Happy, Healthy at Home
North East Hampshire and Farnham Vanguard
2015-2018

Summative Evaluation Report

September 2018
Contents

1. Recap – The Five Year Forward View and vanguards
2. Happy, Healthy, at Home – the NEHF vanguard
3. Independent evaluation partner
4. Summative findings from care model activity
5. Summative findings from R-Outcomes – patients
6. Summative findings from R-Outcomes – staff
7. Summative findings from team evaluation of the 5 ICTs
8. Summative findings from qualitative interviews
9. Summative findings from activity impact evaluation
10. Summative findings from economic evaluation
11. Summary of findings
12. After the vanguard – spreading and learning
13. Resources
1. Recap – The Five Year Forward View and Vanguards

“The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need.” Five Year Forward View (FYFV) October 2014.

FYFV goes on to discuss taking action on three widening gaps:

- Health and wellbeing – getting serious about prevention
- Care and quality – reshape care delivery, harness technology and drive down variation
- Funding and efficiency – wide ranging and sometimes controversial system efficiencies

Proposed a small number of ‘new models of care’ to be trialled in selected sites. Most ambitious were the primary and acute care systems (PACS) – a model that envisaged a single entity or group of providers taking responsibility for delivering a full range of primary, community, mental health and hospital services. It was seen as a route to integrated systems where a new organisation might take accountability for the whole needs of a registered list of patients, under a delegated budget.

The key feature of vanguards is that their principle aim was for wider roll-out. “The success of vanguards will not be defined by successful local delivery in the vanguard systems, but the extent to which they have made it easy to spread learning across the NHS and social care.” NHS England
2. Happy, Healthy, at Home – NEHF Vanguard

System leaders across health and social care in North East Hampshire and Farnham backed an application to become a PACS vanguard. They had formed a system Transformation Board in 2012 and were working with the King’s Fund to develop a different way of working together. PACS vanguards looked like a continuation of this direction.

On 2nd March 2015, leaders from across the system presented their case to become a PACS vanguard at an event at Lords Cricket Ground. There was a lot of competition and systems applying were asked to vote for the systems they felt should go through, and NEHF was one of 9 selected.

The vanguard had a triple aim of developing and delivering a new model of care, a new provider model and a new commissioning model.

This report focuses on the evaluation of the new model of care.
2. Happy Healthy at Home – NEHF Vanguard

The new care model was organised around 3 aims

Introducing our new care model – Happy, Healthy at Home:

- We are taking targeted action to prevent ill health and promote self care:
  - Social Prescribing
  - Recovery College Courses
  - Crisis Café
  - Support to carers and staff

- We are strengthening local primary and community care:
  - Practices working together
  - Separation of on-the-day urgent primary care from planned primary care
  - Integrated Care Teams
  - Proactively managing the health and social care needs of the population

- We are improving services for patients in a crisis and those who need specialist care:
  - Expanding the capacity of community and social care services, and extending their working hours to 8am-9pm
  - Redesigning the interface between hospital care and primary care – eg hospital consultants supporting locality hubs, GPs working in hospital

The programme logic model provided the detail on the individual workstreams and their outcomes, and measurable and impacts
2. Happy Healthy at Home – NEHF Vanguard

The vanguard received £14.3 million of national non-recurring funding spread across three years.

This table describes how it was spent – which included:

- £5.7 million spent on the direct additional costs of the new care models
- £1.8 million on the Project Management Office
- £1.2 million on organisational development
- £0.5 million on evaluation

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<td>350</td>
<td>580</td>
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<tr>
<td>MSK Extended Scope Practitioners</td>
<td>-</td>
<td>-</td>
<td>300</td>
<td>300</td>
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<tr>
<td>Making Connections</td>
<td>49</td>
<td>178</td>
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<td>392</td>
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<tr>
<td>A&amp;E Emergency Streaming Index</td>
<td>-</td>
<td>-</td>
<td>160</td>
<td>160</td>
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<td>Recovery College</td>
<td>45</td>
<td>120</td>
<td>120</td>
<td>285</td>
</tr>
<tr>
<td>111 Triage and Pharmacists</td>
<td>-</td>
<td>143</td>
<td>100</td>
<td>243</td>
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<td>MISSION</td>
<td>-</td>
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<td>1,912</td>
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<td>Pump Priming</td>
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<td>Infrastructure</td>
<td>248</td>
<td>1,096</td>
<td>865</td>
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<td>Project Management Office</td>
<td>517</td>
<td>780</td>
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<td>89</td>
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<td>Workforce</td>
<td>441</td>
<td>149</td>
<td>200</td>
<td>790</td>
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<td>Other Enabling Projects</td>
<td>446</td>
<td>1,152</td>
<td>635</td>
<td>2,233</td>
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<tr>
<td><strong>Total</strong></td>
<td>3,383</td>
<td>5,337</td>
<td>5,585</td>
<td>14,305</td>
</tr>
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</table>
3. Independent evaluation partner

