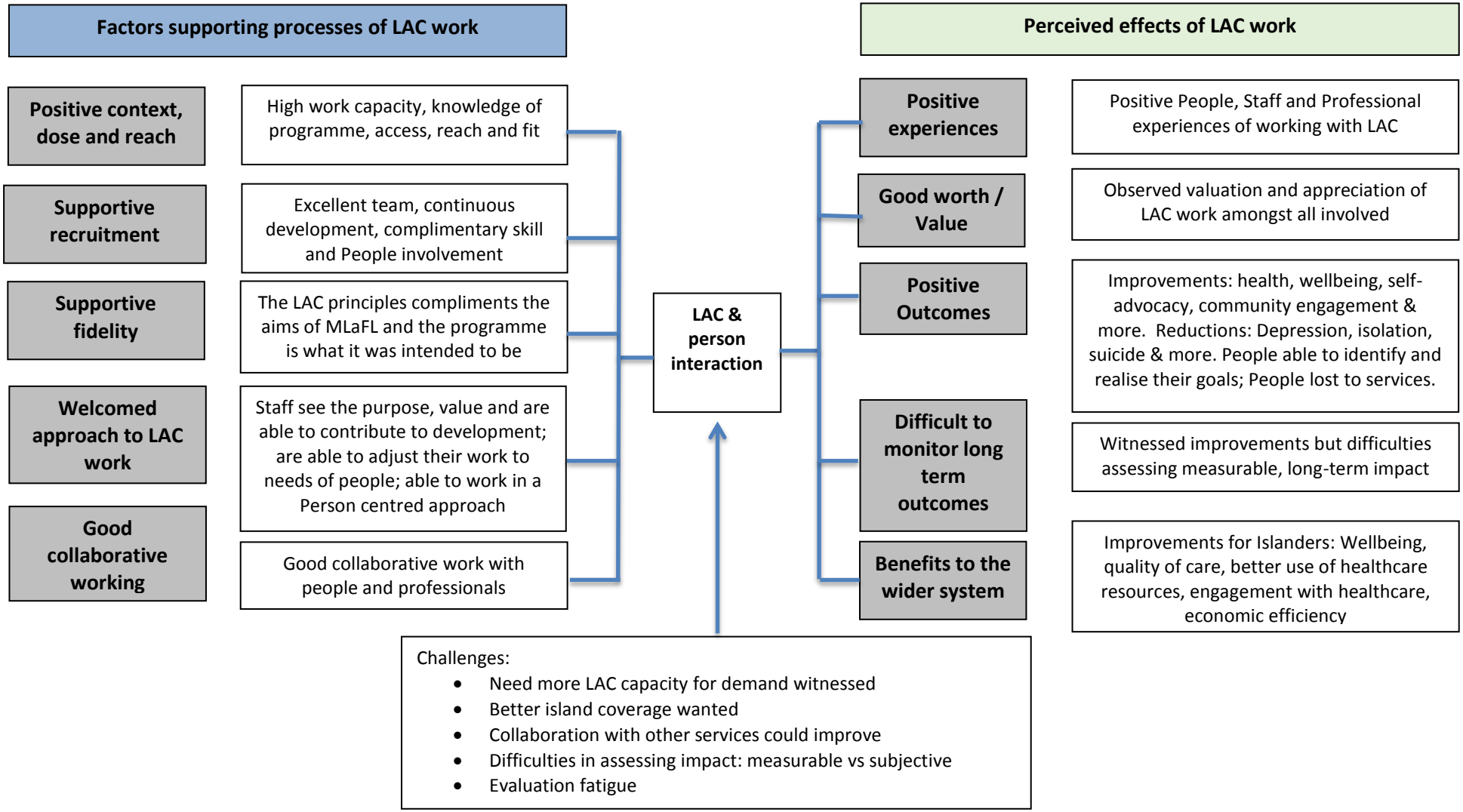
All qualitative data was collected between February and July 2017. Specific data collection methods are presented in Appendix 1. At the end of the data collection period, eight staff interviews, seven people interviews, 22 case studies and 23 surveys had been obtained. Free text from a fifth data source, the R-Outcomes surveys of people and staff, was also included in the synthesis.

Whilst the aims and methods were slightly different in each evaluation element, they all contribute to answering the overarching evaluation question: *What is the nature, extent and impact of Local Area Coordination as part of the My Life a Full Life new care model?*

To address this question, it was important to examine the overlap between themes from each of the four components. An understanding of the processes and contextual factors revealed by this synthesis also helped to determine some active ingredients of the LAC role. Factors were considered active ingredients if they were discussed as important and in the context of a described impact. Figure 1 provides a graphical representation of the qualitative synthesis. The triangulation of the four qualitative components permitted the development of a conceptual diagram to understand the inputs and outputs of LAC work. The themes identified from different qualitative methods, and the overlap between them, are presented in a table in Appendix 2.

Ten themes were identified from the synthesis of all qualitative data. Five of the themes were related to factors that supported the processes of LAC work and another five themes were related to the perceived effects of LAC work on people, staff, and wider system. A number of challenges to operationalising LAC work were also identified.