From 2016/17 NHS England required each vanguard to appoint an independent evaluation partner to work alongside them to understand how changes were being made and the outcomes they were delivering. This recognised the central aim of vanguards was to test new care models to support their spread to the rest of the NHS.

NEHF appointed Wessex AHSN to be its independent evaluation partner. The AHSN has described its 3 aims as:

1. To understand the patient, staff and system outcomes of the new models of care and how they were implemented

2. To work with the Vanguard to use the evaluation findings in further development of the programme

3. To share the learning from the evaluations to enable spread and adoption to other health care systems
3. Independent evaluation partner

The AHSN agreed a programme of evaluations with the Happy Healthy at Home team that covered 23 separate services over 2016/17 and 2017/18. Detailed reports for each have been approved by the Vanguard Steering Group and submitted to NHS England to support the national learning and spread of care models.

A typical evaluation process for each would include:
- A meeting with the service to help the evaluation team understand the service and its aims. Wherever possible, individual logic models have been used.
- Co-design the evaluation, methods and timescales with the service and evaluation steering group.
- Circa 3 months of focused data collection, observation, interviews and analysis.
- Report writing, discussion with the team, presentation and approval from evaluation steering group. Submission to NHS England.
- Joint presentation by service team and evaluation team at a Symposium.
3. Independent evaluation partner

These are the principle evaluation methods that have been used.

**Self reported outcomes**

A set of short, generic, validated person reported outcomes measures that can track changes in how people feel over time as they experience a new care model. Widely used for patients and staff.

**Activity impact**

Analysing pseudonimised patient records to measure the impact of new care models on activity levels in other services – principally hospital emergency services.

**Economic evaluation**

Modelling evidence of an impact on activity levels over time to estimate potential system savings. Comparison with costs to identify a potential return on investment.

**Team observation and evaluation**

Observing teams in practice using Normalisation Process Theory - a validated evaluation tool to understand the extent to which a team was able to embed the implementation of the new care model.

**Qualitative interviews with patients, carers and staff**

Experienced researchers undertaking structured interviews using qualitative methods to explore the extent and nature of a change.

**Themed analysis of case studies**

Experienced researchers undertaking thematic analysis of case studies collected by staff.

**Synthesising findings**

Synthesis meetings bring together all of the people involved in gathering the data and evidence from quantitative and qualitative sources. All of the material is pooled and worked through together to triangulate the evidence and identify and agree findings.
3. Independent evaluation partner

To share the learning from the individual evaluations and to enable spread and adoption to other health care systems, the AHSN has held 3 Symposiums and produced a range of summary ‘flash cards’

The 3 Evaluation Symposiums were an opportunity for the service team and evaluation team to jointly present and discuss the findings in a workshop format.

They were attended by a good mixture of all parts and sectors of North East Hampshire and Farnham, community ambassadors, people from other systems and the national team.

They grew in popularity:
• January 2016 – 63 attendees
• May 2017 – 79 attendees
• April 2018 – 100 attendees

To help communicate the highlights from detailed evaluation reports, the AHSN produced a series of summary ‘flash cards’
4. Summative findings from care model activity

The following activity was recorded as being facilitated by the new care models, demonstrating that a large number of people and patients have been supported in new ways over the duration of the Vanguard project.

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,275 attendances in a year at Safe Haven</td>
<td>supporting people in, or at risk of, mental health crisis (August 16 to Jun 17)</td>
</tr>
<tr>
<td>1,069 students enrolled at Recovery College</td>
<td>training people to better self-manage long term health conditions (Sept 16 to Mar 18)</td>
</tr>
<tr>
<td>651 people referred to Making Connections</td>
<td>social prescribing provider connecting people to services in their community that will improve their wellbeing (Jul 16 to Mar 18)</td>
</tr>
<tr>
<td>1,687 patients referred to 5 Locality Integrated Care Teams</td>
<td>providing person-centred support to local people with complex needs at Mar 18</td>
</tr>
<tr>
<td>1,200 visits in a year by Farnham Rapid Home Visiting</td>
<td>paramedics providing home visits throughout the day</td>
</tr>
<tr>
<td>16,000 appointments per annum at Farnham Integrated Care Centre</td>
<td>offering same-day appointments for urgent care</td>
</tr>
<tr>
<td>14,000 appointments in a year at Yateley Urgent Care Centre</td>
<td>offering same-day appointments for urgent care</td>
</tr>
<tr>
<td>1,348 patients supported by Enhanced Recovery and Support at Home</td>
<td>intensive support to help people return home from hospital more quickly or to prevent a hospital admission (at Mar 18)</td>
</tr>
<tr>
<td>628 patients supported by 111 GP Triage</td>
<td>enhanced service for 111 linking into GP out of hours (at Mar 18)</td>
</tr>
<tr>
<td>9,028 referrals reviewed by Farnham Referral Management Service</td>
<td>giving GPs confidence in identifying which patients need to be referred to hospital (Jul 16 to Apr 18)</td>
</tr>
</tbody>
</table>
5. Summative findings from R-Outcomes - Patients

R-Outcomes family of short generic patient-reported measures have been used to evaluate the impact on health status, patient experience, personal wellbeing and health confidence. These tools are research-based and short, quick and easy to use and measure trends, changes and comparisons.

Patients have been asked to record how they feel when they are first referred, and then once they have been supported, to enable us to measure any change.

More than 3,300 patient responses received and analysed for the following new care models:

- Marking Connections - 461
- Enhanced Recovery at Home - 319
- Farnham ICC - 141
- Yateley UCC - 123

**Health status**

**How are you today?** (past 24 hours)
- How do you feel and how much can you do?
  - Choose one answer on each line
  - None
  - A little
  - Quite a lot
  - Extreme

**Health confidence**

**Health Confidence**
- How do you feel about caring for your health?
- How much do you agree?
- Strongly agree
- Agree
- Neutral
- Disagree

**Personal wellbeing**

**Personal Wellbeing**
- How are you feeling in general?
- How much do you agree?
- Strongly agree
- Agree
- Neutral
- Disagree

**Patient experience**

**How are we doing?**
- What do you think about our service?
  - Choose one answer on each line
  - Excellent
  - Good
  - Fair
  - Poor

- Treat you kindly
- Listen and explain
- See you promptly
- Well organised
5. Summative findings from R-Outcomes - Patients

The **total vanguard scores** before (at referral) and after (once supported) – covering 3300 responses

Scores are presented on a 0–100 scale, with 100 being the most positive.

Patients being cared for and supported by the new care models report significant improvements in how they feel about their health status, confidence, wellbeing and their experience.

The biggest improvement is in the measure recording patient’s **experience** of the service and the care they receive.

This chart shows the scores for the individual questions that make up the four measures. The **biggest improvements** are:

- Experience: Well Organised
- Health Confidence: I can get the right help if I need it
- Experience: Listen and explain
- Experience: See you promptly
While all of the ICTs have evidence of improvements in how their patients feel once they’ve been supported by them, there are variations between them. These have been discussed with each ICT and are explored in more detail in their individual reports.

For ICTs as a whole, the biggest improvements (dark blue bars) were in the questions that related to their sense of personal wellbeing and the degree to which they felt supported and involved. The ICTs feel that this accurately reflects the nature of their patients needs being psychological at least as much as physical; and the way they aim to work with and support each one.

Most responses are recorded by the patient, though it is possible for the carer or team member to do this by proxy when they are unable to. Aldershot recorded the lowest number of proxy responses (25%) and Fleet the highest (59%).

5. Summative findings from R-Outcomes - ICTs

These charts show the before and after scores for each of the 5 Locality Integrated Care Teams:

- **Aldershot (73 responses)**
- **Farnborough (348 responses)**
- **Fleet (353 responses)**
- **Farnham (132 responses)**
- **Yateley (260 responses)**

All ICTs improvement chart:

- **Pain or discomfort**
- **Feeling low or worried**
- **Limited in what I can do**
- **Need help from others**
- **I was satisfied with my life**
- **What I do in my life is worthwhile**
- **I was happy yesterday**
- **I was not anxious yesterday**
- **Listen and explain**
- **See you promptly**
- **Well organised**
- **I know enough about my health**
- **I can look after my health**
- **I can get the right help if I need it**
- **I am involved in decisions about me**
6. Summative findings from R-Outcomes – All staff

Staff R-Outcomes are a family of short generic outcome measures that work in the same way and complement the patient reported measures described in section 5 above. They have been used to measure the impact of new care models on staff working in General Practice and the new care models based in each locality.