Figure 1: Processes, effects and challenges of Local Area Coordination on the Isle of Wight



2.2 Factors supporting the process of LAC work

The first theme described the **positive context, dose and reach** of LAC work. It was clear the LAC team have a range of positive contextual factors to their working activities. In particular, a high level of flexibility in their ability to work with anyone introduced to them (no age or particular health limits), also in how long they can work with people (unlimited) and their work not being as subject to professional boundaries as other services.

The dose, or how much, LAC work was ongoing also appeared to be of a good level. It was reported that the LAC programme complements other health and social services on the island, as described by this staff member:

"It [LAC] complements other services by providing flexible, comprehensive support in a user friendly way. It helps people before they need to access other services (thus reducing the pressure on those services), helps them access appropriate services, and supports them when or after they are using such services."

In addition, the dose, or depth of intervention, was also apparent in the findings. Overall, this staff member described what LAC work often involved:

"[working with] isolated people of all ages, those with mental illness, low self-esteem, physical health difficulties and those who have been through a big life change".

Furthermore, the reach of LAC work was positively reported. There was good knowledge and understanding, amongst different professionals, of LAC work and what they do. This was welcomed and will likely increase the chance of introductions for people who may benefit from LAC support. However, this was not the only way people learned about the option of LAC support. They also heard about it in a number of ways:

"Through advertisement in the local press; when they introduced themselves to the company that I work for; Through work within my role in Community Mental Health; Through the Foodbank Headquarters in Cowes; Local media; Age UK."

A wide remit of LAC work was apparent as introductions came from a wide variety of sources in community. In the 22 case studies, introductions came from Children's Services, GPs, Inclusion North, Counsellors, Community Support Officers, Our Place Drop In, Housing, Local Links Trust/ People Matters, Police, local craft group, Children Around the Family (school), Primary Mental Health, Local Health Trainer, self (received leaflet from church), parents, foodbanks, Adult Social Care, Seagrove Social Group, Mothers Union Group, or another community members.

The reach of LAC work was also demonstrated by the wide variety of reasons for introductions; a selection of reasons being child protection/drugs/anger/school; isolation; frequent GP visits; learning/health disabilities; falls and problems getting support; police involvement; mental health problems; not managing at home; separation; cancer; fear of falling, recently diagnosed with multiple-sclerosis; homeless; carer struggling and respite needed.

The second theme described a **highly supportive recruitment context** for LAC work. It was unanimously reported, in the staff interviews, that LAC staff benefit from an excellent team in terms of leadership, support and continuous professional development. The team has a good mix of

complementary skills as staff came from a variety of backgrounds e.g. social worker, mental health, youth worker. This was considered very important to their success.

The third theme described how LAC work was a **supportive programme with high fidelity to its principles**. In short, many professionals and people felt it did what it intended to do. Many staff felt it made sense and achieved its aims:

"Local Area Coordination is the most effective program I have ever worked in when empowering individuals to achieve their reality of a good life."

Staff also described how they engaged in key aspects of the approach to LAC work, namely flexibility in working practices, highly person-centred focus during interactions, and empowerment as a key goal, as described by these staff members:

"That they aren't seen as a statutory service so they are viewed differently, that they are able to work outside formal boundaries, that they enhance the multidisciplinary approach and often offer a refreshing insight to routine care".

"No referral and no red-tape. It makes those 'hard to reach' people that every agency is trying to engage with take ownership and direction of what they want to change in their lives rather than us telling them what we think needs to change".

"Staff mentioned several times that asking 'what do you want to achieve?' was a shock for many people who were not used to being listened to. One staff member said a disabled person was in tears being asked what they wanted as they had never been asked this before."

Furthermore, LAC principles were described by people supported by LAC work. They emphasized the active listening, patient centred, and empowering nature of LAC interactions.

"My LAC can recognise things in you that you can't see for yourself."

"You can tell my LAC really cares and is really interested."

"[My LAC] changed my ways of thinking from negative to positive."

"I've got something to think about now [volunteering] and it's made a massive difference."

The fourth theme described how staff **welcomed the approach to LAC work**. All staff saw the purpose, value and contributed to the development of the LAC programme. Staff described how the wider boundaries of the role gave them more freedom than seen in other services, and permitted creative thinking to problem solving. Staff also reported how the role gave them freedom to fit what they do with the needs of the individual. The freedom with contact time was also seen as a positive, as LAC staff are not time-limited or session-limited. Removing time limitations means staff had time to listen and build trust with people which staff considered key to identifying people's needs and abilities to self-manage.

The fifth theme highlighted how a **collaborative working environment** has been created and maintained. This was considered important to the success of the LAC programme. Many LAC staff and other health professionals stated:

"The LACs provide an invaluable service."

"I now work with 4 LACs in two areas on the IOW, and find each incredibly helpful, supportive and proactive in supporting people."

"I have complete trust in [the] LAC [I work with] and feel confident to share relevant confidential information with him…I feel him being in his role has meant there is a much clearer strategic vision to what support is actually already available out there. [LAC] being in this post is money very well spent because I feel it saves a huge amount of statutory resource and money."

In the survey of other health professionals, the vast majority (95%) said they work collaboratively together and 86.5% were clear about who was appropriate to introduce to LAC.