530 staff outcomes have been received and analysed across 6 collection periods from Spring 2016 to Spring 2018:
- 20% from GPs
- 20% from clinical staff
- 20% from receptionists and
- 35% from management and administration staff

Three R-Outcomes measures were used as well as the Friends and Family test on whether staff would recommend this as a place to work.
6. Summative findings from R-Outcomes – All staff

523 staff outcome responses were recorded across 6 points in 2 years. These are the results:

Between Spring 2016 and Spring 2018 there was a:
- 15.4% improvement in Work Wellbeing*
- 6% improvement in Job Confidence
- 14.9% improvement in Service Experience*

* = Statistically significant improvement, at P<0.01
7. Summative findings from Team Evaluation – 5 ICTs

New teams are an essential element of new care models. The 5 Integrated Care Teams (ICT) bring together up to 17 people from 8 different organisations to work together daily and weekly to design and implement the new care model and work collectively for the good of their locality’s patients with the greatest need.

Normalisation Process Theory (NPT) (May and Finch 2009) is a validated instrument developed to understand how innovations in healthcare are implemented in practice – and in particular how new ways of working become embedded and sustained. It is an Action Theory, concerned with explaining what people actually do rather than how they describe their attitudes or beliefs.

The theory is based upon the following 4 components:

1. **Coherence** – mobilisation of practice; making tasks meaningful
2. **Cognitive engagement** – participation in a practice; how they decide to and then actually engage
3. **Collective action** – enacting a practice; how the work is organised and actually structured
4. **Reflexive monitoring** – appraisal of the practice; how its effects are fed back and understood

Researchers from the Centre for Implementation Science spent time with each locality ICT to observe them at work together, deploy the NoMAD questionnaire (see opposite) and run a focus group to explore the barriers and drivers for the ICT. Individual reports have been discussed with each ICT. The summative results of the surveys are on the next slide.

### NPT NoMAD Questions

**Coherence**

1. The ICT is distinct from previous ways of working
2. Team members have shared understanding of the purpose of the ICT and of specific responsibilities required
3. Team members understand how the ICT affects the nature of their work
4. Team members can see potential value for the ICT for their work

**Cognitive Participation**

5. Key individuals drive the ICT forward and get others involved
6. Team members are open and willing to work in new ways
7. Team members believe that contributing to the ICT is a legitimate part of their work
8. Team members continue to support the ICT

**Collective Action**

9. Team members can easily perform the required tasks
10. The ICT does not disrupt working relationships
11. Team members trust the ICT and trust each other
12. Work is seen as appropriately allocated to staff with required skills
13. Sufficient training is provided to staff
14. Sufficient resources are available
15. The vanguard programme management team adequately support the team

**Reflexive Monitoring**

16. Team members are aware of the effects of the ICT
17. Team members agree that the ICT is worthwhile
18. Team members value the effect of the ICT on their work
19. Feedback about the intervention can be used to improve it in future
20. Team members can modify how they work with the intervention
7. Summative findings from Team Evaluation – 5 ICTs

Summative findings:

- **Farnham have the highest** overall NPT scores and is highest for each of the 4 components (average score 8.7/10). Farnborough is the second highest (8.3).
- **Fleet is markedly lower** than the other ICTs (average score 7.4/10). Issues with a lack of engagement from GPs with the ICT were observed and reported – this is different to the other 4 localities.
- **Coherence** – evidence that team members believe there is a move from reactive to proactive care. The role of the Paramedic Practitioner was widely recognised to have made a big contribution to the teams practice.
- **Cognitive engagement** – non-participant observation and focus groups confirmed high levels of buy-in in all ICTs.
- **Collective action** – focus groups identified the following common barriers and drivers to the work of the ICTs:

  **Barriers:**
  - Staff shortages and competing demands
  - Not understood by other parts of the system
  
  **Drivers:**
  - The multidisciplinary team
  - Improving patient outcomes
  - Flexibility and autonomy

- **Reflexive monitoring** – ICTs were able to follow individual patients, but have less information on the overall impact they are having and how they are perceived by others.
8. Summative findings from qualitative interviews

Qualitative methods used

Typically, two or three qualitative methods were employed to explore the role and impact of the new models of care.

**Patient/carer/staff interviews:**
- Individuals were purposively recruited by invitation, consent obtained and interviews audio recorded
- Interviews were semi-structured and open-ended to allow for exploration of issues not pre-judged to be relevant

**Case Studies:**
- Staff used a short template to describe the circumstances, intervention and outcomes for 8-10 of their patients

**Thematic analysis:**
- Our qualitative research used a recognised process (Braun and Clark, 2006) to produce a table of themes after data saturation was reached

**Approach to synthesis:**
- The themes emerging from qualitative and quantitative data analysis were brought together to assess the extent to which the intended outcomes of the new care model were achieved

Over 645 sets of data analysed on the experience of new care models

- 62 patient interviews
- 124 case studies
- 51 staff interviews
- Focus groups with 80 staff
- 193 patient surveys analysed
- 137 staff surveys analysed
8. Summative findings from qualitative interviews

Commonly reported ‘active ingredients’ of NEHF new care model

BARRIERS TO IMPLEMENTATION
1. Information Governance – Sharing data between clinical teams, which prevented reflexive monitoring
2. Short term staff contracts
3. Lack of joined up IT
4. GP buy-in with New Models of Care
5. Disproportionate buy-in from different organisations and managers to a new model of care
6. Cultural differences between teams and organisations, and the integration of such cultures

A synthesis of all of the qualitative evaluation findings has identified these commonly reported ‘active ingredients’, barriers to implementation and commonly reported impacts.

NEHF New Care Model (NCM)

COMMONLY REPORTED IMPACTS

Patients
- Improved patient experience and sense of wellbeing
- Patients’ confidence to self-manage improved

Staff
- Patients’ prevented from falling into crisis by timely holistic intervention
- Burden of treatment of patients reduced by better service coordination
- GPs workload positively supported by other health professionals
- Staff have better inter-service and inter-professional awareness

System
- Avoidance of secondary care use
9. Summative findings from activity evaluation

Changing the pattern of service activity for the patients cared for by the new models was a key objective and outcome for the vanguard. In particular a reduction in emergency hospital activity – A&E attendances and emergency admissions. This would be evidence of a shift in care to supporting people at home and would in turn, reduce system costs and contribute to the long term case and sustainability for new models of care.

The principle method used to evaluate this has been for the CSU to use the NHS Numbers to undertake pseudonymised analysis of A&E attendances and emergency admissions. Using the date of referral as a ‘pivot point’, it is possible to compare the rates of activity in the period before and after patients are cared for by the new model. This approach has been developed and refined over the life of the evaluation and for some services there are trends covering up to four years (2 years before and 2 years after intervention).

There are constraints with this “before and after” approach:

- Obtaining data sharing agreements to analyse linked data for the purposes of evaluation
- Despite efforts, information governance arrangements have prevented similar activity analysis using the information systems that record primary care, community care and social care activity.
- There is a methodological constraint. A study in 2005 that tracked and the admission rates for people in England that were admitted two times or more found that over the following five years their admission rates fell and converged with those of the general population (BMJ 2005;330;289). This is thought to be partly due to mortality (which they weren’t able to account for) and regression to the mean. They recommend that activity impacts are better measured by comparison with a matched control group. The NHS England Improvement Analytics Unit have undertaken this form of analysis and will be reporting this separately. It is important to note that this method also has methodological constraints and relies on accurately identifying the matched control group. There is no perfect method.

The following slides present a selection of the evaluations of activity that have taken place including whole population in addition to “before and after”.
9.1 Activity evaluation – whole population

The national New Care Models team and North East Hampshire and Farnham CCG have been tracking total emergency admissions and beddays to look for evidence of reductions during the implementation of the vanguard.

This chart shows the monthly number of emergency admissions with a length of stay (LOS) of one day or more over four years. Zero day LOS admissions were excluded because of changes in the pathway at Frimley Park Hospital during this time period.

SPC charts allow us to distinguish between common and special cause variation.