The five themes above can be considered 'active ingredients' of LAC, particularly in the context of making it happen and sustaining it. These active ingredients were presented to LAC staff for further discussion and confirmed during that follow-up discussion.

2.3 Perceived effects of LAC work

The first of these five themes related to the perceived effects of LAC work and described how people and staff perceived the LAC work as an overwhelmingly **positive experience**. Findings from all data sources reported people had very positive experiences of the LAC programme. Most stated they felt heard, listened to, empowered, able to look forward, linked with community, and safer. For example:

"I felt listened to and understood, made to feel like a human being, not a nuisance".

"The help has been life saving for me as I was so low. She [LAC] helped me to open up and realise I can find help. She is lovely and I am so grateful for her kind visits."

Staff also expressed a high level of job satisfaction and motivation to deliver the services:

"Working within public health, with their support, and support from my manager I am really fulfilled at work. I have autonomy but can get support at any time. I love my job as a local area coordinator despite working long hours."

"I think that because my role allows me to get to know people and build a trusting relationship, it positively affects how we are doing".

The second theme highlighted how people and staff perceived **worth and value** in the LAC programme. Findings from a range of data sources reported staff, people and other health professionals value the work of the LAC programme and demonstrated an appreciation of what the programme can achieve.

"The most effective program I have ever worked in when empowering individuals to achieve their reality of a good life." (LAC staff)

"The LACs provide an invaluable service and sometimes when a service does not know how to help they pass to a LAC." (Other health professional)

"I love what my LAC has done in the village for the community and the children." (Person supported by a LAC)

The third theme represents a range of reported **positive outcomes** from LAC work. Many positive outcomes were reported and these are summarised below. The synthesis identified findings about *improvements* in the wellbeing of islanders (e.g. physical and mental health, community participation and happiness, resilience, self-advocacy, income, child protection and looking forward with future plans) and the *prevention* of worsening welfare (e.g. avoidance of hospital, suicide/death, overcoming self-doubt, depression, police involvement, fire, agoraphobia) and less people 'lost to services'.

Many people reported positive outcomes, for example:

"I am now involved in decisions about me"

"I have been helped to get on with my life"

"I am now empowered to make my decisions and do what I want"

"I know more about what I can do now and am not afraid to do things myself to change my life, I know you can give me pointers when I need it".

"I know I have a long way to go still but I have a plan now and know you are beside me to help me get there".

"My LAC is excellent and assists me talking to other services. I have been helped with my ESA & P.I.P. if I didn't have a LAC I would not have attended appointments and been homeless or in hospital."

A range of positive outcomes were also reported in the survey of other health professionals. They reported a wide section of statement, summarised here:

"I've seen people blossom; improve in confidence; be more connected with their local community; gain employment; more involved and heard within service meetings; manage their medical conditions better and gained control of their life; able to complete forms; receive benefits; less dependence on services; gone from isolated to attending social groups; become uplifted and happier; moved home; looked well; mobility was better; self-esteem improved; parents able to support their child's education; making friends; identifying their own strengths; identify what they want to change and how; homelessness tackled/avoided; mental health needs dealt with early on; getting out more; GP surgery calls reduced; foodbank vouchers accessed; more aware of support available; know someone is interested in them."

The fourth theme highlighted that long-term outcomes were witnessed but that there are significant **difficulties measuring long-term impact**. This was a concern of LAC staff as they appreciate some, if not much, of their work may not realise benefits for many months or years. The changes they seek to support are often not quick-fixes. LAC staff reported there may be difficulties assessing the wider system/long-term impact of the service via quantitative data collection due to difficulties collecting the right data/outcomes that LACs likely affect, e.g. use of the fire service, social services, GP phone calls, employment information. Moreover, staff were concerned that the impact of LAC work might not be in the expected direction e.g. people's use of health services may increase in the short term as they engage with health services and receive the care required.

The fifth theme described staff perceived **benefits to the wider system**. LAC staff believed there were improvements for islanders in wellbeing, quality of care, engagement with healthcare staff, better use and economic efficiency of healthcare resources. Staff reported 87.5% strongly agreed LAC work had improved the wellbeing of islanders, 62.5% agreed LAC work had improved the quality of care for islanders, 75% strongly agreed or agreed LAC work has been a good use of healthcare resources, 75% strongly agreed LAC work has enhanced engagement with and between islanders and healthcare staff, and 87.5% strongly agreed or agreed LAC work has enhanced the economic efficiency of island healthcare resources.

2.4 Challenges to LAC work

A number of perceived challenges exist to operationalising and acknowledging LAC work. LAC staff reported that they needed more island coverage and time to optimise their work. They also described an increasing demand for LAC services as multi-disciplinary teams (MDTs) and other services introduce people to them. The beginnings of LAC and health service working has begun, e.g. in the West Wight area where LACs work with care navigators and other roles, but this could be improved to support effective collaborative working. Other issues of professional collaboration that were highlighted included there sometimes being a lack of feedback from LACs to other services after an introduction has been made, and a frustration from other health professionals that some people that may have been appropriate for the service hadn't been introduced to LACs. Potentially, the benefits of LAC work could be improved with action taken to address these issues.