With 21 months below the mean from July 2016, we can identify a significant reduction in the trend of emergency admissions early in the vanguard’s second year.
9.2 Activity evaluation – locality level

There are large variations in emergency admissions at locality level. Farnham was the first to implement new models of care and has had the biggest impact. Fleet has been the slowest and has yet to have an impact on emergency activity.
9.3 Activity evaluation - ICTs

These charts compare the emergency activity rates, 2 years before and after referral, to each of the 5 locality ICTs.

The difference between the localities are of interest, for example:

- Emergency activity increases in the period leading up to referral to the ICT – but by very different amounts. The rate of emergency admission in Fleet is around double that in Farnborough and Yateley – which could be because patients with increasing need are being identified later in Fleet.

- The activity reduces in the period following referral to a comparatively lower level – but the trends beyond 4 months differ. In Farnham, the comparative rate of emergency activity is markedly lower for 19 months and then rises. In Fleet the rise happens after 13 months.
9.4 Activity evaluation –ERS@H & MC services

Emergency hospital activity rates for ERS@H

The Enhanced Recovery and Support at Home service (ERS@H) supports people with complex needs in their home for up to 6 weeks on discharge from hospital (75% of their patients); and offer additional short term support that could avoid an admission (25% of their patients).

Patients on the ERS@H caseload experience increases in emergency activity at the higher end of those on the ICT caseloads (see previous slide).

28% of the ERS@H patients are also on an ICT caseload.

Emergency hospital activity rates for Making Connections

The Making Connections (MC) service is a social prescribing service with most referrals coming from GPs - as well as a wide range of other organisations – to help address people’s wellbeing, social and non-health needs. Their clients experience a similar increase in A&E attendances to other care models – but not in admissions.

The MC Coordinators are part of the Locality ICTs and 39% of MC clients are also on an ICT caseload. These people have greater needs and experience before and after emergency admissions similar to the ICTs.
9.5 Activity evaluation – Urgent Care Centres

Yateley and Farnham localities have each implemented a centralised urgent primary care service. ‘Before and After’ A&E analysis of patients attending these urgent care centres found different results:

<table>
<thead>
<tr>
<th></th>
<th>No. of attendances</th>
<th>A&amp;E attendances in preceding 120 days</th>
<th>A&amp;E attendances in following 120 days</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yateley</td>
<td>3566</td>
<td>629</td>
<td>709</td>
<td>+80 (+13%)</td>
</tr>
<tr>
<td>Farnham</td>
<td>7057</td>
<td>1187</td>
<td>1154</td>
<td>-33 (-2.7%)</td>
</tr>
</tbody>
</table>

Though taking a wider view, both localities have a positive trend in A&E attendances.

The evaluations found some important differences between these 2 localities. Yateley’s urgent care patients are older, Farnham’s largest group are children and young people. Yateley is nearer the local A&E department. The GP survey results for access issues before these services were introduced were more positive in Yateley.

Good evidence was found for both services of a positive impact on patient experience, staff experience and organisational benefits for the practices.
9.6 Activity evaluation - Other

Safe Haven Crisis Café
Supporting people in, or at risk of, mental health crisis. 670 different users were recorded as attending the Safe Haven in a year – with NHS numbers recorded for 92 of them:
• For the 92 patients there was a 48% reduction in A&E attendances after 12 months of first attending the Safe Haven
Since the opening of the Safe Haven (2014) the following wider trends were evident:
• A 16% reduction in admissions to acute inpatient psychiatric beds
• A 42% reduction in mental health related phone calls to the police
• A reducing trend of section 136 detentions – bucking the wider trend for the mental health Trust

111 GP Triage
Enhanced service for 111 linking into GP out of hours.
• An average of 52 patients per month have been diverted by NHS 111 to the GP out of hours service as an alternative to advising them to attend A&E
• 59% of these patients are successfully dealt with by a GP phone call and avoided over 300 A&E attendances

Farnham Referral Management Service
Giving GPs confidence in identifying which patients need to be referred to hospital.
Analysis of the outcome of the review of 9000 referrals to secondary care over 88 weeks found that 1200 were re-directed:
• 50% to local tier 2/ community services
• 14% deferred or rejected
• 11% followed up in primary care
• 8% upgraded and given greater urgency

Recovery College
Training people to better self-manage long term health conditions. 120 students attending longer recovery courses completed a questionnaire asking them about their use of services before and after the course, they reported reductions in service use:
• From 27% to 10% had gone to their GP
• From 12% to 6% had attended A&E
• From 3% to 1% had had contact with the police
• From 56% to 40% had had contact with the community mental health recovery service
10. Summative findings from economic evaluation

Where it has been possible to measure changes and shifts in activity, economic evaluations have been undertaken and ‘return on investment’ (ROI) calculated. Here are three examples.

Farnham Referral Management Service (RMS)
This new care model cost £59,920 per annum to run. Two methods were used to evaluate the economic benefit:
1. The value saved by avoiding or redirecting referrals to cheaper alternatives is £69,000 per annum – a ROI of 15%, or a return of £1.15 for every £1 spent.
2. The other 4 localities have not implemented a similar model of care and their referrals have maintained a similar level – whereas in Farnham they have reduced. A counterfactual has been calculated by modelling a continued trend of the rates before the RMS was introduced. This identifies savings of £260,000 – a ROI of 334%, or a return of £4.34 for every £1 spent.

Farnham Rapid Home Visiting (RHV) Service
In this care model, Paramedic Practitioners undertake home visiting instead of GP’s at an annual cost of £102,000. The evaluation estimated that this saved 845 hours of GP time per annum – or 0.64 wte of a GP – which for a salaried GP would cost £45,000. The Paramedic Practitioners record each time their professional judgement is that their visit has avoided an emergency admission (144 times) or A&E attendance (38 times). Using the tariff, the commissioning value of this avoided activity would be £420,000 per annum. It is acknowledged that this is based upon professional judgement.
Taking both savings together generates a ROI of 357%, or a return of £4.57 for every £1 spent.

111 GP Triage
• The cost of this service in year 1 was £75,000. The value of the reduced activity using the tariff was £23,000. A ROI of -69%
• In year 2 the costs were reduced to £48,000. With an increase in catchment population, activity increased to a level that would save £37,000. A ROI of -23%.
• For the service to break even, 109 redirections to the service are required.
The vanguard’s original value proposition (business plan) identified a ‘do nothing’ health system financial gap of £55 million by 2020/21.

Three years later, the CCG reports that the system has kept to its collective financial plan and has spent £33 million less than predicted in their ‘do nothing’ scenario – and a prediction that they will remain in financial balance.
11. Summary of findings

• A large number of people and patients have been supported in new ways over the duration of the vanguard. Overall, the evaluation covered **50,000 patient contacts and interventions in 23 new services**.

• **3,300 patient reported outcomes** demonstrated significant improvements in how they feel about their health status, confidence and wellbeing – with the largest improvement being in their experience of being cared for (well organised, listening and explaining and seen promptly).

• **530 staff reported outcomes** from the new care model teams and primary care, demonstrated statistically significant improvements in work wellbeing (+15%) and service experience (+15%) and an 8% increase in their recommendation as a place to work.

• A range of methods have identified positive impacts on the use of other services, particularly emergency hospital care. **From the second year of the programme there was a significant reduction in the trend of emergency admissions.**

• **Qualitative interviews and case studies found positive benefits for patients, staff and the system** – including an improved experience, confidence to manage, support to GPs’ workload and reduced used of secondary care. These benefits could be limited by IT, disproportionate buy-in from GPs and managers and different professional and cultural working practices.

• **The evaluation highlighted the importance of allowing time to establish new teams and ways of working. GP engagement was a key ingredient in successful delivery.** The interoperability of disparate IT systems and Information Governance rules further limited the pace of developing new ways of working.
12. After the vanguard – Spreading the Learning

The principle aim of vanguards was to create learning for the wider roll-out of new care models to the rest of the NHS. The Happy, Healthy and at Home vanguard came to an end in March 2018 – with a third evaluation symposium and a showcase event.

North East Hampshire and Farnham CCG have always operated across 2 systems – Hampshire, their administrative boundary – and Frimley, their acute hospital.

As part of the Frimley Health and Care system, they are part of one of 10 national pilot sites for Integrated Care Systems (ICSs). These systems are charged with building on the learning of the 50 vanguards to explore how new provider and commissioning models can continue and accelerate the transformation of care.

As part of the Hampshire system, they are part of a new Hampshire & Isle of Wight CCG Partnership of five CCGs that have come together under a single leadership team with the aim of accelerating improvement and reducing duplication.
The Frimley Health and Care Integrated Care System (ICS) is one of just 10 systems in England piloting what comes after vanguards in delivering integrated care. They build on the learning from the new care models – with an additional focus on how the current organisational arrangements for providing and commissioning care can be changed to support integration. For example, for 2018/19 there was one NHS Operating Plan for the Frimley Health and Care system, instead of 5 separate CCG plans and 5 separate NHS Trust plans.