The experience of 'being evaluated' also had issues for LAC staff. They described a sense of evaluation fatigue and frustration at attempts to capture certain measures that they believed did not represent the most likely areas of impact, e.g. LAC staff felt their work would more likely benefit someone's social wellbeing and situation rather than their likelihood of becoming an in-patient admission. Whilst the latter impact was something they could help avoid, an overly focused evaluation on those metrics would potentially miss much of the benefit of LAC work.

Whilst the evaluation of activity was not within the scope of this report, these issues are noted here for consideration in the design of future evaluations.

3. People who use the service and Staff Reported Outcomes

3.1 People R-Outcomes

Information was collected for this review using the R-Outcomes measures. These are a set of validated short generic patient reported outcome measures (PROMs) being used by Wessex AHSN as a way to evaluate innovations and new services. This review used four of the R-Outcomes measures for people who use the LAC service – each is introduced below. Data was captured at the point someone was introduced to the LAC service, and then again approximately eight to 10 weeks after introduction.

HowRu – Health Status

People record how they feel physically and mentally and how much they can do in terms of loss of function and independence. It asks how are you today? – meaning the past 24 hours. It has been validated against other measures including SF12 and EQ-5D.

Health Confidence Score

This score monitors people's confidence in their ability to manage their own health and engage with health care providers. The first two questions address personal capability, while the second pair are informed by provider engagement. This measure is closely associated with the concepts of empowerment, perceived self efficacy, activation and engagement.

Personal Wellbeing

This is a short generic measure of happiness or subjective wellbeing and is closely based on the Office of National Statistics personal wellbeing questions used in the Annual Population Survey.

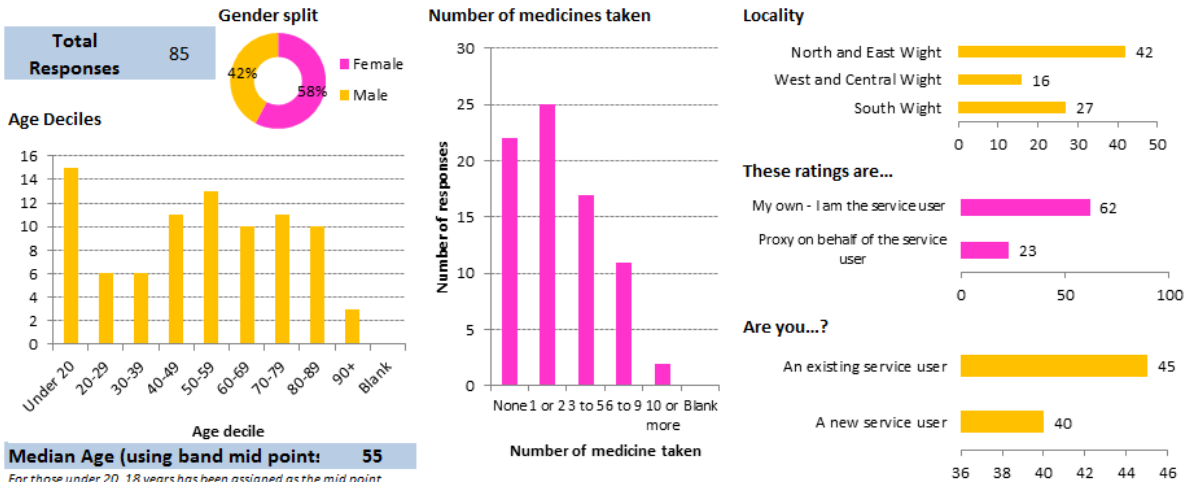
Experience of using the service

This is a person reported experience measure of a person's perception of their care. It includes both relational (clinical) aspects of their care, such as kindness, listening and explaining as well as systems (administrative) aspects such as promptness and organisation.

3.2 Results from people who use the service

The following charts describe the demography of the 85 people who completed R-Outcomes. It shows that:

- The service works with people of all ages, with most people being of working age
- The median age, calculated from age band mid points, is 55 years
- 40% of people don't take any prescribed medication daily, and a further 45% of people only take 1 or 2 prescribed medications daily
- More women than men completed R-Outcomes surveys



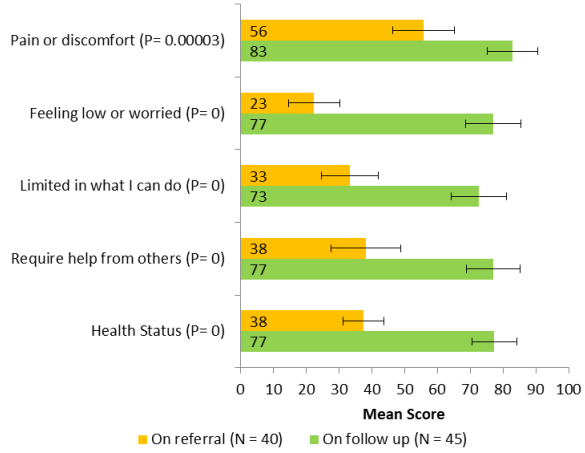
The LAC service supported the collection of R-Outcomes measures for **40** people when they were introduced to the service, and **45** people following that introduction.

The results are set out in the charts on the following page. All R-Outcomes results show mean scores on a 0-100 scale. If all respondents choose the best response, the score is 100. If they all selected the worst, the score is 0. What we are looking for is evidence of an improvement in reported scores from the two separate cohorts of people and whether those improvements are statistically significant.

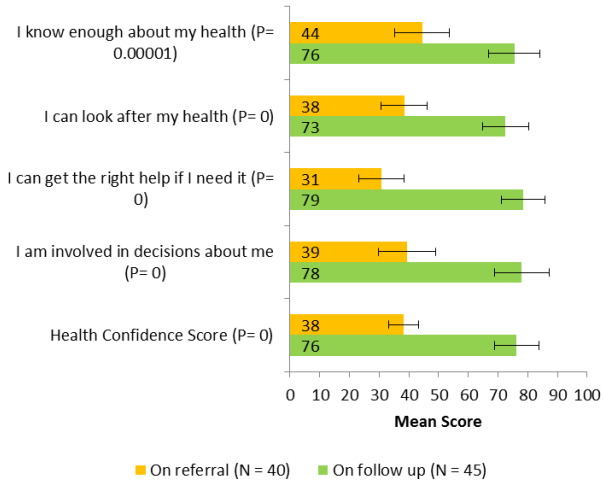
The orange bars represent how people scored themselves when the service first made contact with them, and the green bars show the scores for people who have been supported by the LAC service (approximately eight to 10 weeks later).

The lines at the end of each bar signify the confidence intervals for each score. A T-Test P Value is shown in the vertical axis label. A P value of less than 0.05 demonstrates a where the difference in score is considered statistically significant.

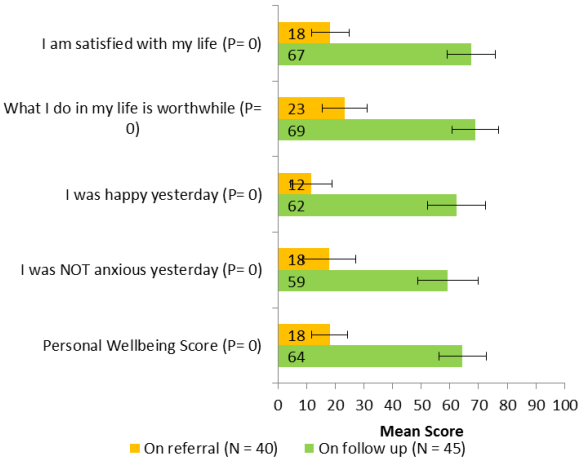
Health Status



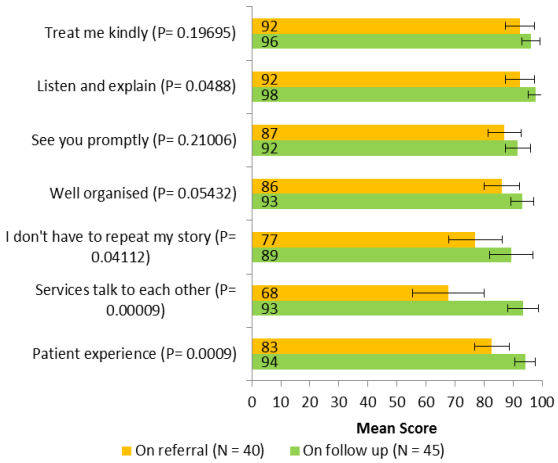
Health Confidence



Personal Wellbeing



Experience of using the service



Results of the R-Outcomes surveys for **Health Status**, **Health Confidence** and **Personal Wellbeing** demonstrate **statistically significant improvements** in each individual question within the three question groups.

Scores of less than 40 points in any question are very low, while scores of over 80 points are high. At the point of introduction to the service, 10 of the 12 individual questions are scored at less than 40 points. This indicates people who require urgent help. The lowest scores are demonstrated in the Personal Wellbeing question group – with "I was happy yesterday" receiving the lowest score of 12 points. This is the lowest recorded score amongst a cohort of people completing R-Outcomes.

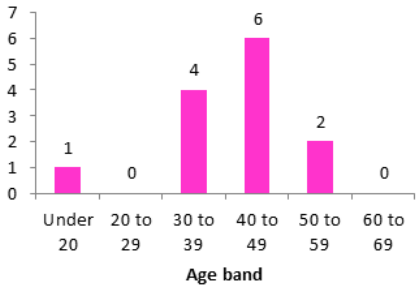
Across all three question groups named above, there **are large increases in score when people were re-surveyed following support from the LAC service**. Health Status and Health Confidence scores improve to scores in the region of 75 points – scores of over 80 points are high. This demonstrates a significant improvement in the outcomes of these people. People also showed large improvements in Personal Wellbeing, but not quite to the same extent – the average score was 64 points in this question group.

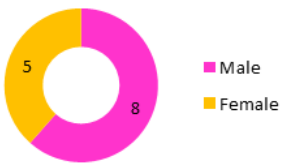
People who use the LAC service report high scores for four of six experience questions – only "Services talk to each other" and "I don't have to repeat my story" score less than 80 points (68 and 77 points respectively), indicating there remains scope for improvement by the service.

3.3 Staff R-Outcomes

In addition to collecting R-Outcomes for people who use the service, staff R-Outcomes surveys were collected by the LAC service. This review used three R-Outcomes measures; work wellbeing, job confidence, staff experience and service integration[2]. The scoring scales described for patient R-outcomes applies to staff surveys too – scores are on a 0-100 scale, and higher scores are better.

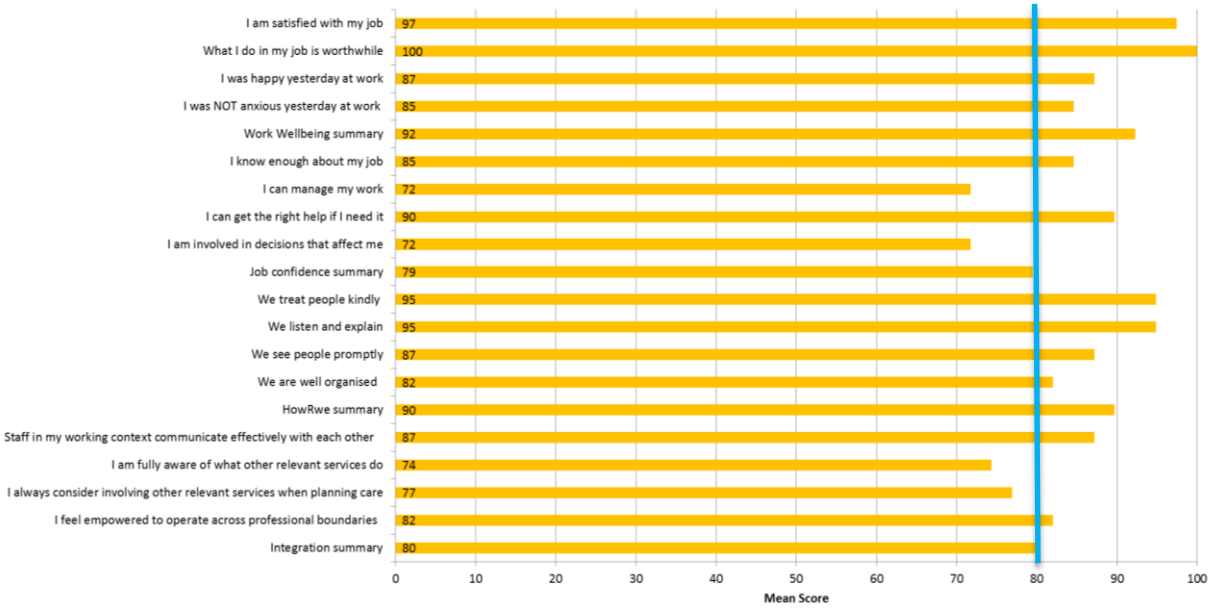
The service collected data and a total of 13 responses in March and July 2017. The demographic of the participants set out in the following charts.





The results of the survey are shown below. Overall, the scores from LAC staff are high – most questions score over 80 points, with "what I do in my job is worthwhile" being scores 100 out of 100. Four questions fall below the 80 points threshold, suggesting there is ability for service development in these areas. These questions comprise:

- "I can manage my work" (72 points)
- "I am involved in decision that affect me" (72 points)
- "I am fully aware of what other relevant services do" (74 points)
- "I always considering involving other service when care planning" (77 points)



[2] This is an early iteration of the R-Outcomes Service Integration

4. Activity and Economic Analysis

The original scope of this evaluation identified the need to understand the impact of the LAC service on the wider health and social care system – including its impact on Emergency Department attendances and emergency hospital admissions but also on the use of adult social care services, police services, fire services and others.

Solent University has been separately commissioned by the IoW Council Public Health Department to evaluate this element of LAC work through activity analyses and econometric analyses. These findings will be reported separately. Unfortunately the results of this study were not available at the time of writing this report to permit a cross study synthesis of findings.

5. Conclusions

Considering the combined findings of four qualitative elements and the R-Outcomes surveys in the evaluation, the following conclusions can be drawn. These are first done to address the evaluation question and secondly to reflect on the broad aims of the MLAFL new model of care.

A wide range of evidence was gathered to address the evaluation question: *what is the nature, extent and impact of Local Area Coordination as part of the My Life a Full Life new care model?*

- The nature of LAC work was to be true to its aims and approach. It was widely reported that staff enacted LAC work based on its principles. It was also considered to have been enacted at the right intervention level, the dose so to speak was appropriate. They supported people in a person centred way to the depth and time required.
- Importantly, a number of active ingredients were important to enacting LAC work and these were evidenced by the five themes in section 2.2. LAC work benefited from a positive working environment within their core team, strong recruitment practices, support to maintain their core principles, staff welcoming the LAC approach, and from collaborative environments with other services.
- The extent of LAC work can best be seen in its various reported impacts. Compared to other services, the unrestricted nature of LAC support (time and type of person introduced) was considered one of the most important strengths of the programme. Subsequently, LACs affected a wide range of impacts, as described in section 2.3.
- The impact of LAC work was seen in a number of areas, for people, staff and the wider system. These are explored in detail in section 2.3. Importantly, people overwhelmingly welcomed the LAC support provided and described how it had changed their lives. The nature of their feedback highlighted the long-term focus of LAC work, compared to quick fix approaches which may characterize some other services.
- People R-outcomes findings highlighted an overwhelmingly strong improvement in their wellbeing, confidence and health status. This synthesised well with the qualitative findings and once again highlights the strong support from people for LAC.
- Staff R-outcomes findings similarly found LAC staff largely satisfied with their work, which synthesised with the qualitative findings about staff valuing the LAC role.
- One staff R-outcome finding about being 'fully aware of what other relevant services do' was lower than expected, however, collaborative working relationships were at the center of LAC work and they acknowledged they could be improved in section 2.4 on challenges.
- Despite the perceived impacts, choosing and measuring the most appropriate long-term impacts of LAC work has yet to be determined. There was considerable concern from staff about whether hospital-based metrics about admissions were 'the right metrics' to assess LAC work.
- Overall, the evaluation suggests people are getting a good service, tailored, timely, time-generous and empowering.

Reflections on the MLAFL aims:

Prevention of people from becoming ill – access to information, advice and support; take control and manage own health more easily.

There is good evidence the LAC programme is meeting this aim. People reported statistically significant improved R-Outcomes for their health status, wellbeing and confidence to look after their own health. The qualitative evaluation identified strong themes which indicated support from people. The synthesis identified a wide range of findings about improvements in the wellbeing of islanders (e.g. physical and mental health, community participation and happiness, resilience, self-advocacy, income, child protection and looking forward with future plans) and the prevention of worsening welfare (e.g. avoidance of hospital, suicide/death, overcoming self-doubt, depression, police involvement, fire, agoraphobia) and less people 'lost to services'.

Collaboration of service and people

There is good evidence the LAC service is meeting this aim. People reported high R-Outcomes for not having to repeat their story and services talking to each other, but compared to the other domains in the survey these elements appeared to be the ones to focus improvements work upon. Collaborative working was reported in the qualitative synthesis and considered important to the success of the LAC programme. An example being the collaborative working practices in the West Wight by its LAC, Care Navigator, Community Navigator and practice staff in that area. However, the qualitative synthesis also acknowledged there was room for improvement island wide in this area (see section 2.4).

Making sure people can get the right support, at the right time and place from the most appropriate service – across the Island.

There is good evidence that the LAC service is meeting this aim. People reported statistically significant improvements (R-Outcomes) for being able to look after their own health and feeling that they can get the right help if they need it. The qualitative evaluation found that a person centred approach was strongly reported by staff and people receiving support. The flexibility of LAC work, to walk alongside people for as long as it takes, was welcomed by people receiving support, thus suggesting that support was given in a manner that is 'right' for each person. No concerns were raised by people about 'how' LACs supported them and this is important to note.

Changing the way we provide better quality care, with the money and people we have available.

The activity and economic analysis of LAC programme is being conducted by Solent University. It was not possible to evaluate this aim using the qualitative and R-outcomes evaluation methods. The qualitative evaluation suggests people are getting a good service, tailored, timely, time-generous and empowering. This is likely to compare well against other services who cannot offer these options. However, such comparisons require a careful analysis of activity and economic factors.

6. Active Ingredients

Five themes from the qualitative synthesis were considered 'active ingredients' of Local Area Coordination, particularly in the context of making it happen and sustaining it. These active ingredients were presented to LAC staff for further discussion and confirmed during that discussion. A final list of active ingredients of the service were identified and listed below:

I. **Trust, honesty, credibility and integrity**: These are key attributes of the service, and key characteristics of the people working within the service. These are a key ingredient when working with people who are often hard to reach.
II. **Support and trust of management:** LAC staff have the support and trust of management to work from their own initiative and to have autonomy within the community.
III. **Integrated leadership promoting whole system impact and outcomes:** LAC staff felt their integrated leadership team was important, providing strong governance, a shared vision, and helping to embed LAC within pathways and the behaviour of other teams.
IV. **Long term approach:** The service is not time limited, and is able to work with people over the longer term. The service does however manage relationships so that long term relationships do not transition into a long term dependency on the service.
V. **No operational targets:** The LAC service does not work to any short-term operational targets, such as waiting list or intervention times. Staff describe this 'freedom from targets' as an enabler of their model of care.
VI. **Listen to the needs of people**: Listening to the needs of the people in a genuine, neutral, and non-judgmental way to enable those using the service to maintain their integrity, set their own goals, and for the LAC service to work *with* someone, not *for* someone.
VII. **Listen to understand**: LAC staff listen to understand (not to respond), and support people in making the changes they wish to make, contributing to the concept that there is a future for everyone. This is done in a non-medicalised approach which is not time limited.
VIII. **Communication approach**: LAC staff use simple, plain English in their communication with people. This prevents complex language becoming a barrier to engagement.
IX. **Community involvement in recruitment:** People in the community are involved in the recruitment and selection of new staff. The aim being to embed a staff member in their community from the outset which is thought to contribute to low staff turnover rates.
X. **A team with a diverse range of professional backgrounds:** LAC staff have a wider range of past experience, which brings a diversity of ideas, experiences and approaches to the team.
XI. **Being visible and easy to access:** The service does not operate an appointment led delivery model. People can drop in to see LAC staff without pre-notification to facilitate ease of access.
XII. **Becoming "Network Knitters":** LAC staff create extensive networks within their community, and staff act as a network hub within their community. Large networks do not necessarily mean larger caseloads as the LAC staff and service enables other networks and relationships to develop around them.

Appendix 1 – Data collection methods

Qualitative data collection methods		Areas of Enquiry
Multiple-illustrative case studies	Local Area Coordinators provided a case study each month. The Local Area Coordination Programme Lead selected a certain number to submit to the AHSN to provide a range and variety of work	Case studies were completed using a framework with the following headings: Introduction; Scenario; What happened; Outcomes for the family; What next; Critical Elements
Interviews – LAC Staff	All LAC staff and People who engage with the programme were given information about the evaluation and invited to interview. The interviews were audio-recorded with consent and conducted using a semi-structured interview schedule. Notes were also taken during the interview. The recordings were later listened to but not transcribed and a very brief form of framework/thematic analyses was used to summarise the findings from the data.	*Early experiences*: Attraction to role, what is the role, training and support *Challenges:* Improvement suggestions, barriers and facilitators *Implementation*: Sense-making, participation, action, monitoring *Impact:* How people experience LAC, difference to lives, people who benefit most and least *Impact: Factors linked to MLAFL strategic logic model:* Quantitative – scale of agreement with statement about wider impact of LAC
Interviews - People		How LACs discovered; Experience of LAC; How aims agreed on; Outcomes of work LAC; Improvement suggestions; anything else
Survey of Professionals	A set of 11 survey questions were designed collaboratively with the researcher, the AHSN project lead and the lead of the LAC service. The survey was created in Survey Monkey and emailed out with a covering letter to a list of Professionals the LAC programme had interactions with. Analyses were performed through simple summaries of data collected with the aid of Survey Monkey followed by framework summaries of findings.	Discovery of LAC; understanding the programme; Who benefits most and least; Views on Introduction method; Appropriateness of introductions; What LAC adds to existing services; Outcomes for people; Improvement suggestions

Appendix 2: Synthesised themes, their description and source

Higher order theme	Themes	Examples of the theme	Qualitative data source(s)
Factors supporting the process of LAC work	**Positive context, Dose and Reach**	High capacity: work load, most island coverage and broad remit (does not have boundaries like other services) Good knowledge and understanding of LAC amongst People and Professionals Appropriate People: those introduced were in the majority complex, multi-morbidity, vulnerable Access: LACs able to visit people at home – overcomes People mobility issues Good reach: Introductions came from a wide variety of professionals in community; Widespread knowledge of the programme amongst other professionals Good fit: LAC is complimentary to other services	S, P, PS, RP, C
	Supportive recruitment	Excellent team: leadership, support and continuous professional development (NPT) Complimentary skills: staff come from a variety of backgrounds (NPT) People involvement: in the recruitment of staff to the programme	S S S
	Supportive fidelity	Meets LAC principles – does what it intends to do	S, P, PS, C
	Welcomed approach to LAC work	All staff: see the purpose, value and contribute to the development of the LAC programme (NPT) LACs wider boundaries/more freedom than other services – allows creative thinking/ problem solving; Their roles give freedom to fit what they do with the individual needs of the People they work with (unlike strict boundaries of roles in previous experiences). (NPT) Contact is not time-limited: Taking time to listen and built trust is key to identifying people needs and abilities Holistic/ person centred approach of LAC work: it 'mirrors' the Care Act; seen as 'enabling' people to find their own solutions. LAC approach: listening, empowerment and sustainability, choices, awareness	S P, PS, C, S S, P, PS

	Collaborative working	The majority of professional's (63%) say it is easy to understand what the LAC programme offers and are able to work collaboratively together (95%) The way People are introduced to LAC (no assessment or referral) is thought to be good, by most professionals (54%) but there is room for improvement Most professionals feel clear about who might be appropriate people to introduce to LAC (86.5%) Strong Partnership working ethos with People and other services, with limitations	PS C RS
Perceived effects of LAC work	**Positive experiences**	Positive People experiences: felt heard and listened to, empowered, able to look forward, linked with community, safe, High Staff job satisfaction and motivation to deliver the services Positive Professional experiences of working with LACs	C, P, RP S, RS PS
	Good worth/Value	LAC work was appreciated and valued; of high worth to People, Staff and Professionals	S, P, PS, RP
	Positive outcomes - People Staff, Wider system	Improvements: Wellbeing, physical and mental health, community participation and happiness, resilience, self-advocacy, income and looking forward with future plans Prevention e.g. Reductions in protection register levels, avoidance of hospital, suicide, overcoming self-doubt, depression, agoraphobia. Less People 'lost to services'	P, S, PS, C, RP
		People able to identify and realise their aims, goals and achievement through trusting relationships with LACs	P
	Difficult to monitor long-term impact	LAC staff engaged well but found it difficult to assess the wider system/long-term impact. It was very positive anecdotally but will be difficult in the data e.g. hospital admissions.	S, PS, P
	Benefits to the wider system	Staff believed there were improvements for islanders in wellbeing, quality of care, engagement with healthcare staff, better use and economic efficiency of healthcare resources.	S

Data Sources: S = Staff interviews; P = People Interviews; PS = Professionals Survey; C= Case Study; RS = R-Outcomes Staff free text; RP = R-Outcomes People free text.