The ICS has agreed a set of 7 Transformation Initiatives (see opposite) with a number that link with and build upon the learning from Happy Healthy at Home:

1. Prevention and Self-Care includes the roll-out of social prescribing services similar to Making Connections. All of these new services have decided to collect the R-Outcomes measures to support understanding and comparison of their impact.

2. Integrated Care Decision Making – is very similar to the Locality ICTs in North East Hampshire and Farnham.
12. After the vanguard – Frimley Health and Care ICS

Sir Andrew Morris retired in March 2018 after leading the Frimley Park Hospital and following the take over of Heatherwood and Wexham Park Hospitals, Frimley Health – for 29 years. He is now providing the leadership for the Frimley Health and Care ICS. Andrew was interviewed as part of this summative report and this is a summary.

The work in NEHF pre-dated the vanguard. The local system had stable leadership that had built a collective view that we would have to work very differently to meet the growing demand for services without growing resource. This was particularly clear from a hospital perspective – with fast rising activity and costs and a flawed national tariff system. This created the conditions for a successful vanguard application.

An approach that brings together clinical leads, managers and local people to co-design services has energised our people to improve services and create new pathways of care, particularly for long-term conditions. In the ICS we are telling people to forget which organisation they come from and focus on what is right for patients – and I think you get different answers.

This has been the first time in my career that transformation work in primary and community care have reduced activity in the acute sector. In 2017/18 emergency hospital activity did not increase.

The work done in NEHF to develop the Locality ICTs and similar work in Surrey Heath, have provided the learning for rolling-out what we call Integrated Care Decision Making Hubs across the rest of they system. We are also investing in leadership through extending the 2020 Leadership programme.

The new care models have made progress in localities, but there is more to do now on models with the acute hospitals. Relationships are important and we’re investing in identifying link Consultants with localities. We’re also looking at international examples of care models for complex conditions in which GPs and Consultants work differently together.
12. After the vanguard – Hampshire & IOW CCG Partnership

The Hampshire & Isle of Wight CCG Partnership brings together 5 CCGs under single leadership to accelerate transformation and reduce duplication.

An early piece of work was to create a common description of the new care model. This was important because the Partnership covers 3 vanguards and 2 STPs and all of these have their own description of a new model of care. The findings from the local vanguard evaluations were used to inform this work – and the Happy, Healthy, and at Home evidence summarised in this report formed the major part of this.

The next step was to use the evidence and experience of transformation at locality level to create a New Care Model Locality Checklist.

The leadership teams used this checklist to place each of the eighteen localities (pre-Isle of Wight joining) along the diffusion curve for adoption of the new care model.

The plan is to develop differential transformation support programmes for the continued spread and development of the new care models – drawing on the evidence base for how innovation is adopted.

For NEHF, Wessex AHSN will continue to work as their evaluation partner for new care models through 2018/19.
12. After the vanguard – Hampshire & IOW Partnership

Maggie MacIsaac has been the Chief Officer of North East Hampshire and Farnham CCG since its creation and is now the Chief Executive Officer of the Hampshire & Isle of Wight CCG Partnership. Maggie was interviewed as part of this summative report and this is a summary.

The vanguard was able build upon strong system leadership. The CEOs formed a Transformation Board in 2012 to provide joint collective leadership and agree joint priorities. The vanguard helped us take this to the next level by supporting a large system change programme. The CEOs continued collective and visible leadership was an important ingredient. The vanguard gave us a bigger shared agenda and opportunity to make the changes we’d agreed we were committed to.

The investment in organisation development was an important part of the vanguard. Our locality teams have grown in confidence and have an expectation that they can and should be supported to make progress.

The Project Management Office was also important - underpinning our collective ambition with clear plans and milestones and holding ourselves to account.

Looking back at our vanguard and its evaluation gives us confidence that it was a success. When we modelled the system’s do nothing financial scenario in 2014 we were very concerned about the sustainability of our system and together we have delivered a different, sustainable scenario.

The Hampshire & Isle of Wight system is more complex, with many more players involved. The work done by the vanguard has provided the genesis of a larger change programme and provides evidence of what works, the benefits that can be delivered and the confidence to invest time and resource in their delivery.
13. Resources

For further information please contact:
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All of the full evaluation reports described in this summative review can be found at: