Appendix 1: Programme Methodology and Deep Dive Methodologies

This Appendix outlines the overall Methodology of the programme report in greater detail, as well as summaries of the methodologies used for the deep dive evaluations.

Project Initiation

After agreeing the scope and objectives of the evaluation at a project initiation meeting with the BLC team on the 5th October 2016, the team set out an outline methodology in a research implementation plan. This method was largely adhered to, although the timing of certain stages varied (however, this was recognised as a possibility early on and a 'flex' approach was built into the evaluation).

Landscape review, evidence synthesis and theories of change

Background documentation was forwarded to the evaluation team following the Project Initiation Meeting, which the team then reviewed in detail. The literature review stage covered these materials, existing evaluation evidence and documentation for the wider strategic and policy landscape. A summary of the evaluation evidence was created and made available to the HBLC projects.

National and local policy and landscape review

RSM PACEC reviewed and summarised the national and local policy context surrounding HBLC, as well as crafting profiles of the local CCG and Natural Communities of Care areas in which the HBLC programme operate[1]. The national and local policy documentation which was reviewed included (but was not limited to)

- NHS Five Year Forward View, October 2014;
- NHS New Care Models, Vanguards: Developing a blueprint for the future of NHS and care services, June 2016;
- Hampshire County Council Joint Strategic Needs Assessment, October 2015
- Southern Health Foundation Trust Business Plan, April 2016;
- Operating Plans for the 5 CCGs currently involved in HBLP, various dates; and
- Better Local Care Hampshire MCP Value Proposition, 2016.

RSM PACEC made considerable use of the National General Practice Profiles (available through Public Health England) and the GP Patient Survey, both of which provided extensive detail on the demographic profiles of local areas and key issues relating to patient access and health. The above culminated in a landscape review which addressed the following questions;

- How does the HBLC vanguard make positive contributions to the objectives of current national policy and strategies?
- What other interventions across Hampshire are also seeking to improve the health, well-being and independence of local residents by helping them to take greater control of their own health and to feel confident about the support they receive?
- How does the HBLC 'fit' i.e. where are the synergies and potential overlaps within the wider regional landscape?

As part of this landscape review RSM PACEC conducted semi-structured telephone interviews with GPs, MCP delivery group members, project leads and other strategic stakeholders. The interviews were used to introduce relevant stakeholders to the RSM PACEC team and to the evaluation process. In total 20 of these interviews were conducted between November and early December

[1] *"New Care Models, Local Evaluation: A summary of the approach to the local evaluation of new care models".*

2016. Key interventions that could contribute to HBLC outcomes were also identified through these interviews, which informed further desk research relevant for the landscape review. The topic guide used for these interviews can be found in Appendix 12.

Evidence synthesis

A draft landscape review was provided in November with a synthesis of the evidence collected so far. The evidence synthesis provided a summary of the evaluation evidence that was available to the team across the 12 projects, identifying gaps in evidence where they appeared and describing implications that this had on the evaluation's research.

The synthesis of evaluation evidence examined the following key questions:

- What inputs, activities, outputs and outcomes are to be achieved across the 12 projects?
- What monitoring data is currently available against project level logic models; what gaps in data exist, and can these be filled (in consultation with individual projects)?
- What variation exists in the extent of monitoring and evaluation data and documentation across the 12 projects, which projects need more support to gather an appropriate level of evidence?
- Are there any projects which present a risk to the effective use of evaluation resource due to their level of maturity?
- What best practice in the identification and use of metrics should be shared across projects in project workshops?
- What metrics are common across projects at thematic level, and what if any adjustments need to be made to allow these metrics to be aggregated?
- To what extent does the existing evidence effectively evidence progress, and impact, against individual project objectives and anticipated outcomes?
- What secondary data is currently being used to provide baselines within localities; which datasets are most useful for analysing progress within the current evaluation timeframe; and are there additional metrics within existing sources that could usefully be added?

The evaluation team conducted a review of all the project's logic models and filled in gaps or updated them as necessary based on any new background documentation that was provided.

Baseline analysis of secondary datasets & early case studies

A baseline analysis of secondary datasets was carried throughout the evaluation period in parallel to other stages. This included an analysis of quantitative data (in line with Vanguard New Models of Care Guidance) and of the datasets outlined in section 8.3 of the MCP Manual. This analysis was done to establish baseline levels for indicators, the direction of travel for these indicators prior to the introduction of the Vanguard pilot (with assessment of any seasonal variability in the baseline data) and a set of comparator sites. This allowed the team to identify indicators and assess what difference the new Vanguard care mode may have made relative to what would have occurred anyway.

All new care model vanguards are ultimately looking to improve efficiency, to reduce hospital emergency admissions and shift care from hospitals to the community. As such, the national NCM team identified the following metrics as relevant to evaluate these key areas:

Efficiency

- Emergency admissions derived from secondary user service (SUS)/hospital episode statistic (HES) data; and
- Total bed days, derived from SUS/HES data.

For emergency admissions, the NCM team look at the rate per head of registered population.

Care and quality

- Patient involvement in care (GP – Q21 part d);
- Patient involvement in care (Nurse – Q23 part d);
- Patient involvement in care plan (Q37);

Health and wellbeing

- GP Patient Survey: Quality of life (Q34) – average of the EQ5D score.

Suggested data sources were identified and agreed in November. The team also attempted to work with the Commissioning Support Unit to access pseudonymised HSCIC data to understand actual usage of health services over time. However, this was unable to be completed due to information governance issues.

RSM PACEC worked closely with the BLC team and academic advisors to design a comparative analysis method which was agreed upon in November. This analysis was at the CCG geographic level and used an analysis of trends before and after the intervention using Public Health England's National General Practice Profiles data[2]. This trend analysis was used to identify CCGs in England that had similar patient profiles to the Southern Trust CCG areas.

Early evaluation case studies

To facilitate the commissioning planning cycle, the evaluation team subsequently agreed to complete five case study write ups. The early case study write ups were on the following projects.

- SDAS
- One Team
- WebGP
- MSK
- Paramedic

These write ups were completed in addition to the original scope of work and were done while the RSM PACEC team conducted the wider research. The write-ups were roughly 10 pages long and covered:

- Context, need and objectives;
- Model and activity to date;
- Current and potential future outcomes (including net cost savings where was made available).

Theories of change

Having completed the review of existing evidence the team then updated the theories of change for each of the four models of care, building on the existing theories of change by documenting the secondary evidence base that supported the key assumptions already identified. Four refreshed thematic theories of change were delivered at the end of 2016.

Stage 3: Research tools and evaluation workshops

Research tools were designed by the RSM PACEC team in late 2016 in order to collect data from the range of intended beneficiaries of BLC. The table below presents an illustration of the key stakeholder groups and research focuses.

[2] As required in the Vanguard New Care Models Evaluation Guidance

Type and focus of evaluation research by stakeholder group

Stakeholder Group	Research Focus
Patients / relatives / carers	• Satisfaction; • Care quality; • Perceived short-term health & social care outcomes.
GPs / Project Leads Hub / wider practice staff Staff at acute sites	• Care quality; • Person centred care; • Process / capacity / workload improvements; • Perceived health outcomes; • Improvements in integrated care; • Key successes / learning; • Formative areas for development.
Strategic stakeholders i.e. key staff at ST, CCGs, Health Alliances etc.	• Key strategic issues / contextual assessment; • Process / capacity / workload improvements; • Key successes / learning; • Formative areas for development.
MCP Board members	• Key successes / learning; • Formative areas for development.

In Q3 2016, RSM PACEC held an initial evaluation workshop, inviting project leads and commissioners. At this workshop, key findings were presented and evaluation questions were re-confirmed.

Stage 4: Data collection & analysis

The following quantitative and qualitative data was collected at project level:

- Patient / service user feedback data (quantitative & qualitative)
- Project level monitoring data (quantitative)
- GP / Project Lead and staff survey data (quantitative & qualitative)

Project level monitoring data

RSM data collected project level monitoring data which included databases / reports regarding key output metrics (summarised below). To minimise the burden of evaluation the team requested monitoring data twice, from project leads or other named points of contact. These two-time points were used to provide a baseline trend against which future monitoring data could be measured. As RSM PACEC anticipated as a possible risk in the project initiation, stage in some cases coverage of monitoring data was of poor quality, and for certain projects data was not provided in a timely manner. In such cases, the team worked with the programme management unit to understand the reasons or issues that faced these projects so that team could adjust delivery plans whilst remaining cognisant of the pressures on service delivery staff.

Theme	Quantitative data (anticipated)
Access	• Number of registered (unique) patients accessing services; • Number of calls • Number triaged • Number of face to face – clinician • Number/% of DNA • Call back timeframe
Prevention	• Number of registered patients using the online services / tool • Number of people signposted to social and community support • Number of e-consults per practice • % e-consults managed remotely • % face to face GP / PN appointments needed • % of patients they said they no longer needed a face to face GP appointment • Number of people trained
EPCT	• Number of single shared care / record plans produced • Number of onward referrals to community support services that result in further care at home • Number of visits by the Paramedic Support Service that do not require a primary care contact • Number of patients seen the Paramedic Support Service that require an admission into acute care within 48 hours of being seen
Delayering	• % uptake of appointments • % of appointments completed • Number of patients by referral sources • New to follow-up ratio • Number of specialist clinic(s) running in local primary care settings • Quantity of shared specialist primary care resource available

Source: PACEC, HBLC Project Logic Models

GP / Project Lead in-depth interview and staff survey data

In depth telephone interviews were conducted with GPs and project leads in the November. Any who were unable to complete a telephone interview were also sent a topic guide with the questions via e-mail so that they still had the opportunity to give their views.

An on-line survey was also administered to wider staff. The surveys were tailored by Vanguard theme / major care model strand where appropriate, using validated tools (e.g. P3CEQ), and asking key questions regarding processes and perceived impact of the projects according to specified project outcomes. The survey (Appendix 14) included a mix of quantitative and qualitative / open box questions to encourage a balance of quantitative data regarding e.g. satisfaction, quality of care and other outcomes, and qualitative data regarding the 'how' and 'why' successes and learning have been derived[3].

Based on a GP surgery population of c.80 GP practices involved in BLC[4], and assuming an average of 3 key staff members per GP practice (e.g. lead GPs and / or Practice Managers) RSM PACEC estimated a survey population of c.250+ staff and targeted between 175 and 215 survey responses between February 6th and March 13th 2017.

[3] As required in the Vanguard New Care Models Evaluation Guidance

[4] Based on data provided on the HBLC web page accessed 1st August 2016

Analysis of quantitative and qualitative local data

All the above data (i.e. qualitative data from site visits, early patient feedback data, project monitoring data, and staff survey data) has been used to produce key findings for individual projects and at the programme level. Key findings have been identified and shared with GPs / project leads through project level reports and will be shared with a wider audience at the final three locality workshops which are to be confirmed with the BLC team. These reports identify successes as well as formative areas for improvement.

Stage 5: Deep Dive Case Studies

The sampling approach

RSM PACEC created deep dive reports on a sample of BLC funded projects to use for case study evaluations, the selection of which was based primarily on the maturity of interventions and coverage across the four BLC themes.

Deep Dive evaluation reports were produced for the following BLC interventions.

- Integrated Care Team
- Extended Primary Care Team (EPCT)
- Eastleigh Frailty Clinic
- Integrated Pharmacy
- Hayling Care Homes
- Make Every Contact Count (MECC)
- Medical interoperability Gateway (MiG)
- Paramedic Home Visiting Service
- Same Day Access Service (SDAS)
- Surgery Sign posters

Stage 6: Strategic Stakeholder Interviews

In-depth follow-up interviews were conducted with strategic stakeholders using semi-structured interview guides (Appendix 13). 18 were conducted in total with stakeholders from various projects, including the MCP delivery group and general managers. These interviews were conducted in March and April 2017.

Stage 7: Locality Workshops, Reporting and Dissemination

Quarterly updates have been provided to the BLC throughout the process. While the evaluation team attended a series of meetings at which localities were represented, bespoke locality workshops proved too challenging to co-ordinate due to BLC operational staff capacity constraints. The evaluation team attended the NHS England NCM evaluation conference in March 2017 and contributed inputs into presentations by BLC representatives.

DEEP DIVE METHODOLOGIES

Below are brief summaries of the methodologies used by RSM PACEC for each of the Deep Dive reports. Most used similar methods but there were slight differences highlighted below. Greater detail for the methodology of each project can be found in the individual deep dive reports.

- Integrated Care Team
- Extended Primary Care Team (EPCT)
- Eastleigh Frailty Clinic
- Hayling Care Homes
- Integrated Pharmacy
- Make Every Contact Count (MECC)
- Medical interoperability Gateway (MiG)
- Paramedic Home Visiting Service
- Same Day Access Service (SDAS)
- Surgery Sign posters

Extended Primary Care Team (EPCT)

For this deep dive RSM PACEC used a mixed-methods approach that included the following steps:

- Secondary analysis: the team reviewed the data and information collected by the project team. This included but was not limited to financial reports, progress reports, monitoring data (i.e. number of participants, attendance etc.) and information on outputs and outcomes.
- Survey of staff involved: our team conducted a survey of staff involved in the One Team project as part of the programme-wide staff survey. This survey included targeted questions regarding EPCT.
- Semi-structured interviews with managers: The team conducted in-depth interviews with the managers responsible for the implementation and delivery of the programme.

Eastleigh Frailty Clinic

RSM PACEC's methodology for the Eastleigh Frailty Clinic deep dive also used a mixed method approach, the main strands of which are detailed below:

- Telephone survey with patients: the evaluation team conducted a survey of 15 patients involved in the Eastleigh Frailty Clinic using the EQ-5D questionnaire
- In-depth semi-structured interviews with Frailty Clinic staff: in-depth interviews were conducted with 5 staff involved either directly or indirectly with the Frailty Clinic. In-depth interviews were conducted to fill a gap in evidence from staff due to lack of responses from Frailty Clinic staff to a programme-wide online staff survey
- Analysis of quantitative primary and acute care data: including a review of relevant CSU data relating to 23 patients that had attended the clinic and EMIS case data relating to 6 of the clinic's early patients.
- Review of pseudonymised patient and carer feedback data collated by clinic staff: analysis of qualitative feedback from interviews conducted with a psychology lead and historic, anonymised GP feedback from patients

Hayling Care Homes

The Care homes survey used a mixed methods approach consisting of the following stages:

- Desk based research: Data from GP practices was used to assess the number of Care Home visits completed over time as well as other metrics. Other Data sources reviewed included Waterside Medical Practice data, Elms Practice data and SCAS data.
- Care Home staff survey: Staff outcomes were captured by a baseline and follow up survey by BLC. The surveys were completed in paper form, and collected by the community nurse. In addition, the nursing team issued a Care Home experience survey for Care Home Managers' to complete in March 2017. Eight survey responses were collected.
- Patient survey: Patient experience of the service was measured using wellbeing surveys. The delivery team used printed-out survey tools asking patients to measure their own satisfaction (or otherwise) with the service using 'smiley face' emoticons.
- Staff Interviews: In addition to the surveys, telephone interviews of Care Home staff, the nursing team and GP practices were conducted by RSM PACEC.

Integrated Pharmacy

The Integrated Pharmacy deep dive used a mixed method approach as summarised below.

- Desk Based Research: focused upon the data and information collected by the project team. This included but was not limited to financial reports, progress reports, databases on activities e.g. number of participants, attendance at each session etc. and information outputs and outcomes.
- 2x in depth interviews with managers (Project Manager and Pharmacy Lead): The team conducted in-depth interviews with the managers responsible for the implementation and delivery of the programme
- Survey of staff involved (x12 responses): staff involved in the project received a survey which they completed and returned to the project manager.
- Survey of patients involved (x10 responses): the pharmacists involved supported the collection of information from the patients benefitting from the service.

Make Every Contact Count (MECC)

This deep dive evaluation used mixed methods including:

- Patient feedback analysis: analysis of pre and post training participant feedback from 15 participants involved in MECC training in February 2017;
- Group consultation: a group consultation with 6 MECC Network Delivery Group representatives in March 2017;
- Staff interviews: in-depth interviews with 4 health sector staff involved in delivering MECC training in Gosport in March and April 2017; and

Medical interoperability Gateway (MiG)

The MiG deep dive also used mix methods and the main strands are detailed below:

- Desk Based Research: focused upon the data and information collected by the project team. This included but was not limited to financial reports, progress reports, databases on activities e.g. number of participants, attendance at each session etc. and information outputs and outcomes.
- Survey of staff involved: our team conducted a survey of staff involved in the Better Local Care, including those with access to MiG

Paramedic Home Visiting Service

The Paramedic Home Visiting service deep dive looked at the programme since its launch in June 2016 – December 2016 using the following research methods:

- Staff interviews: In-depth interviews with clinical staff and practice staff as well as commissioners on the project's strategic fit, sustainability, and the potential for scale-up and roll-out elsewhere.
- Secondary data analysis: Analysis of triage data from the IT/operations team to assess the service's performance against objectives, e.g. testing whether patients are seen earlier in the day as a result of the service. This also included an assessment of clinical outcome data from paramedic team records.
- Staff survey: Online survey of GPs conducted in January 2017 with 19 GP responses. The number of responses by Practice can be found in Appendix 1.
- Patient Survey: Patient surveys handed out by home visiting clinicians and completed by patients or carers.

Same Day Access Service (SDAS)

RSM PACEC evaluated the SDAS using data from its launch (January 2016) through to April 2017. The evaluation used a mixed method approach with stages included;

- Desk research: analysis of SDAS service data for the period January - December 2016 including SDAS service data, Triage outcome data and Patient experience and outcomes.
- Staff surveys: RSM PACEC carried out a programme-wide survey of clinical and management staff involved with the Hampshire Better Local Care vanguard. This data includes the views of 16 staff who responded to the survey and were involved in the SDAS, which has been analysed to inform this report.
- Staff interviews: In-depth, semi structured telephone interviews with clinical and administrative staff (n=4) covering collaborative working and team development, service sustainability, key lessons learned, and barriers in replication, roll-out and scalability

Surgery Signposters

This evaluation used mixed quantitative and qualitative methods as described below.

- Desk review of policy and similar studies: An assessment of the national and regional context and underlying rationale for the Surgery Signposters pilot based on a review of more than a dozen national and regional policy documents, and evidence from existing studies on other social prescribing interventions.
- Collation and analysis of secondary data: Data was used from GP practices to assess the number of people seen by the service, with Signposting data available from all practices delivering the service. Gosport Health Centre data was specifically used to monitor the change in

number of GP appointments attended by service users. Data from the Commissioning Support Unit (CSU) was used to monitor both A&E activity and emergency admissions for Surgery Signposters users both 6 months before using the service and 6 months after. The number of people using support after signposting is tracked by GVA.

- Patient feedback: Patient outcomes were monitored using the AHSN's R-outcomes tool. R-outcomes is a short patient-reported outcome survey used to measure how users perceive their own health and wellbeing. The survey has four measures: health status, experience, health confidence and personal wellbeing and is administered at a minimum of two time-points (baseline and follow-up).
- Staff Survey: Evidence from staff was captured by a primary care staff survey designed by RSM PACEC. The survey was designed to measure project outcomes as well as capturing general feedback.

Appendix 2: Methodology Limitations

METHODOLOGY LIMITATIONS

A lack of consistency in data between projects was a considerable obstacle for RSM PACEC when conducting the deep dive reviews. Data was inconsistent in terms of availability, quality and which metrics were used. For example, the same day access service relied upon home visiting staff to gather patient feedback directly. While this is a perfectly acceptable approach given the profile of patients involved (frailty, home bound patients) this harms the quality of the data and throws caution on how they are interpreted due to a risk of response bias. In addition, robust cost-savings analysis was hindered in places by the lack of a common standard on the unit cost of care by profession.

As well as these project level limitations, there were changes introduced to data protection governing regulations that subsequently affected parts of the original evaluation approach. Over the course of the evaluation NHS England, NHS Digital, Southern Health and local Clinical Commissioning Groups had been in the process of working together to prepare for the introduction of the new EU General Data Protection Regulation (GDPR), which comes into force in May 2018.[5] This directly affected the evaluation because Secondary Uses Service (SUS) became unavailable to the RSM PACEC team due to interpretation of the law surrounding information governance. Since SUS data provides the most granular data regarding patient use of health services, the absence of that data represented a significant limitation to the evaluation, particularly to the economic aspects of it.

[5] https://digital.nhs.uk/information-governance-alliance/General-Data-Protection-Regulation-guidance

Appendix 3: Allocated Budget and funding by BLC Project

Table A.1: Project budgets and funding

Project	Approved Budget	Total paid	Variation
4 Avon Valley GP Practices - Improved access Web GP	£29,547	£29,547	0
7 Day Service	£49,253	£49,170	*-£83*
Community development with Action Hampshire	£57,500	£57,500	0
Diabetes risk stratification	£60,000	£60,000	0
EMIS Remote Consultations Training	£7,195	£2,154	*-£5,041*
End of life	£35,116	£35,116	0
Health Prevention and Self-Management	£25,100	£20,071.50	*-£5,028.50*
Integrated Pharmacy	£194,098	£194,098	0
Integrated Pharmacy for Avon Valley Medicines Optimisation Service	£106,740	£106,740	0
Medication reviews - Clinical Pharmacist Band 8a	£16,668.39	£16,668	*-£0.39*
Medicines Optimisation Pharmacist - Care Homes *2	£57,946	£57,946	0
Mission ABC	£102,847	£102,847	0
One Team	£300,000	£437,911	*-£137,911*
Paramedic Home Visiting Service	£53,036	£55,650	£2,614
Pre-frailty, frailty and delivery of an enhanced ICT	£279,837	£280,146.40	£309.35
Prevention in Practice	£25,000	£8,653.68	*-£16,346.32*
Same Day Access Service	£135,132	£137,559	£2,427
Same Day Access Urgent Home Visits	£117,836	£117,836	0
Surgery Signposters	£59,640	£58,222.60	*-£1,417.40*
WebGP	£21,000	£21,000	0
Total	**£1,733,491.39**	**£1,848,836**	***-£115,344.61***

Source: Hampshire Vanguard Finance report 2016 – 2017 (Please note this does not include all project budgets)

Appendix 4: GP Practices and list sizes arranged by locality

Table A.4: GP practice list size

Locality	Practice	Practice size
East Hampshire	Badgerswood Surgery	1,245
	Horndean Practice	4,811
	Liphook & Liss Surgery	10,642
	Liphook Village Surgery	5,552
	Pinehill Surgery	3,625
	Riverside Partnership	5,712
	Rowlands Castle	3,985
	Swan Surgery	13,545
	The Clanfield Surgery	7,727
	The Grange Surgery	7,558
Total		**64,402**
Gosport	Bridgemary Medical Centre	8,631
	Rowner health Centre	6,880
	Stoke Road Medical Centre	8,458
	Brune Medical Centre	8,838
	Brockhurst Medical Centre	4,574
	Lee on Solent Health Centre	6,596
	Manor Way Surgery	4,782
	Forton Medical Centre	9,497
	Waterside Medical Centre	11,911
	Bury Road	4,069
	Gosport Health Centre	9,107
Total		**83,343**
Havant, Hayling Island and Emsworth	The Homewell & The Curlew Practice	15,451
	The Staunton Surgery	8,020
	Middle Park Surgery/Park Lane Medical Centre	8,210
	Emsworth Surgery	13,074
	Bosmere Medical Centre	17,918
	The Elms	9,244
	Waterside Medical Practice	8,430
Total		**80,347**
Waterlooville	Stakes Lodge	7,537
	Denmead Health Centre	9,109
	Forest End	20,429
	Cowplain Family Practice	9,031
	Queenswood Surgery	4,586
	Village Practice	4,373
Total		**55,065**
Fareham	Portchester Health Centre	8,993
	Whiteley	13,111
	Centre Practice	14,596

	Gudgeheath	8,375
	Jubilee	9,401
	Stubbington	13,136
	Highlands	15,902
	Westlands	10,164
	Lockswood	13,344
	Brook Lane	11,546
Total		**118,568**
Eastleigh	North Baddesley Surgery	6,991
	Park & St Francis Surgery	14,952
	St Andrews Surgey	9,104
	Abbeywell Surgery	18,972
	Brownhill Surgery	6,983
	Alma Road Surgery	12,871
	Fryern Surgery	9,579
	Archers Practice	6,976
	Parkside Practice	11,259
	Boyatt Wood Surgery	5,592
Total		**103,279**
Eastleigh Southern Parishes	West End Surgery	7,536
	Blackthorn Surgery	12,412
	Hedge End Medical Centre	13,336
	Bursledon Surgery	3,732
	St Lukes	12,849
Total		**49,865**
SW New Forest and Avon Valley	Chawton House	6,976
	Barton Webb Peploe	10,570
	Lyndhurst	5,279
	New Forest Medical Group	7,664
	New Milton Health Centre	9,915
	Arnewood	13,294
	Wisteria and Milford	15,252
	Ringwood Medical Centre	11,236
	Fordingbridge Surgery	12,652
	Cornerways Medical Centre	11,894
	Twin Oaks Medical Centre	4,184
Total		**108,916**
Totton & Waterside	Testvale Surgery	13,067
	Totton Health Centre	11,636
	Forest Gate Surgery	13,401
	Forestside Practice	11,057
	Red & Green	24,455
	Waterfront	7,124
Total		**80,740**
Winchester	St Clements Surgery	16,982
	St Paul's Practice	16,626
	Friarsgate Surgery	24,399

	The Alresford Surgery	9,600
	Watercress Medical	7,185
	West Meon Surgery	2,497
	Bishops Waltham Surgery	12,853
	Stokeswood Surgery	16,995
	Twyford Surgery	9,554
	Wickham Surgery	12,186
	Adelaide Medical Centre	9,001
	Andover Health Centre	14,043
	Charlton Hill Surgery	11,590
	Derry Down Clinic	2,810
	Shepherds Spring Surgery	10,966
	St Marys Surgery	11,949
	Gratton Surgery	6,640
	Stockbridge Surgery	9,015
	Whitchurch Surgery	5,493
Total		**210,384**
Southampton East	Bath Lodge Practice	12,452
	Bitterne Park Surgery	8,845
	Chessel Practice Branch Surgery	12,695
	The Old Fire Station Surgery	8,466
	St Peter's Surgery	5,182
	Ladies Walk Practice Branch Surgery	8,396
	Townhill Surgery	5,379
	Weston Lane Surgery	9,250
	Woolston Lodge Surgery branch surgeries	13,686
	Spitfire Court Surgery and Canute Surgery	4,604
Total		**88,955**
Southampton West	Adelaide GP Surgery	4,414
	Aldemoor Surgery	8,202
	Atherley House Surgery	4,659
	Brook House Surgery	4,498
	Cheviot Road Surgery	15,274
	Grove Medical Centre	10,042
	Hill Lane Surgery	8,130
	Lordshill Health Centre	10,480
	Raymond Road Surgery	3,682
	Regents Park Surgery	5,689
	Victor Street Surgery	12,313
Total		**87,383**
Southampton Central & North	Alma Road Surgery	10,091
	Bargate Medical Centre	4,131
	Burgess Road Surgery	8,787
	Highfield Health	4,099
	Homeless Healthcare Team	507
	Mulberry House Surgery	6,107
	Nicholstown Surgery	4,468

	Portswood Solent Surgery	5,001
	St Mary's Surgery	23,290
	Stoneham Lane Surgery	6,405
	University Health Service	15,106
	Walnut Tree Surgery	3,601
Total		**91,593**
North Hampshire	Bentley Village Surgery	3,376
	Boundaries Surgery	3,664
	Bramblys Grange Medical Practice	11,670
	Camrose Medical Partnership	11,473
	Chawton Park Surgery	9,615
	Clift Surgery	6,444
	Crown Heights	24,555
	Gillies Health Centre	19,866
	Kingsclere Medical Practice	5,560
	Oakley & Overton Partnership	11,178
	Odiham Health Centre	10,984
	Beggarwood Surgery	7,341
	Bermuda & Marlowe Practice	13,561
	The Chineham Medical Practice	11,759
	The Hackwood Partnership	13,440
	The Rooksdown Practice	6,558
	The Tadley Medical Partnership	19,640
	The Wilson Practice	14,075
	Whitewater Health	17,019
Total		**221,778**

Appendix 5: Local Metrics Data and Commentary

Table A Local metrics – data quality and performance

Metric	Care pyramid	Progress Rating (Coded)	Quality Rating		Q3 Data Note (commentary from RSM PACEC)	Q4 Data Note (commentary from RSM PACEC)
			Q3	Q4		
% of patients have their issues resolved on the same day following contact with primary care	Urgent care needs (SDAS)	On track	2	3	● Q3 Gosport Data is encouraging given target (see below). ● *Quality rating rationale:* Target previously set: min. 40% of patients have their primary care issues resolved remotely on the same day (extracted from RSM PACEC's Landscape Review based on desk research across project logic models). ● *Plans for improving data quality:* consider adjusting target upwards; additional data now required to evidence spread.	● New data now available for SWNF evidencing spread ● SWNF data suggests 40% target appropriate for early stages of intervention ● SWNF target should remain at 40% through Q1 2017 ● Gosport target should be set at 75% from Q1 2017 onwards
% patients 'satisfied' or 'very satisfied' with the service	Whole population	On track	2	2	● High patient satisfaction across majority of localities. Only H, HI&E below target. ● Quality rating rationale: Target set (85% extracted from Landscape Review based on desk research across project logic models). Benchmarkable with GP Patient Survey. Target deemed appropriate. ● Plans for improving data quality: RSM to consider additional metric better able to evidence 'access to services' in particular.	● H,HI&E percentage moved to above target in Q4 ● SWNF demonstrates consistent performance at 100% (significant survey numbers) ● Check Totton & Waterside data (0% despite survey responses)
Number of first attendances at A&E (all A&E types)	Urgent care needs	Possibly deterior-ating	2	1	● YTD decrease of 3% not being achieved and may need revision. ● Quality rating rationale: Target set, but data only available for Q2. Cannot determine % change from data in time for this review, but majority practices not achieving target. ● Plans for improving data quality: RSM to consider additional metric that better illustrates change over time.	● IG issues mean Q4 data not reported
% of attendances coded VB11Z (no investigation, no	Whole population	No evidence	2	1	● YTD decrease of has not been achieved by most localities. However, Andover (-52.8%) and East Hampshire (-12.8%) are key outliers re reductions.	● IG issues mean Q4 data not reported

Metric	Care pyramid	Progress Rating (Coded)	Quality Rating		Q3 Data Note (commentary from RSM PACEC)	Q4 Data Note (commentary from RSM PACEC)
			Q3	Q4		
significant treatment)		of change			Eastleigh Southern Parishes has had a 28.2% increase YTD - potential flag. The MEDIAN increase is 4.7% across localities (based on %s, not absolute). ● RSM to consult locality leads in Andover and Hants to understand potential reasons for strong performance. ● Data quality rationale: Target set to achieve year on year reduction, however data only available for Q3.	
% patients who say they no longer needed a face to face GP appointment	Urgent care needs	No evidence of change	2	3	● Strong performance against target across majority of localities with exception of Southampton Central which is slightly odd given Southampton Central demographic. ● RSM PACEC to consult with Southampton Central representative to understand reasons for comparatively low performance. ● Data quality rationale: Target set at 8%, baseline can be accessed. ● Plans for improving data quality: RSM to access baseline data and adjust target upwards.	● Coverage of data improved in Q4 ● Notable increase in Southampton Central performance (from below to above target) ● Improving performance across all localities except Fareham
Number of new care pathways developed and implemented for long-term conditions	Ongoing care needs	On track	1	1	● Applicable to: Respiratory model of care (East Hants), Diabetes model of care (New Forest). Paediatric and pharmacy in development - Q3 highlights 24 pathways ● *Data quality rationale*: metric not particularly meaningful. ● *Plans for improving data quality*: RSM to discuss with HBLC evaluation lead to understand objective and identify alternative measure.	● Number of new pathways continuing to increase ● Confirm objective in line with 17/18 objectives (narrower focus, fewer pathways)
LTC population identified and risk stratified. Inc diabetes, COPD, CVD	Ongoing care needs	No evidence of change	1	1	● Little insight available from current metric. ● Applies to respiratory model of care (East Hants), diabetes model of care (New Forest). Paediatric and pharmacy in development. ● *Data quality rationale:* metric not particularly meaningful. ● *Plans for improving data quality:* As a minimum adjust target to e.g. % localities that have identified LTC	● New risk stratification in SWNF ● Risk stratification to happen in Gosport and Fareham as a priority based on 17/18 objectives. ● Risk stratification of populations in other localities should be a priority beyond BLC as part of STP workplans

Metric	Care pyramid	Progress Rating (Coded)	Quality Rating		Q3 Data Note (commentary from RSM PACEC)	Q4 Data Note (commentary from RSM PACEC)
			Q3	Q4		
					population using agreed risk stratification tool.	
Number of people have their complex clinical needs optimised	Ongoing care needs	On track	1	1	● Applicable to respiratory model of care (East Hants), Diabetes model of care (New Forest). Paediatric and pharmacy in development, home visiting model (Fareham & N. Hants). According to Q3 data, appears that 855 have had clinical care needs optimised. ● Data Quality rating rationale: Target has been set as "600 people with complex needs have their care optimised" (extracted from Landscape Review based on desk research across project logic models). ● Plans for improving data quality: RSM to explore potential of new indicator better able to track comparative changes with HBLC evaluation lead. RSM PACEC to explore potential for linkage with risk stratification data.	● New baseline data available in Q4 ● Clarification required regarding very small numbers reported in Hayling, Eastleigh North and Totton
Proportion of complex needs patients with improved quality of life post intervention.	Ongoing care needs	Data not available	1	1	● Applicable to respiratory model of care (East Hants), Diabetes model of care (New Forest). No data available. ● Plans for improving data quality: RSM PACEC currently working with locality leads on deep dive evaluation studies - data to be identified and extracted from that process by mid-February.	● Still very little data available ● Single figure included in dashboard for Eastleigh North (50) requires clarification ● Patient data extracted from Deep Dives in March 2017
Percentage of patients with LTCs who feel ‘very confident in managing their own health'	Ongoing care needs	Data not available	1	1	Respiratory model of care (East Hants), Diabetes model of care (New Forest). Links with Surgery Signposters / care navigators. No data available. ● Plans for improving data quality: RSM currently working with locality leads on deep dive evaluation studies - data to be identified and extracted from that process by mid-	● Still very little data available ● New data available for Gosport and East Hants but one may be a duplicate given identical figures (100%, n=32) ● Patient data extracted from Deep Dives in March 2017

Metric	Care pyramid	Progress Rating (Coded)	Quality Rating		Q3 Data Note (commentary from RSM PACEC)	Q4 Data Note (commentary from RSM PACEC)
			Q3	Q4		
					February.	
# primary care practices live with MIG	Technology enabler	Doing ok	2	2	● Positive upward trend in Q3, 69 practices (out of 129, 53% live with MIG), compared to 29 in Q1/Q2 (22%). Consultation with locality lead has highlighted lack of capacity within practices as key barrier to fuller uptake once system has gone live. RSM PACEC to explore as part of deep dive study. ● *Data quality rationale*: Time bound target of 100% originally set. Data available from Q2. Metric is appropriate for understanding reach / spread but additional metric required for outcomes. ● *Plans for improving data quality*: RSM programme-wide staff survey includes specific questions regard technology enablers including MIG therefore data on staff experience will be available.	● Overall numbers of practices being sustained in most localities ● SWNF number down from 3 to 0 - find out why ● One or two new practices live in Havant and Waterlooville ● 5 new practices live in Eastleigh Southern Parishes which is significant ● Significant drop in numbers reported in SWNF (check data) ● Limited response from staff engaged with MiG to staff survey
# Care homes receiving regular structured in-reach	High care needs	Doing ok	1	1	● 13 care homes in Q3 compared to 10 in Q1 - although only in Havant and SWNF. ● *Data quality rationale*: Metric appropriate to evidence spread but not particularly insightful beyond. ● *Plans for improving data quality*: RSM has included frailty projects for deep dive study and will seek further insights.	● Significant increase in SWNF figure ● Havant & HI numbers sustained ● Hayling Care Homes report in preparation
Number of emergency admissions by residents of care homes	High care needs	Possibly deteriora-ting	2	1	● "Havant and Gosport localities. Links with home visiting models of care" - Data available for Q2 period. Q3 data has no underlying data - therefore only examining performance of Q2 vs the previous year. - Of the available data, 6 localities performed better, and 8 worse - mixed performance ● *Data quality rationale*: Metric appropriate, targets to be	● Data on hold due to IG issues

Metric	Care pyramid	Progress Rating (Coded)	Quality Rating		Q3 Data Note (commentary from RSM PACEC)	Q4 Data Note (commentary from RSM PACEC)
			Q3	Q4		
					set in agreement between RSM and HBLC.	
Number of people identified as pre-frail and frail with a care plan.	High care needs	Doing ok	1	2	● No data available. ● *Plans for improving data quality*: RSM has included frailty projects for deep dive study and will seek further insights.	● Some data now available reflecting frailty clinics in Eastleigh ● RSM PACEC Eastleigh Frailty Report available in draft and Hayling Care Homes report in preparation
Number of emergency admissions for falls	High care needs	Doing ok	2	1	● 8 performing better (reduction) and 6 have had an increase number from the localities regarding reduction in number of emergency admissions. ● Plans for improving data quality: RSM PACEC have included frailty projects for deep dive study and will seek further insights.	● Data on hold due to IG issues
Number of lifestyle behaviour change outcomes (smoking quitters, 5%weight loss)	Whole population	Data not available	1	1	No data collected/reported. RSM PACEC liaising with lead.	● No data available
# frontline workers trained in MECC through the MCP programme	Physical / staff enablers	Data not available	1	2	No data collected/reported. RSM PACEC liaising with lead.	● Some data now available for Gosport and SWNF ● Deep Dive evaluation report for MECC in Gosport drafted
# patients signposted to social support by surgery signposters/care navigators	Prevention	Doing ok	1	2	Data exists re Surgery Signposters. Limited elsewhere. Number of patients signposted has doubled between Q2 and Q3.	● More moderate increases in Gosport in Q4 ● Data available for other localities suggesting spread to

Appendix 6: Access Metrics (Theme 1)

Access – local metrics

Locality	Quarter (2016)	% of attendances coded VB11Z	% patients who say they no longer needed a face to face GP appointment
Gosport	Q2	6.3%	
	AT	No	
	Q3		14.26%
	AA		Yes
	Q4	IG	18.50%
Fareham	Q2	13.8%	
	AT	No	
	Q3		36.47%
	AA		Yes
	Q4	IG	33%
East Hampshire	Q2	-12.0%	
	AT	Yes	
	Q3		18%
	AA		Yes
	Q4	IG	23.20%
Havant, Hayling Island and Emsworth	Q2	-1.5%	
	AT	Yes	
	Q3		20.30%
	AA		Yes
	Q4	IG	23.90%
Waterlooville	Q2	0.4%	
	AT	No	
	Q3		23.25%
	AA		Yes
	Q4	IG	25.60%
Andover	Q2	-52.6%	

Locality	Quarter (2016)	% of attendances coded VB11Z	% patients who say they no longer needed a face to face GP appointment
	AT	Yes	
	Q3		12.50%
	AA		Yes
	Q4	IG	14.70%
Eastleigh North and Test Valley South	Q2	11.2%	
	AT	No	
	Q3		
	AA		No
	Q4	IG	24.30%
Eastleigh Southern Parishes	Q2	28.2%	
	AT	No	
	Q3		35.71%
	AA		Yes
	Q4	IG	36.20%
Mid Hants Rural	Q2	-0.9%	
	AT	Yes	
	Q3		
	AA		No
	Q4	IG	21.5%
South West New Forest and Avon Valley	Q2	1.5%	
	AT	No	
	Q3		18.19%
	AA		Yes
	Q4	IG	18.90%
Totton and Waterside	Q2	5.2%	
	AT	No	
	Q3		17.94%
	AA		Yes
	Q4	IG	20.60%

Locality	Quarter (2016)	% of attendances coded VB11Z	% patients who say they no longer needed a face to face GP appointment
Southampton Central	Q2	5.0%	
	AT	No	
	Q3		5.36%
	AA		No
	Q4	IG	10.20%
Southampton East	Q2	25.8%	
	AT	No	
	Q3		
	AA		No
	Q4	IG	Not available
Southampton West	Q2	4.4%	
	AT	No	
	Q3		
	AA		No
	Q4	IG	Not available

Appendix 7: Delayering Metrics (Theme 2)

Theme 2: Delayering – Local Metrics

Locality	Quarter	Number of new care pathways developed & implemented for long-term conditions	LTC population identified and risk stratified. Inc diabetes, COPD, CVD	No. people have their complex clinical needs optimised	Proportion of complex needs patients with improved Quality of Life post-intervention	Percentage of patients with LTCs who feel 'very confident in managing their own health'
Gosport	Q2	0	0	0		
	Q3	0	0	0		
	Q4	0	0	0		100% (n=32)
Fareham	Q2	0	0	0		
	Q3	0	0	0		
	Q4	0	0	0		
East Hampshire	Q2	0	23000	0		
	AT		Identified			
	Q3	5	23000	164		
	Q4	13	23000	328		100% (n=32)
Havant, Hayling Island and Emsworth	Q2	0	23000	0		
	Q3	6	23000	14		
	Q4	11	23000	28		
Waterlooville	Q2	0	23000	0		
	Q3	6	23000	664		
	Q4	11	23000	1000		
Andover	Q2	0	0	0		
	Q3	0	0	0		
	Q4	0	0	0		
Eastleigh North and Test Valley South	Q2	0	0	0		
	Q3	0	0	4	0.5	
	Q4	0	0	4		

Locality	Quarter	Number of new care pathways developed & implemented for long-term conditions	LTC population identified and risk stratified. Inc diabetes, COPD, CVD	No. people have their complex clinical needs optimised	Proportion of complex needs patients with improved Quality of Life post-intervention	Percentage of patients with LTCs who feel ‘very confident in managing their own health'
Eastleigh Southern Parishes	Q2	0	0	0		
	Q3	0	0	0		
	Q4	0	0	0		
Mid Hants Rural	Q2	0	0	0		
	Q3	0	0	0		
	Q4	0	0	0		
South West New Forest and Avon Valley	Q2	0	0	0		
	Q3	6	163	186		
	Q4	11	9519	510		
Totton and Waterside	Q2	0	0	0		
	Q3	1	0	1		
	Q4	0	0	1		

Appendix 8- Extended Primary Care Team Metrics (Theme 3)

Theme 3: Extended Primary Care Teams – Local Metrics

Locality	Quarter	Number primary care practices live with MIG	Number care homes receiving regular structured in-reach	Number of emergency admissions by residents of care homes	Number of emergency admissions for falls
Gosport	Q2	10	0	76	69
	AT			No	Yes
	Q3	11	0	0	0
	AA			No	No
	Q4	11			
Fareham	Q2	5	0	118	110
	AT			Yes	Yes
	Q3	10	0	0	0
	AA			No	No
	Q4	10			
East Hampshire	Q2	9	0	57	96
	AT			No	No
	Q3	9	0	0	0
	AA			No	No
	Q4	9			
Havant, Hayling Island and Emsworth	Q2	3	10	72	90
	AT			Yes	Yes
	Q3	4	10	0	0
	AA			No	No
	Q4	5	10		
Waterlooville	Q2	2	0	58	62
	AT			No	Yes
	Q3	2	0	0	0
	AA			No	No

Locality	Quarter	Number primary care practices live with MIG	Number care homes receiving regular structured in-reach	Number of emergency admissions by residents of care homes	Number of emergency admissions for falls
	Q4	3			
Andover	Q2	0	0	44	69
	AT			No	No
	Q3	5	0	0	0
	AA			No	No
	Q4	5			
Eastleigh North and Test Valley South	Q2	0	0	114	161
	AT			Yes	No
	Q3	7	0	0	0
	AA			No	No
	Q4	8			
Eastleigh Southern Parishes	Q2	0	0	85	71
	AT			No	Yes
	Q3	4	0	0	0
	AA			No	No
	Q4	9			
Mid Hants Rural	Q2	0	0	75	104
	AT			No	No
	Q3	0	0	0	0
	AA			No	No
	Q4	0			
South West New Forest and Avon Valley	Q2	0	0	237	213
	AT			No	Yes
	Q3	11	3	0	0
	AA			No	No
	Q4	0	15		

Locality	Quarter	Number primary care practices live with MIG	Number care homes receiving regular structured in-reach	Number of emergency admissions by residents of care homes	Number of emergency admissions for falls
Totton & Waterside	Q2	0	0	82	143
	AT			Yes	Yes
	Q3	6	0	0	0
	AA			No	No
	Q4	6			
Southampton Central	Q2			121	129
	AT			No	No
	Q3			0	0
	AA			No	No
	Q4				
Southampton East	Q2			126	187
	AT			Yes	Yes
	Q3			0	0
	AA			No	No
	Q4				
Southampton West	Q2			73	159
	AT			Yes	No
	Q3			0	0
	AA			No	No
	Q4				

Appendix 9: Local Population Data

Elderly population distribution by locality

The evaluation team has compiled secondary data at practice level, grouping the population at locality level. The figures below present the proportion of registered population that is aged 65 years and over. The England average represents the population in 2015.

Figure A.1: Population aged 65+ and 75+

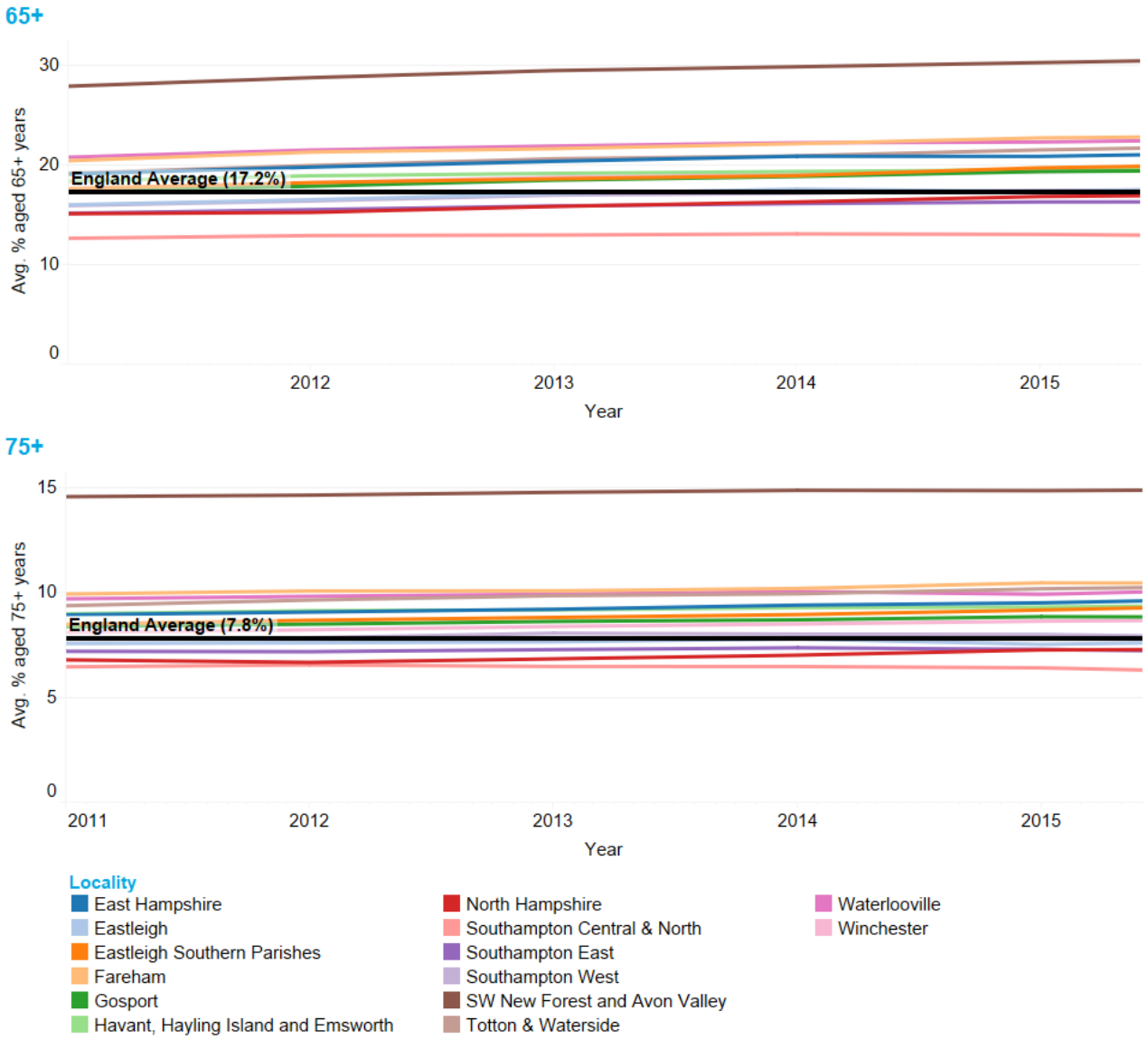


Figure A.1 shows major differences in elderly population across Hampshire, South West New Forest and Avon Valley have a significantly higher proportion of elderly people (aged 65+ and aged 75+) in comparison to all other localities, with a steadily increasing trend from 2011 – 2015.

Population aged 65 and over

North Hampshire, Southampton Central & North, Southampton East and Southampton West have had a noticeably lower proportion of people aged 65 and over between 2011 and 2015, with the lowest proportion of elderly population located in Southampton Central & North. These localities are steadily

converging towards the England average; of the population in Eastleigh, approximately 16 per cent were aged over 65 in 2011 and 17.5 per cent were aged over 65 in 2015. This exceeds the current England average of 17.2 per cent.

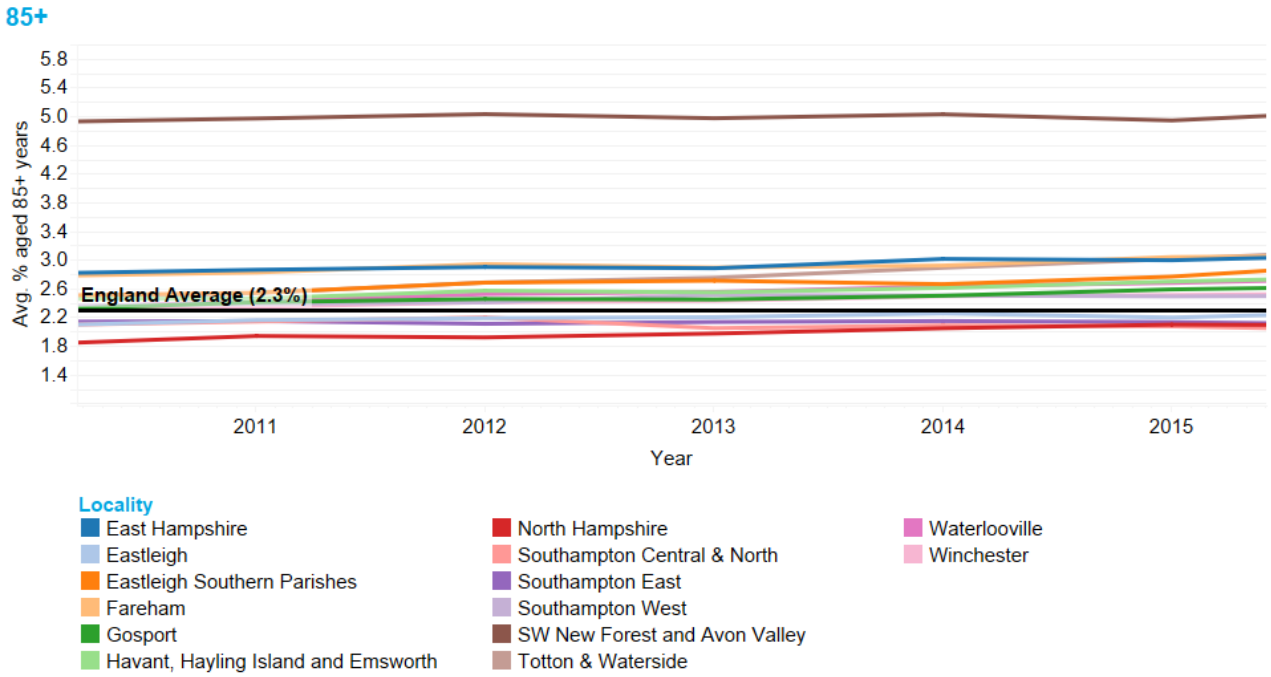
A total of eight localities' population aged over 65 exceeds the national average and these vary in difference. For instance, South West New Forest and Avon Valley exceed the average by over 10 per cent, whilst Gosport and Eastleigh Southern Parishes exceed by roughly 2 per cent. Generally, the trends show all localities to have an increasing proportion of population aged over 65 and most have shown a growth in the proportion of adults aged 65 and over by approximately 2 per cent between 2011 and 2015.

Population aged 75 and over

Similarly to the population aged over 65, Southampton Central & North, North Hampshire, Southampton East and Eastleigh have a proportionately lower population of aged 75 and over in comparison to the other localities. Southampton Central & North and Southampton East show little increase or decrease in the percentage of people aged 75 and over across the four-year period.

Ten localities have a higher percentage of people aged 75 and over than the England average. South West New Forest and Avon Valley have a significantly higher proportion of elderly, at almost double of those with the lowest elderly population. The trends show little difference in the proportion of adults aged over 75 years, with most localities experiencing less than 1 per cent increase over the four-year period.

Figure A.2: Population aged 85 and over



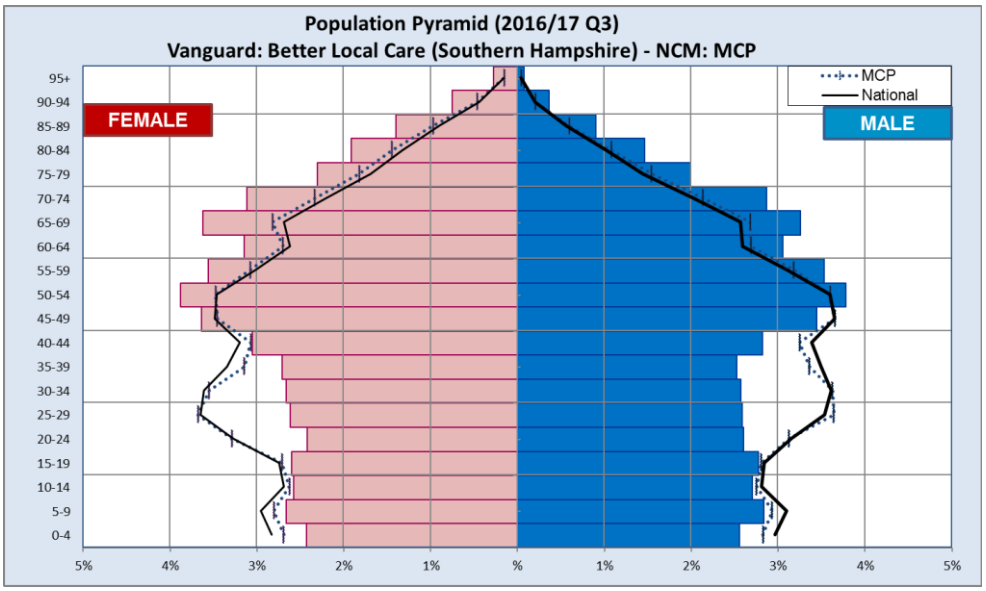
1.1.1 Population aged 85 and over

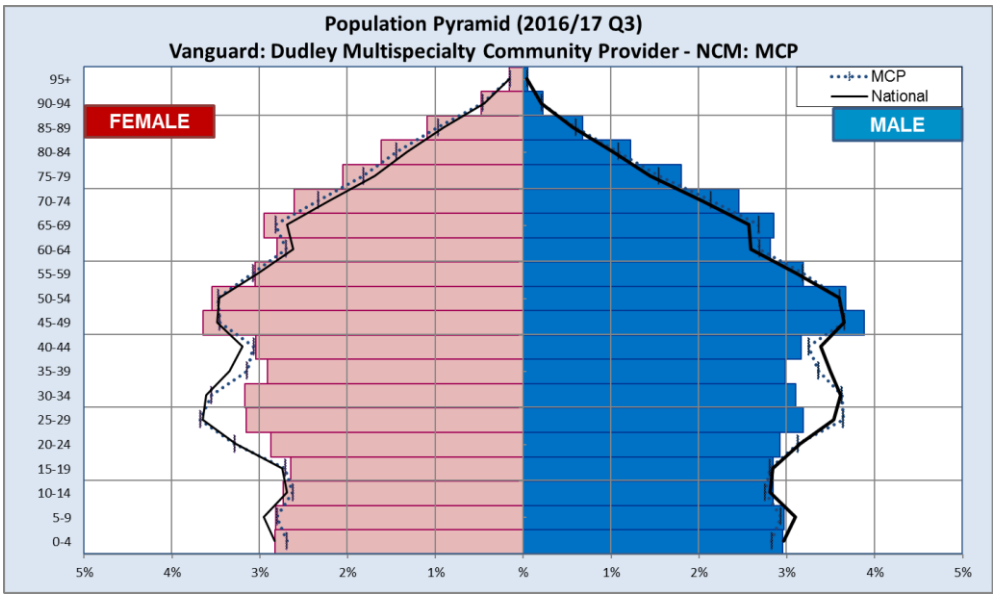
Error! Reference source not found. presents the population aged 85 and over by locality. All

localities hold a 2 to 3 per cent proportion of elderly people aged 85 years or older. Similarly, the localities in Southampton in addition to Eastleigh hold a slightly lower proportion of elderly population, and SW New Forest and Avon Valley hold the highest proportion of adults aged 85 and over. The trends for this age cohort show a slight increase in percentage overtime, although no locality exceeds an increase of 1 per cent.

Appendix 10: MCP Comparison Summaries

Vanguard	Better Local Care (Southern Hampshire)	Dudley Multispecialty Community Provider	Stockport Together
New Care Model:	MCP	MCP	MCP
Number of GP Practices associated with the Vanguard: [2016/17 Q3]	28	46	44
Number of Patients Registered with GP Practices associated with the Vanguard: [2016/17 Q3]	229,664	317,319	303,085
Number of GPs per 1,000 weighted population (Carr Hill formula excluding MFF) [2016/17 Q2]	0.60	0.53	0.58
GP Full Time Equivalent per 1,000 population (Carr Hill formula excluding MFF) [2016/17 Q2]	0.53	0.44	0.43
Number of Care Homes Associated with the Vanguard	Not Applicable	Not Applicable	




Population Pyramid (2016/17 Q3)
Vanguard: Dudley Multispecialty Community Provider - NCM: MCP
MCP
National
FEMALE
MALE
95+
90-94
85-89
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
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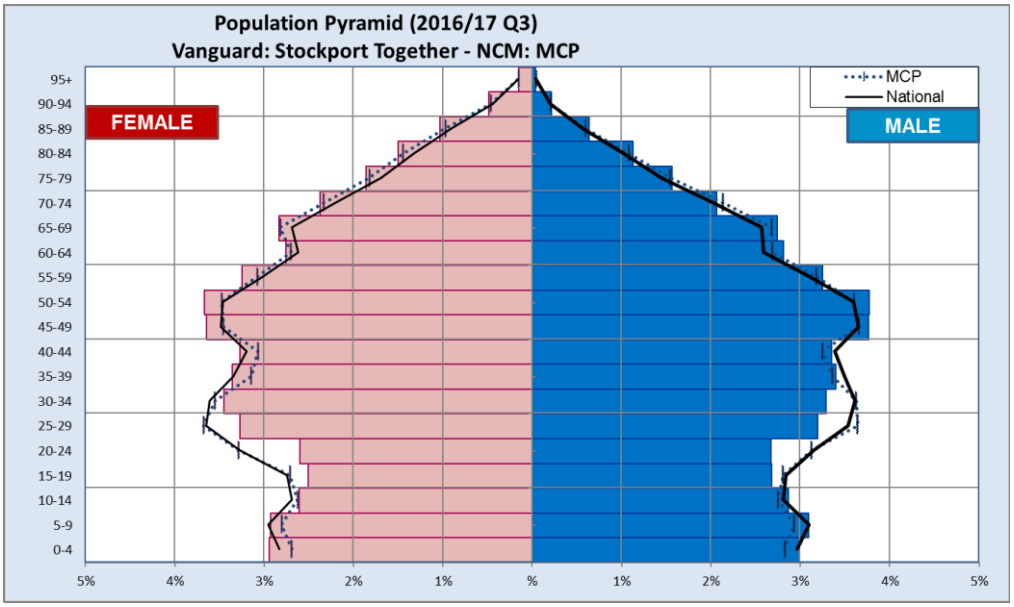
0-4
5%
4%
3%
2%
1%
%
1%
2%
3%
4%
5%


Population Pyramid (2016/17 Q3)
Vanguard: Stockport Together - NCM: MCP
MCP
National
FEMALE
MALE
95+
90-94
85-89
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
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15-19
10-14
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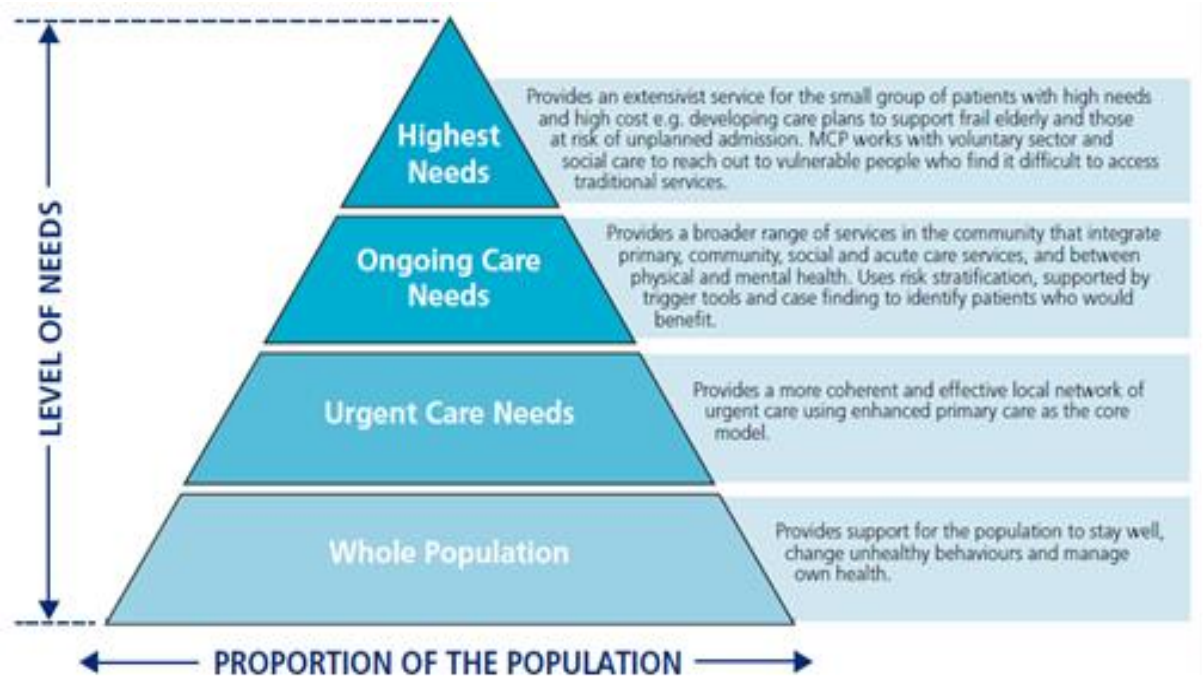
3%
4%
5%

Figure: MCP Care Model



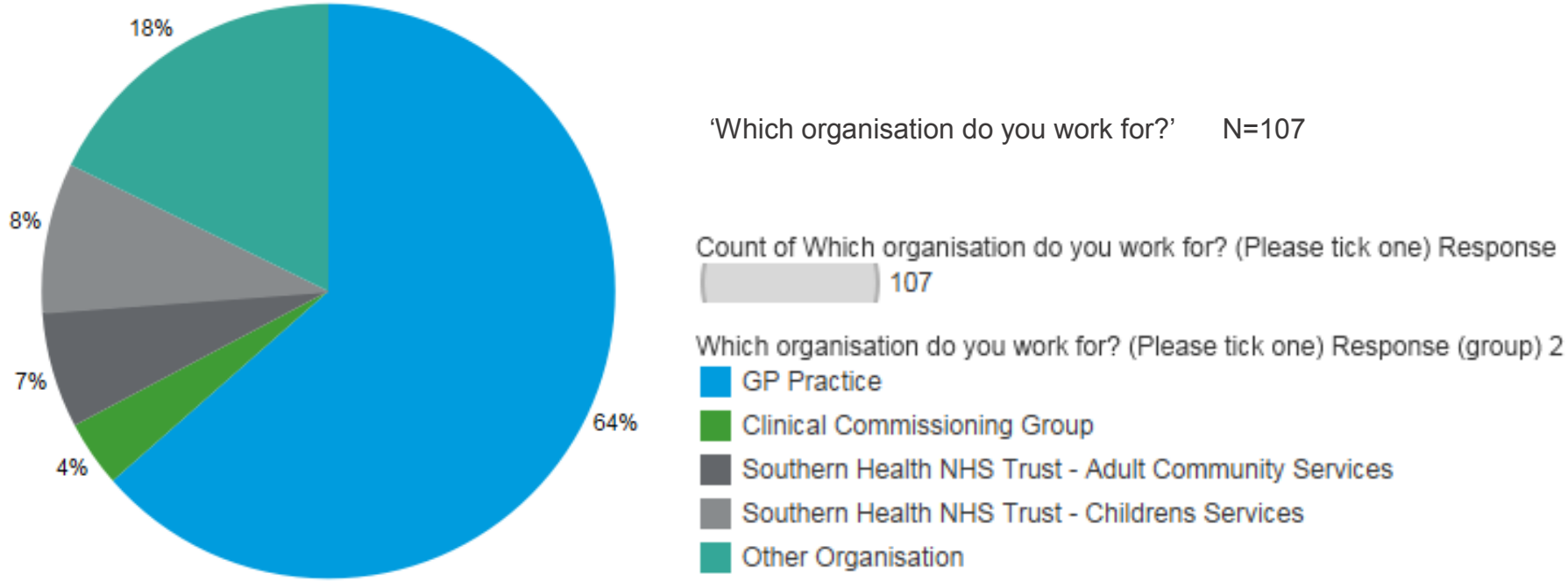
Appendix 11: Staff Survey Summary

1 STAFF SURVEY SUMMARY

1.1 All Respondents

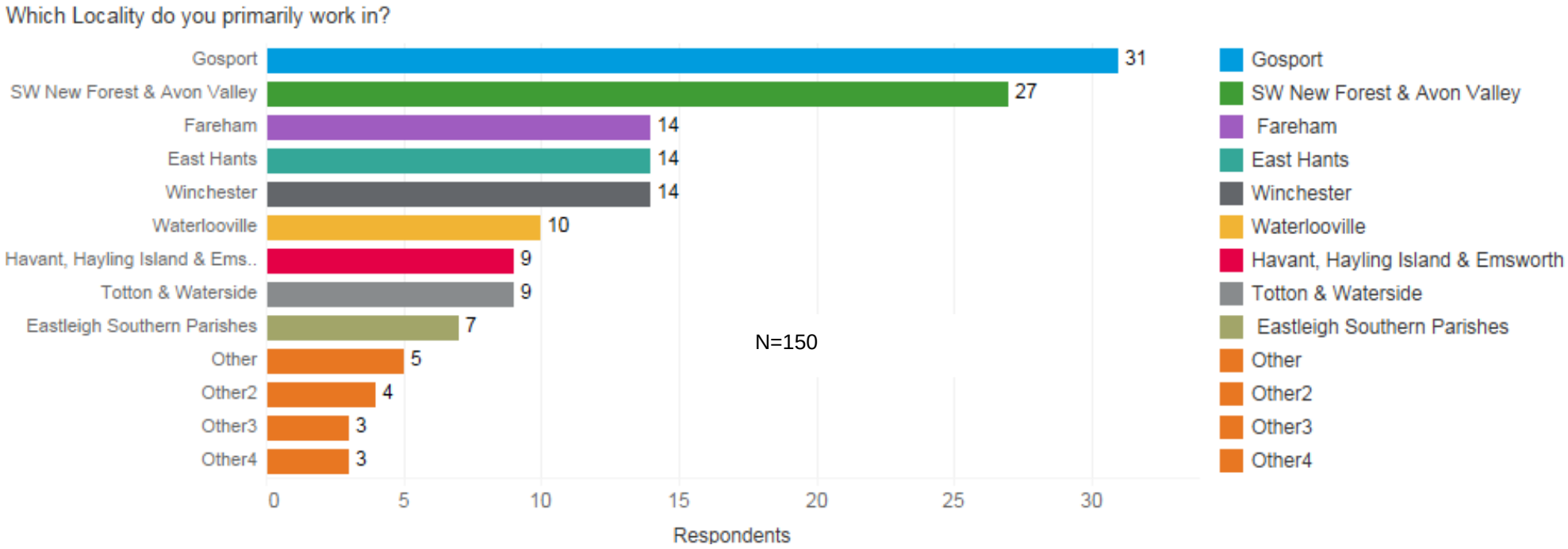
1.1.1 Organisation Details

1.1.1.1 Organisation: 'Which organisation do you work for?'



Source: RSM PACEC Staff Survey (2016)

1.1.1.2 Locality



Source: RSM PACEC Staff Survey (2016)

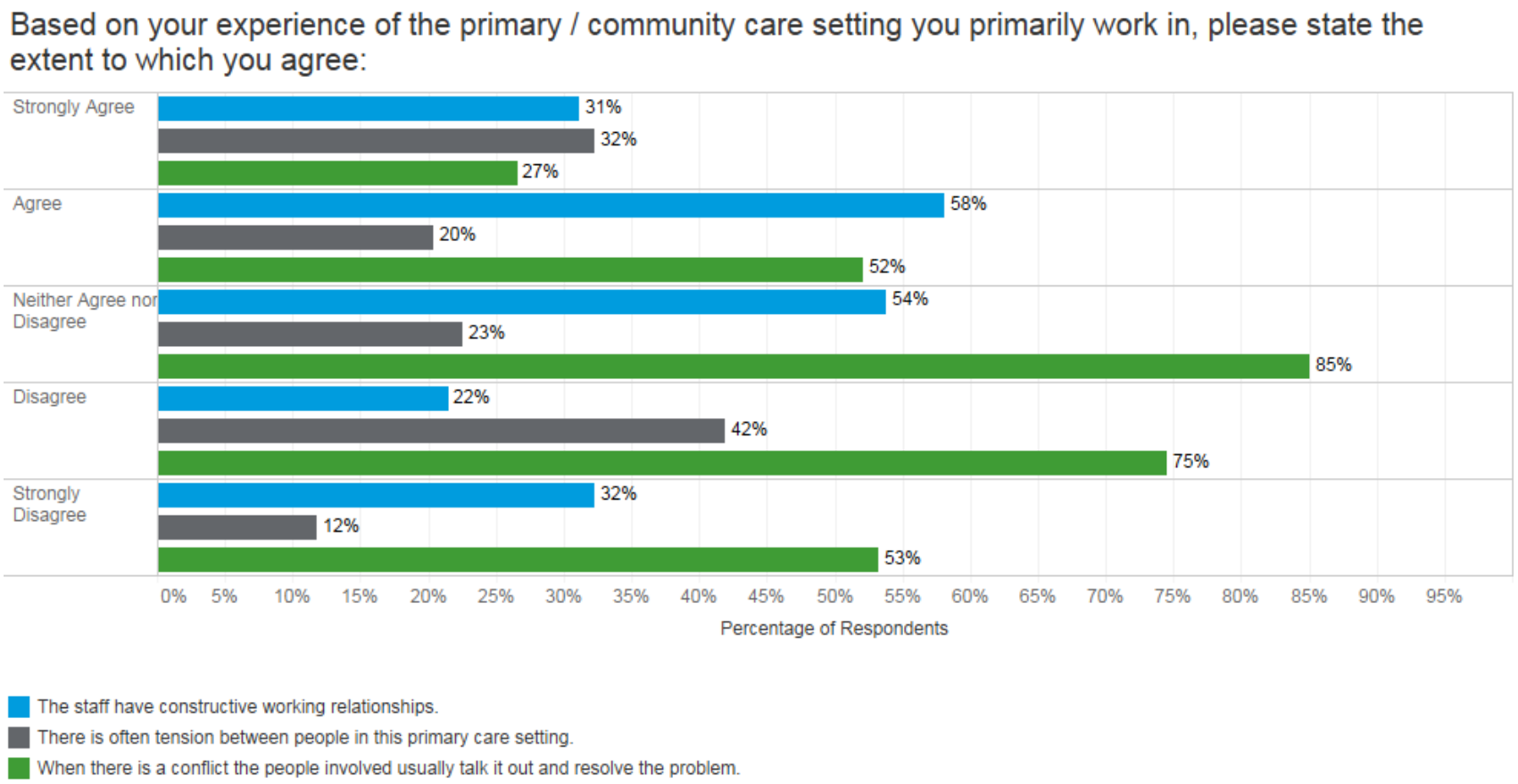
1.1.1.3 Role within Primary/ Community Care

N=102

Source: RSM PACEC Staff Survey (2016)

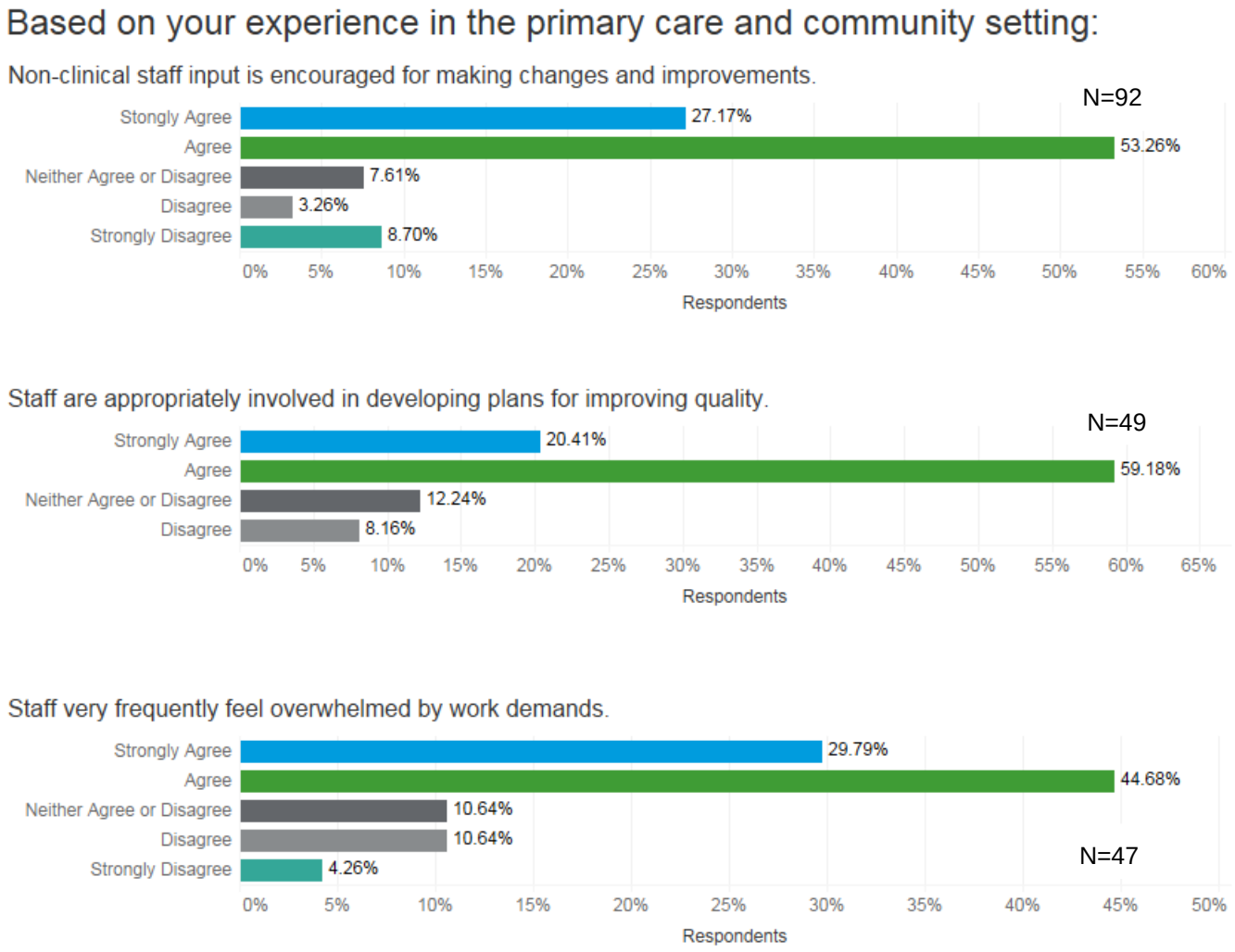
1.1.2 Experience in Primary and Community Care

1.1.2.1 Resolving Conflict



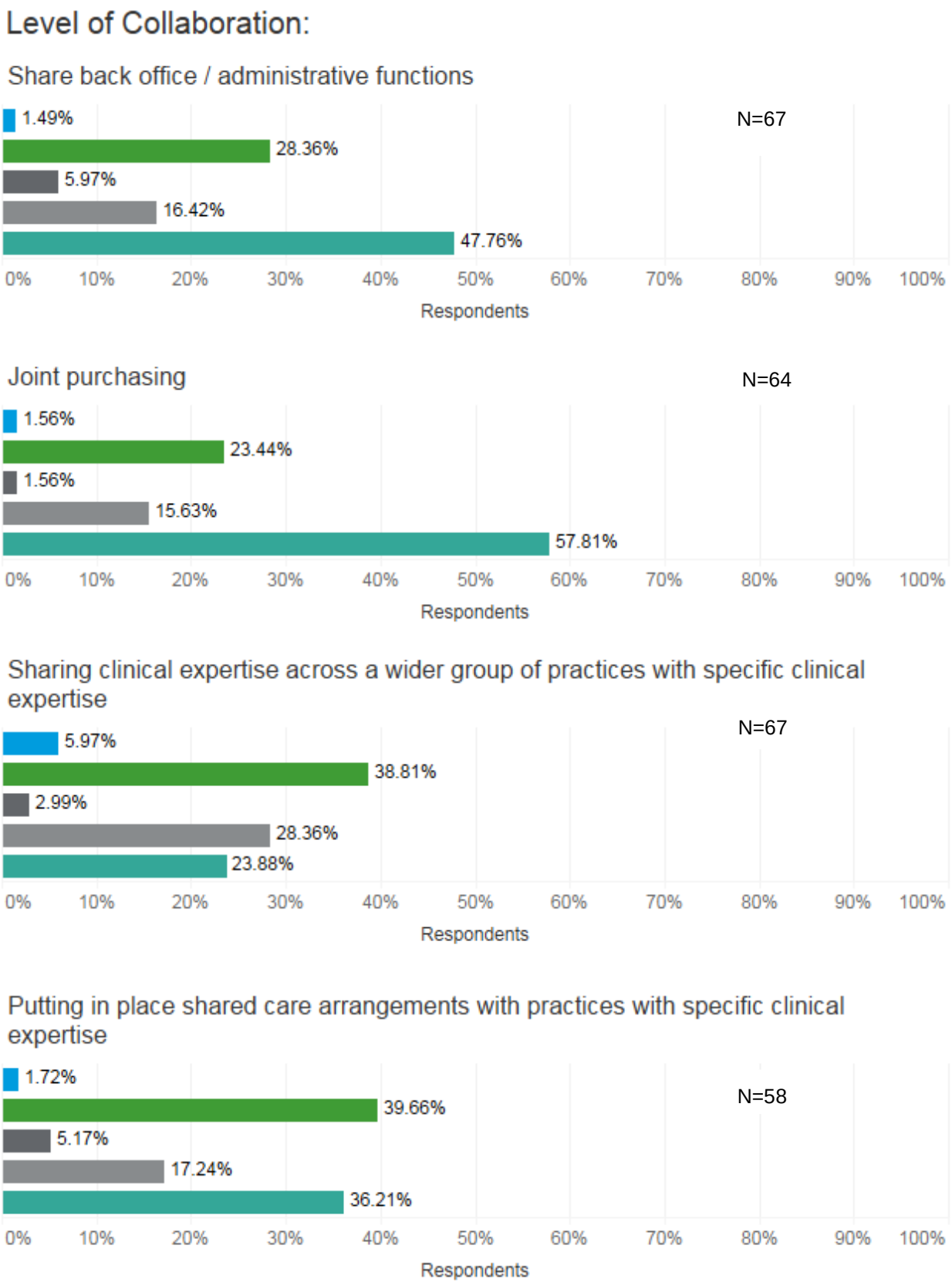
Source: RSM PACEC Staff Survey (2016)

1.1.2.2 Making Changes and Work Demand



Source: RSM PACEC Staff Survey (2016)

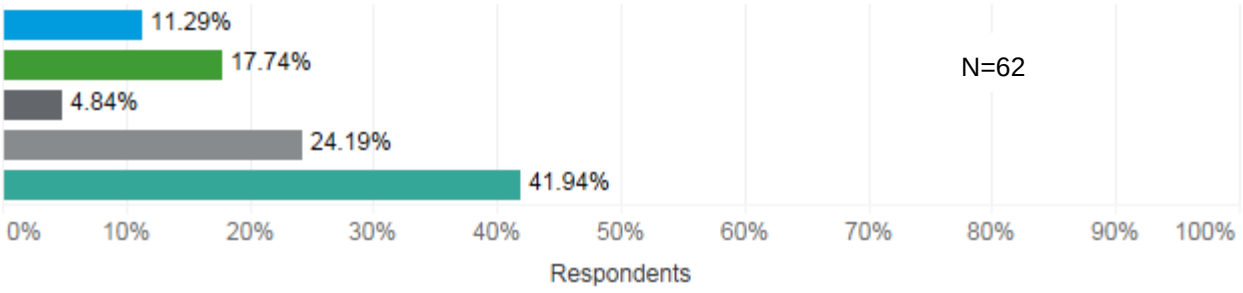
1.1.2.3 Level of Collaboration



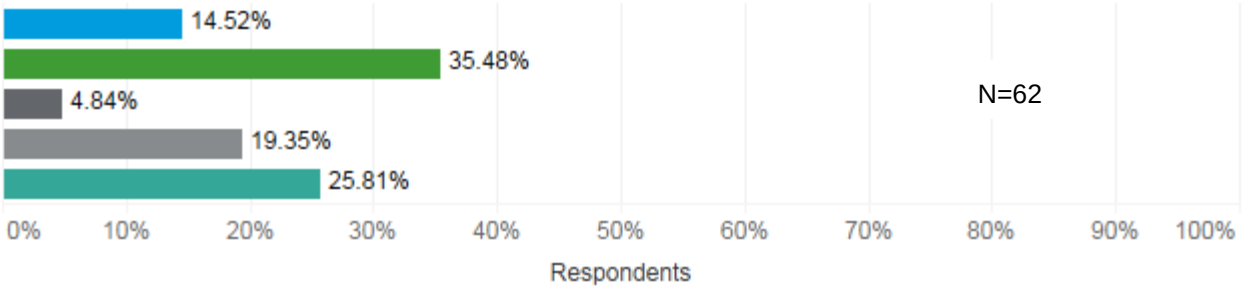
Source: RSM PACEC Staff Survey (2016)

Level of Collaboration:

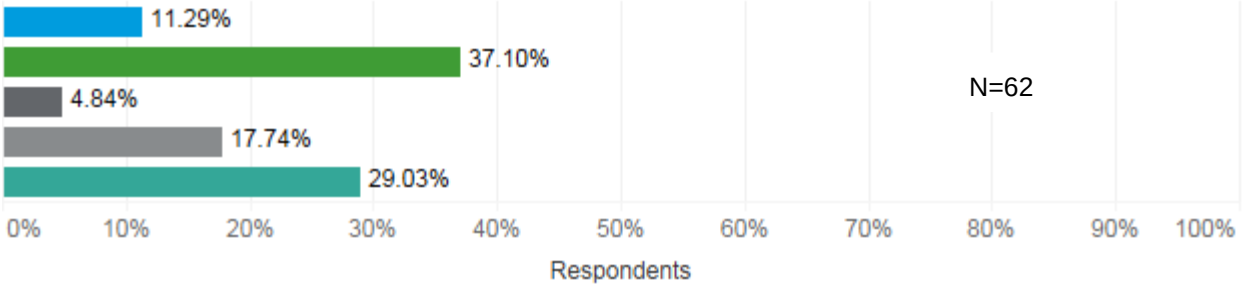
Introducing access to emergency care in a co-ordinated way



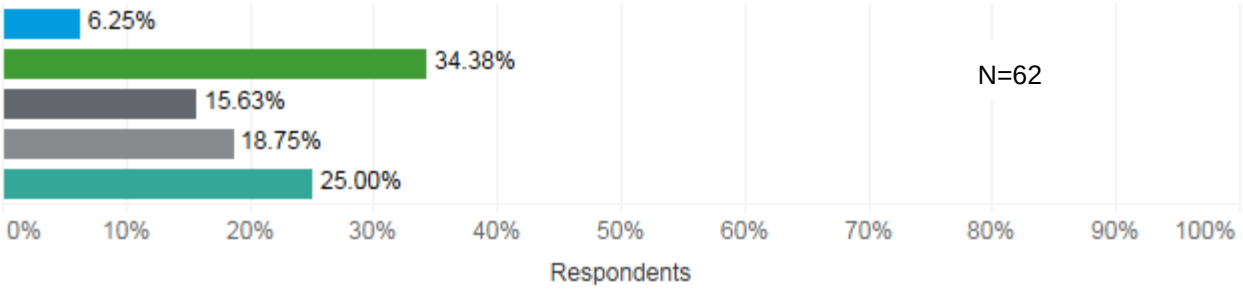
Shared training and education for all clinical staff in general practice

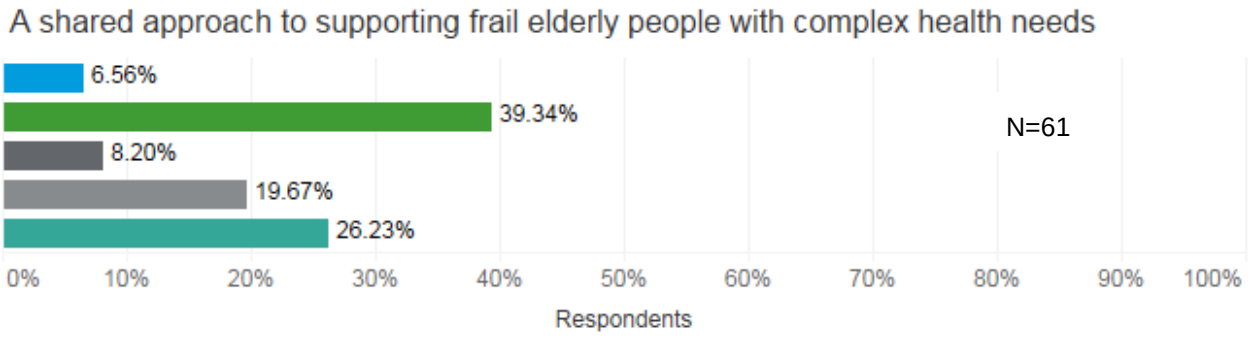


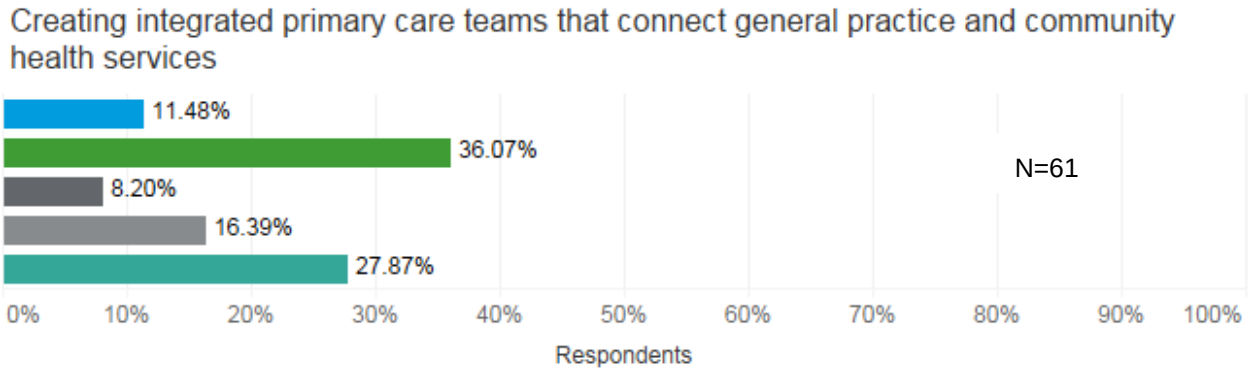
Shared training and education for all non-clinical staff in general practice

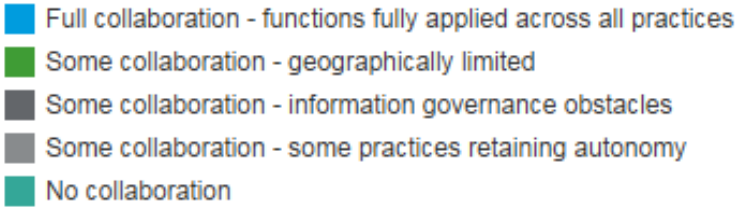


Implementing common information systems so that patient notes can be accessed across all practices, and potentially the wider health and social care system



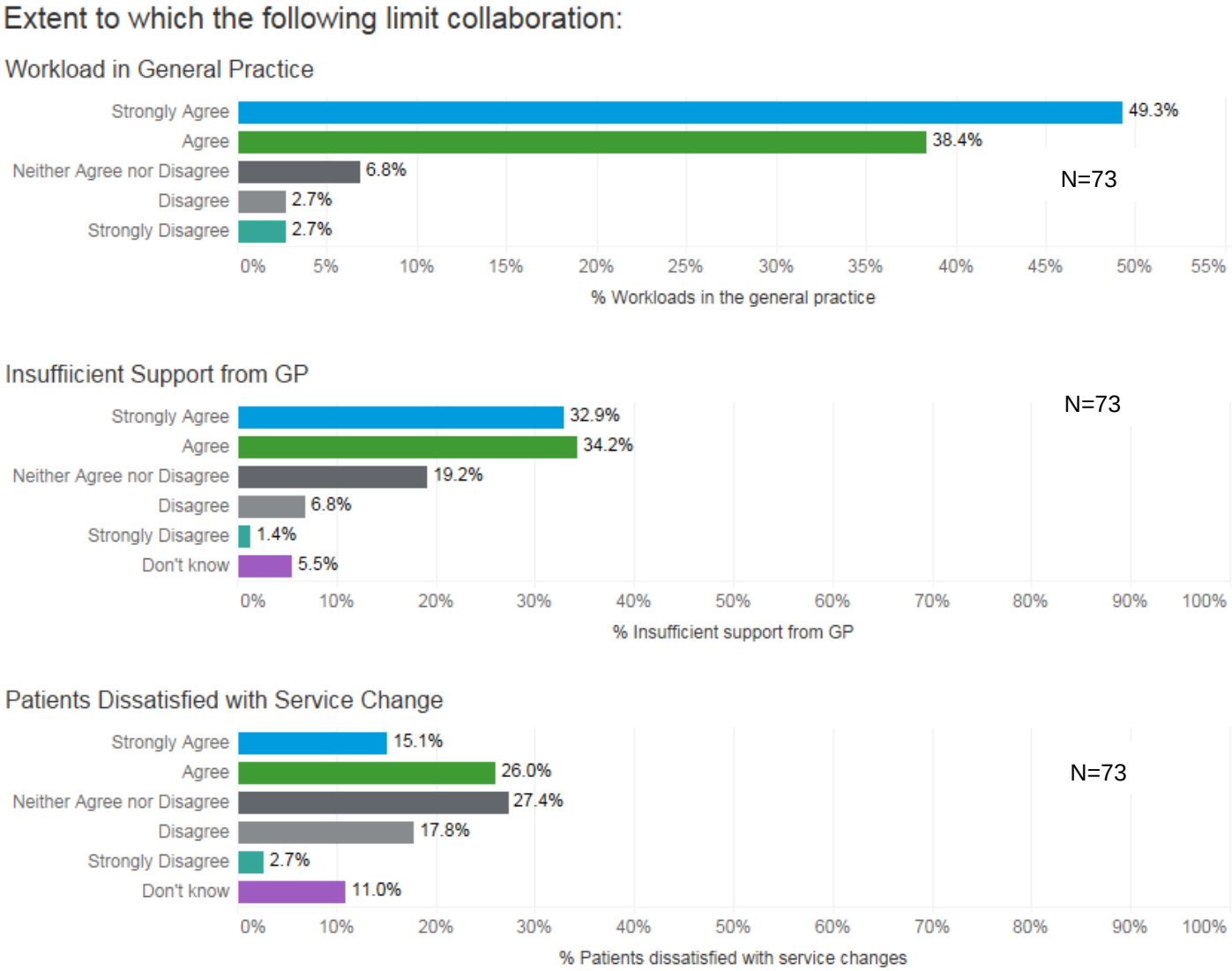


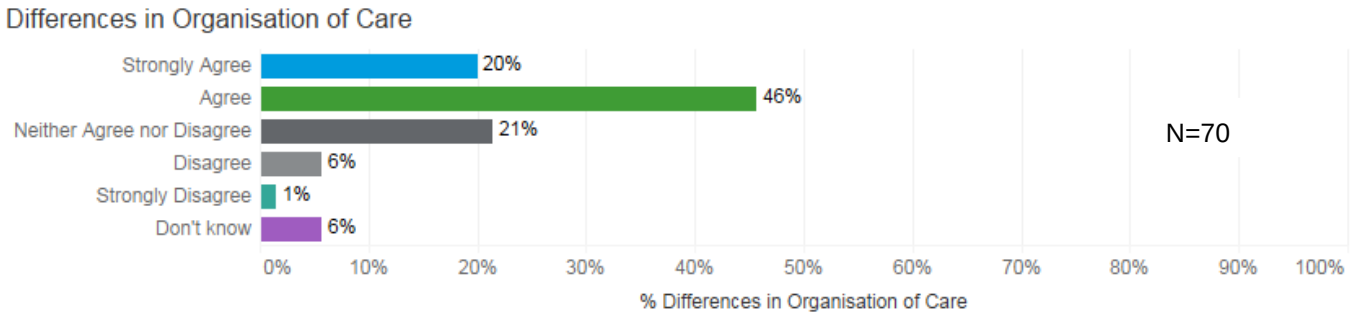


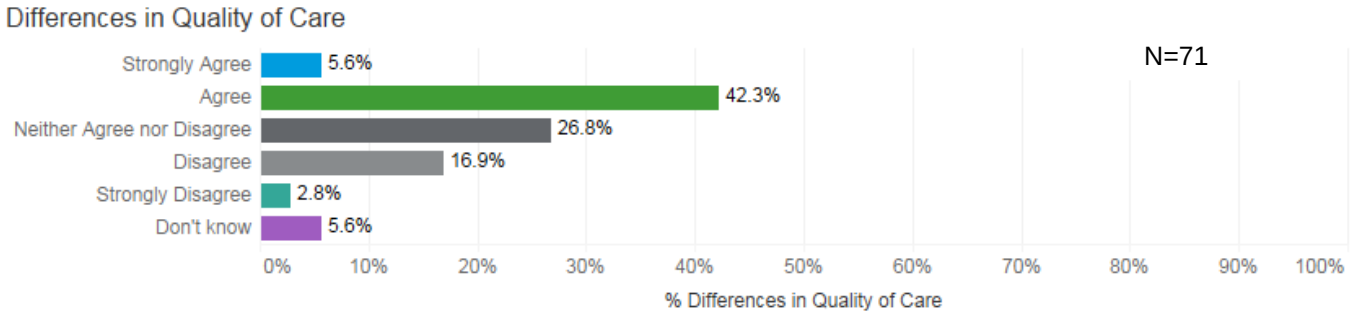


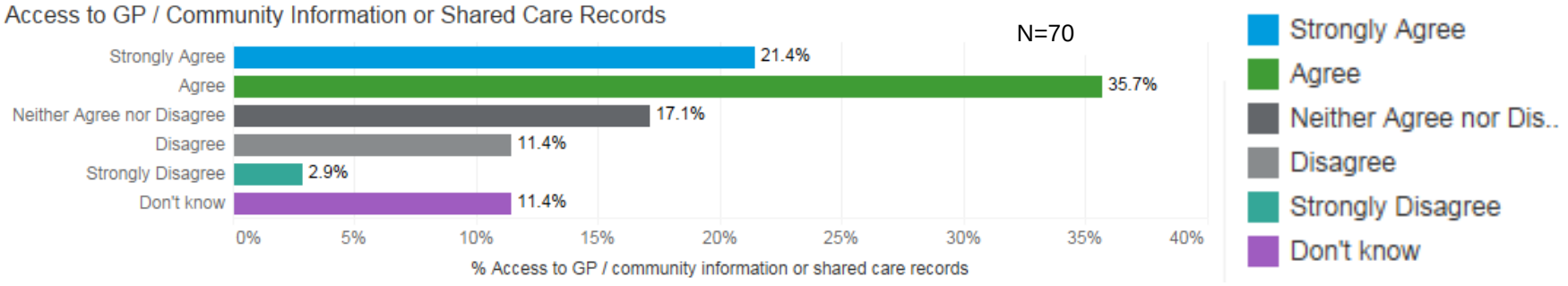
Source: RSM PACEC Staff Survey (2016)

1.1.2.4 Limitations of Collaborative Working



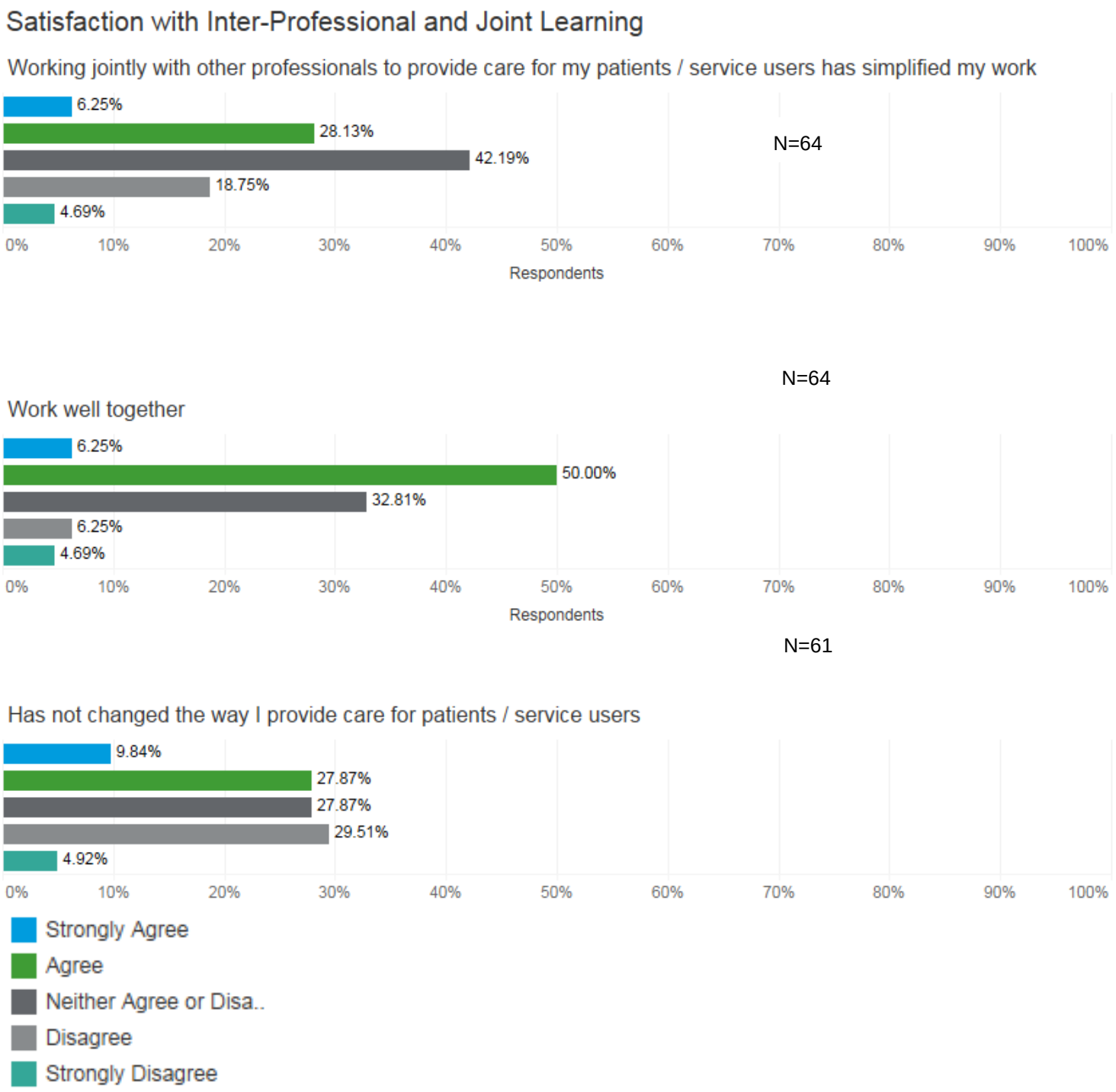






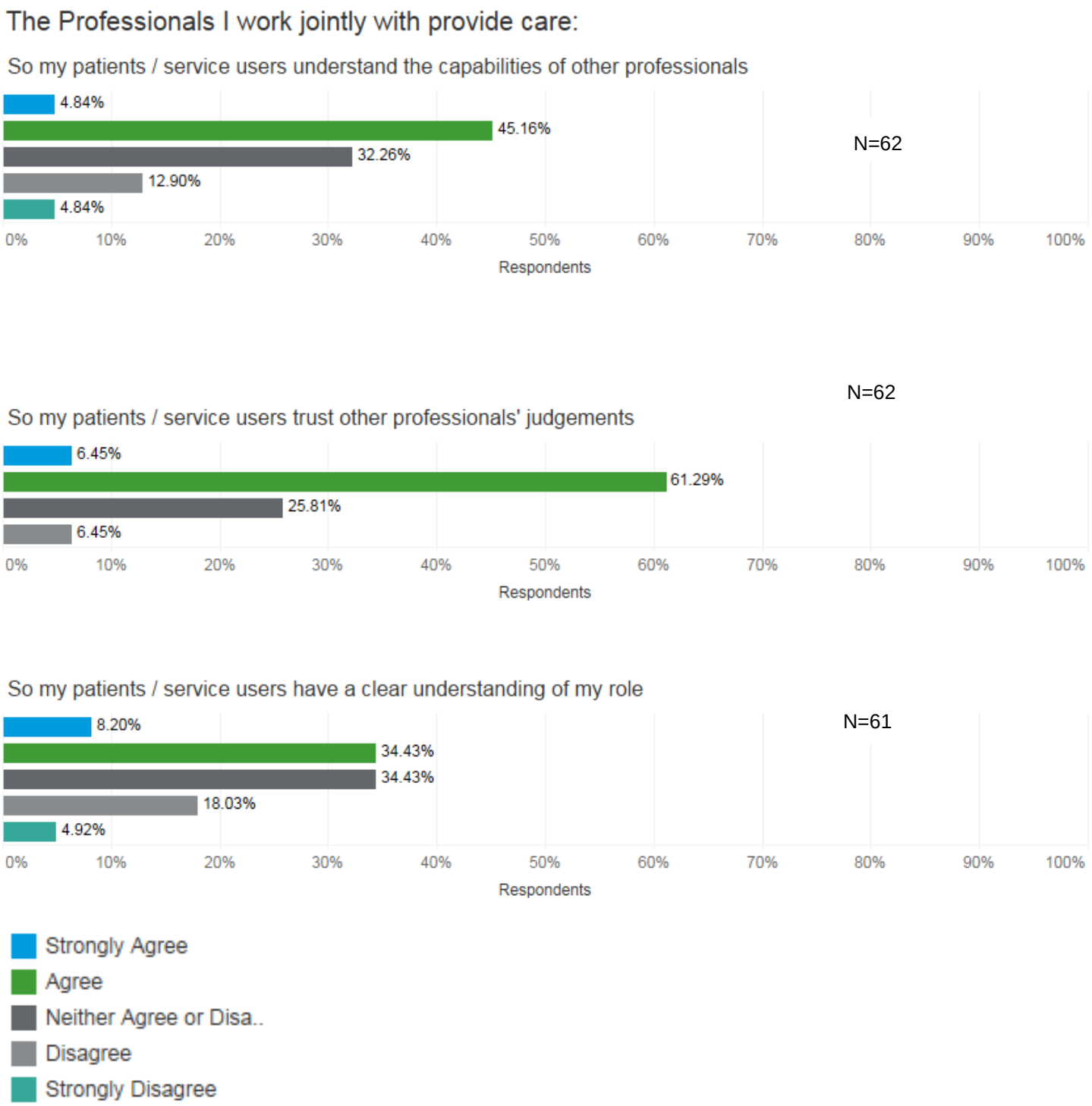
Source: RSM PACEC Staff Survey (2016)

1.1.2.5 Satisfaction with Inter-Professional and Joint Learning

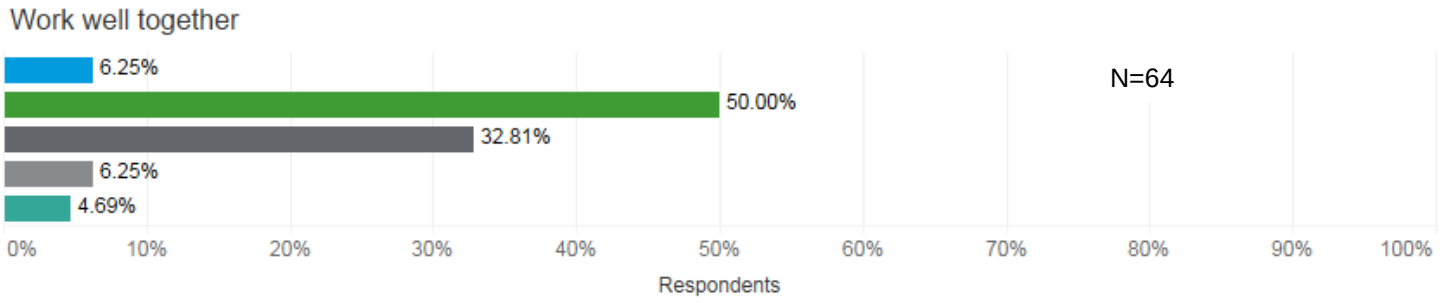


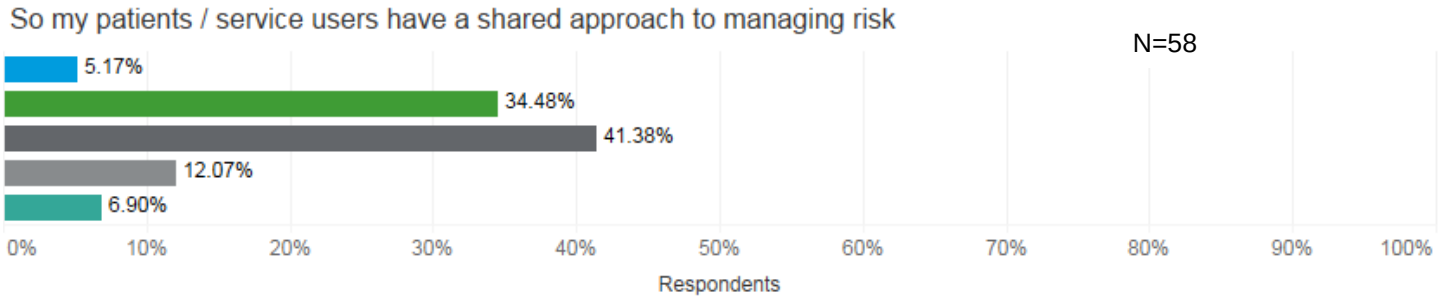
Source: RSM PACEC Staff Survey (2016)

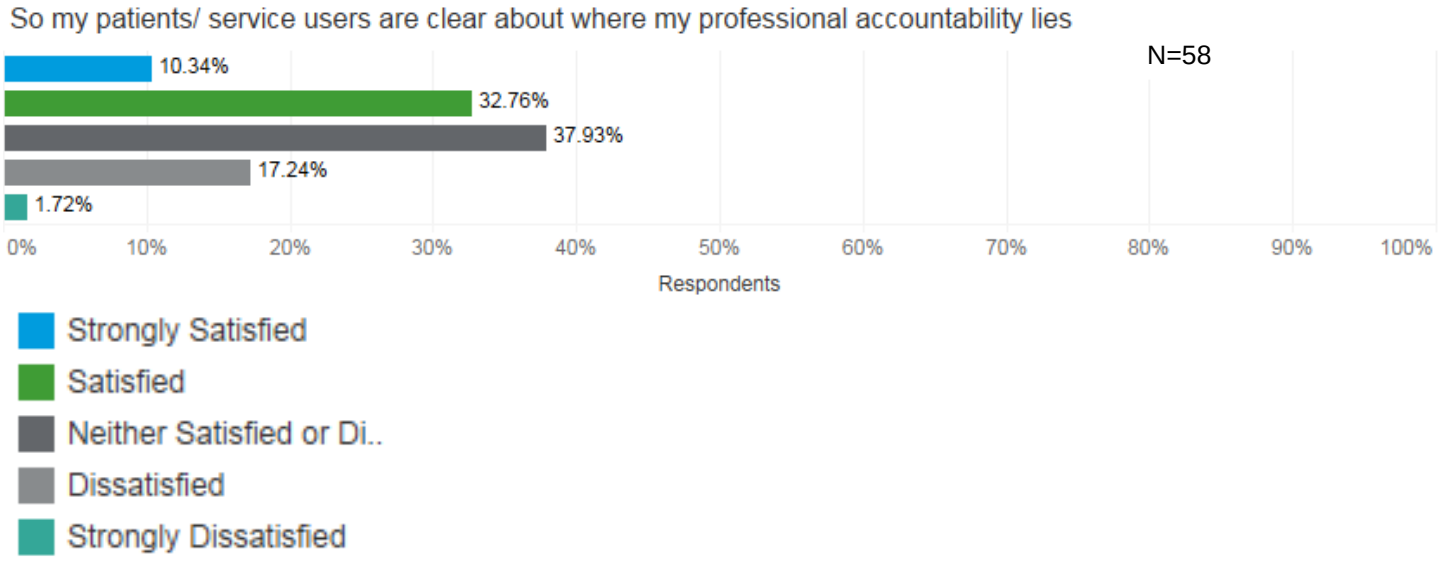
1.1.2.6 Professional Provision of Care



Source: RSM PACEC Staff Survey (2016)

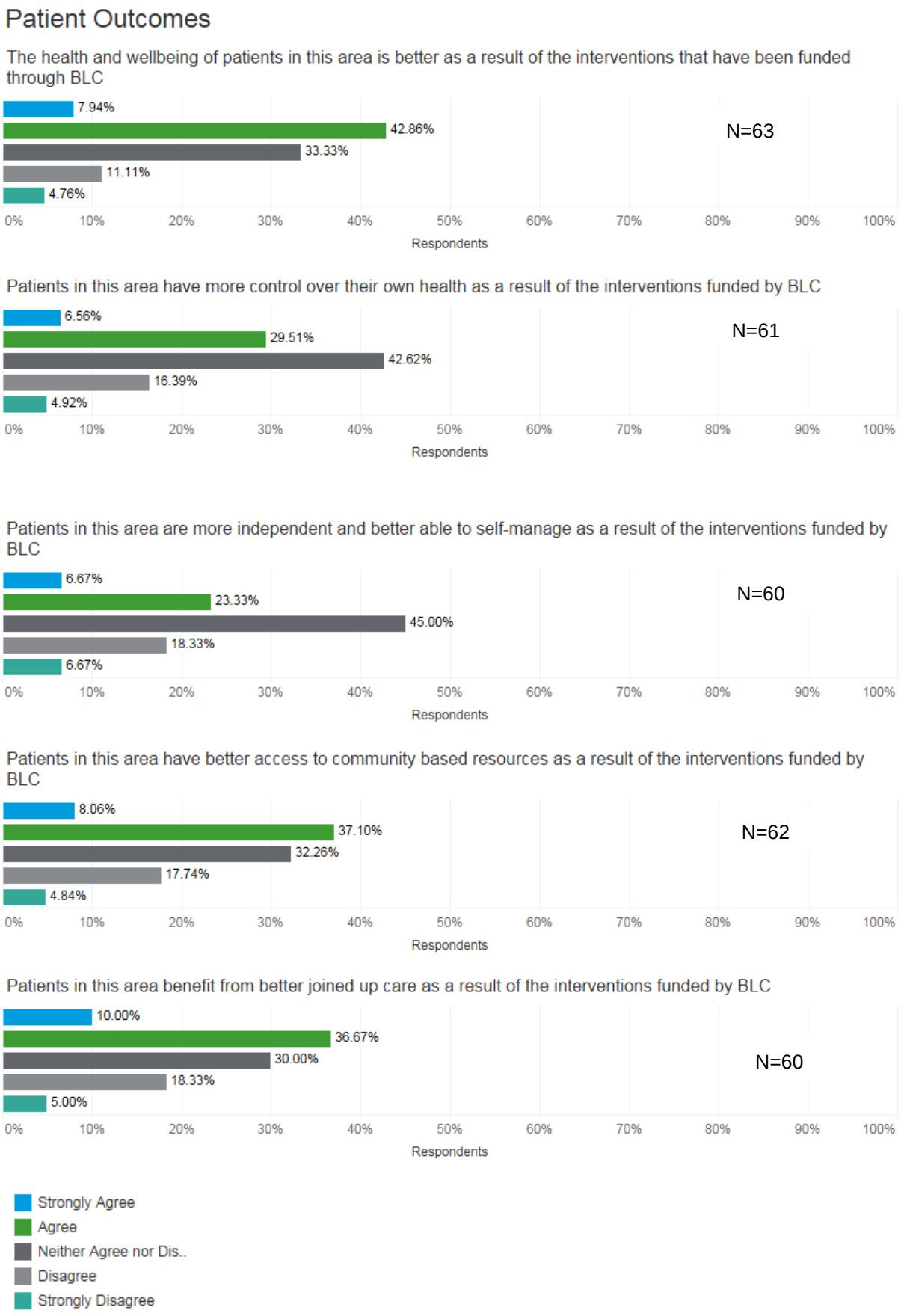






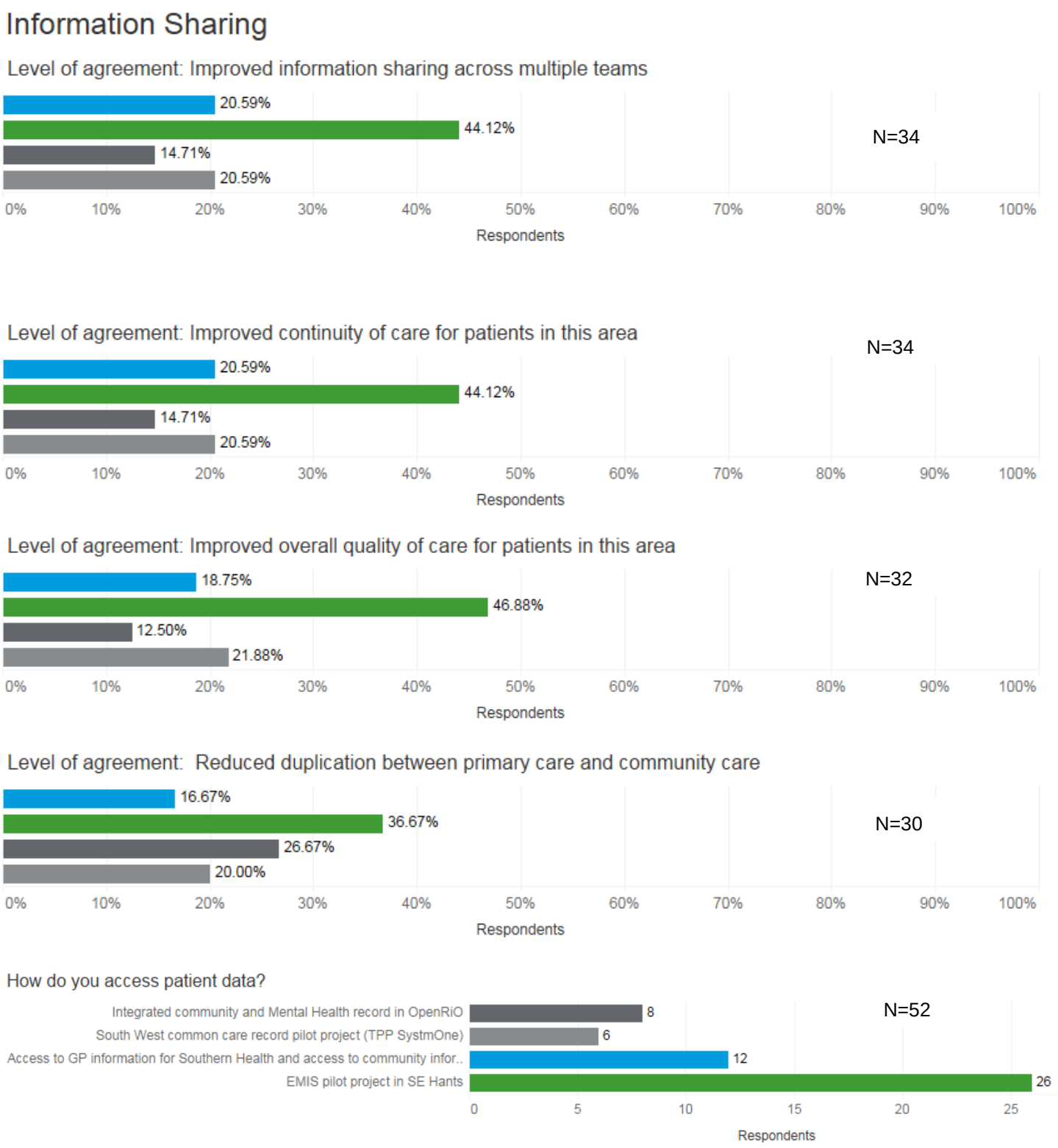
Source: RSM PACEC Staff Survey (2016)

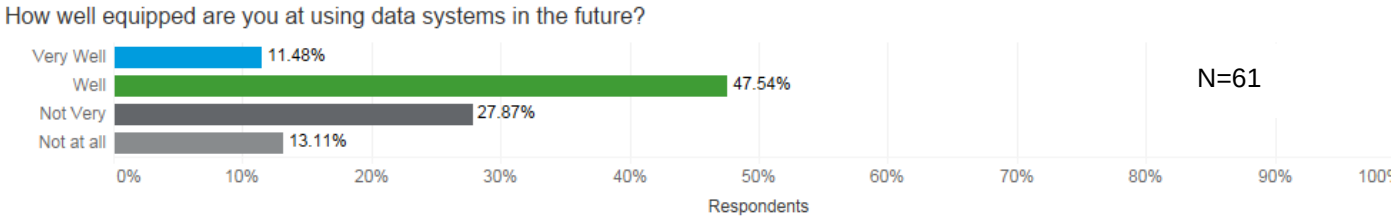
1.1.2.7 Patient Outcomes

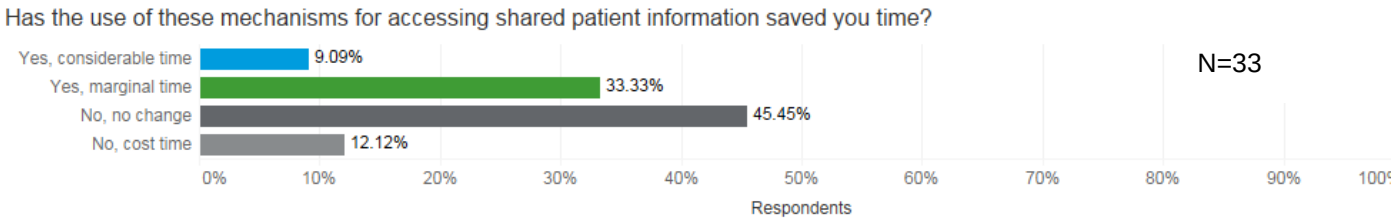


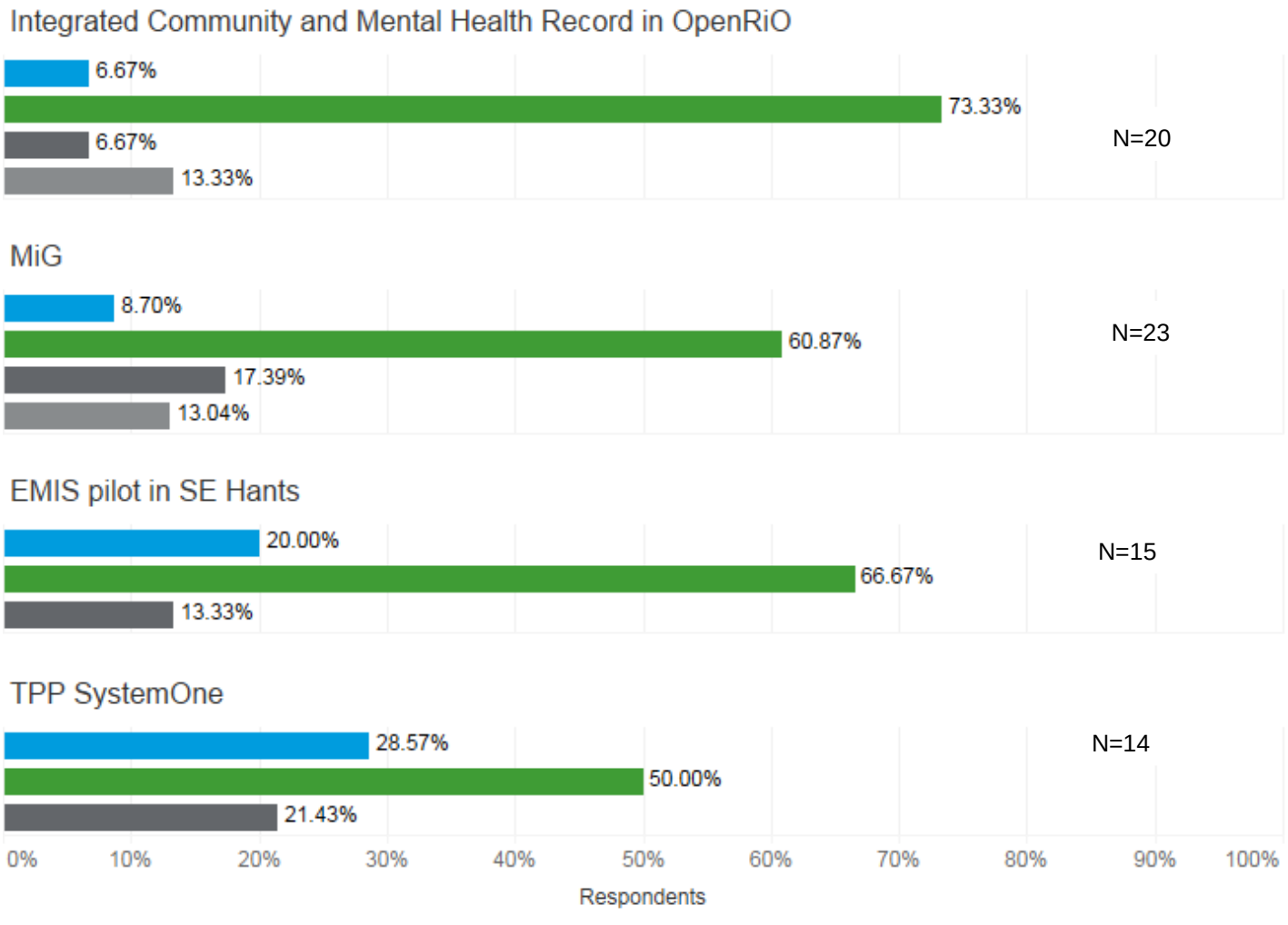
Source: RSM PACEC Staff Survey (2016)

1.1.2.8 Information Sharing









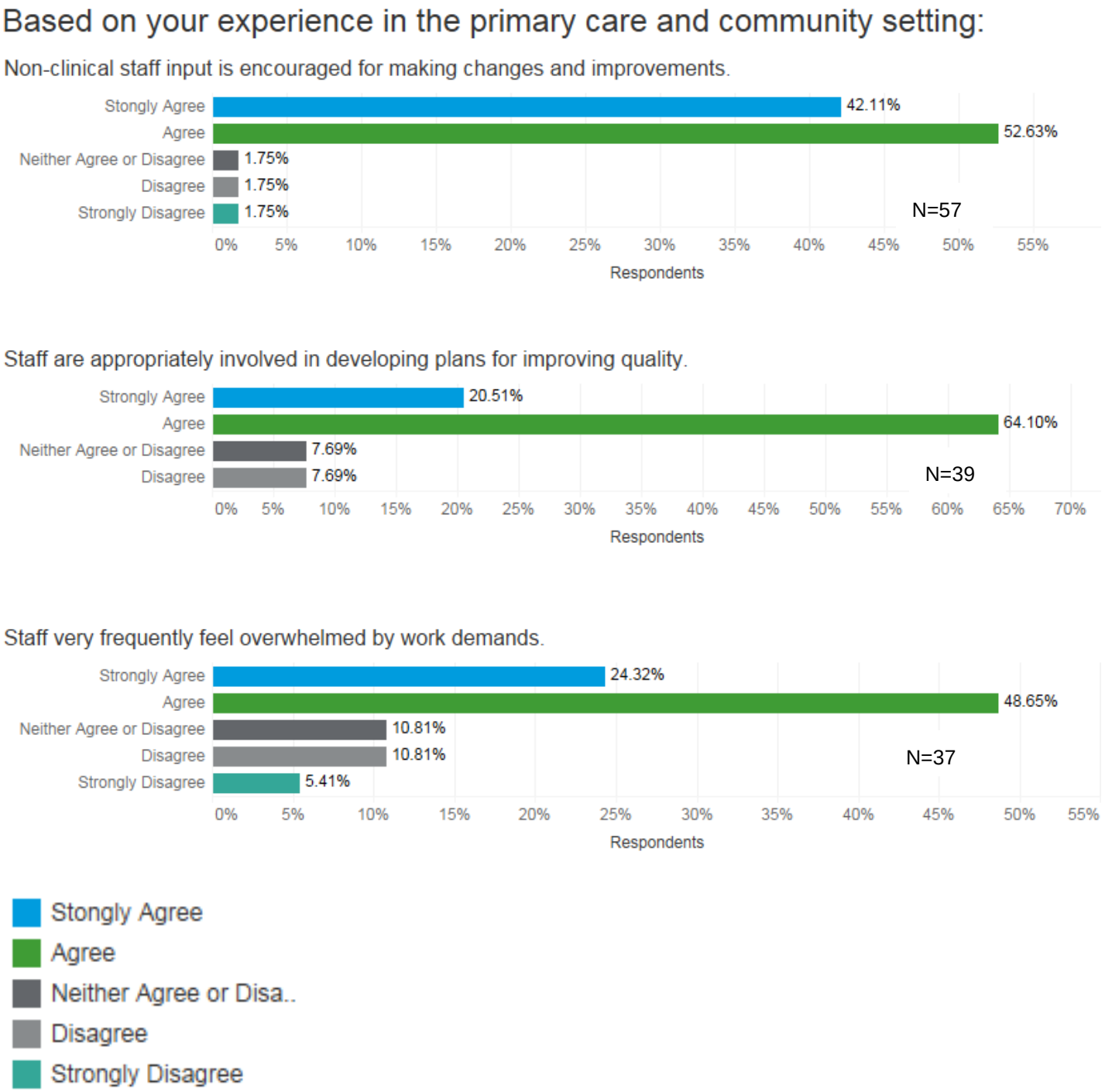
Source: RSM PACEC Staff Survey (2016)

1.2 Staff Survey: Working in GP Practices

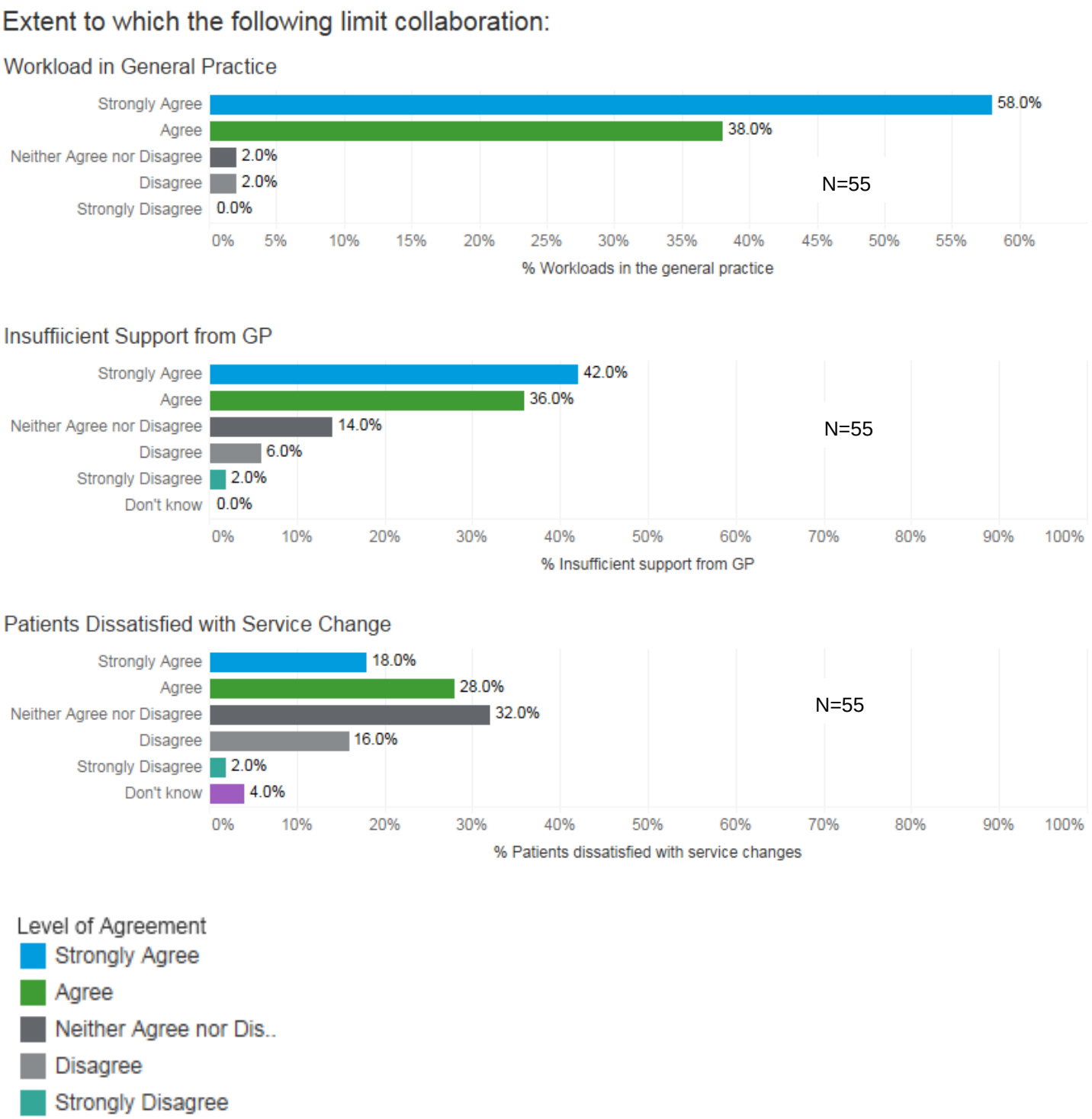
1.2.1 Organisation Details

All Respondents worked in a GP Practice (n=68)

1.2.2 Making Changes and Work Demand



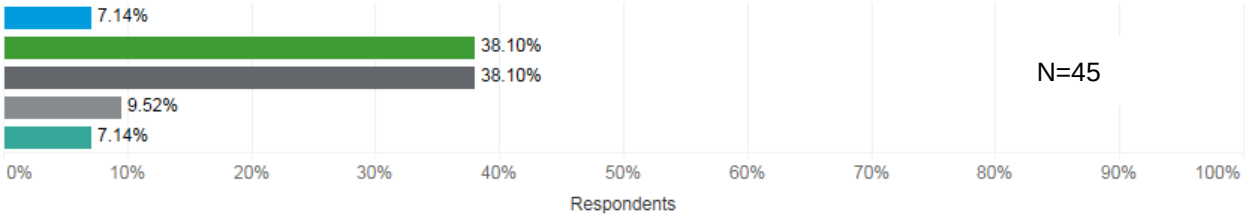
1.2.3 Limitations of Collaborative Working



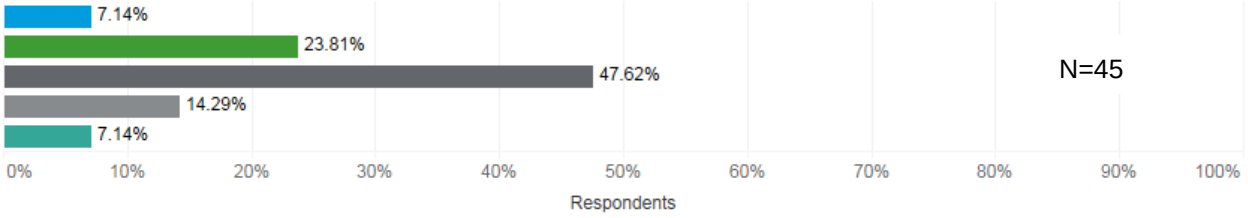
1.2.4 Patient Outcome

Patient Outcomes

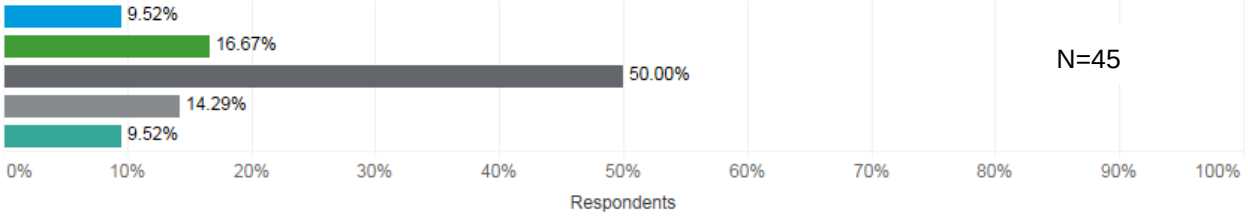
The health and wellbeing of patients in this area is better as a result of the interventions that have been funded through BLC



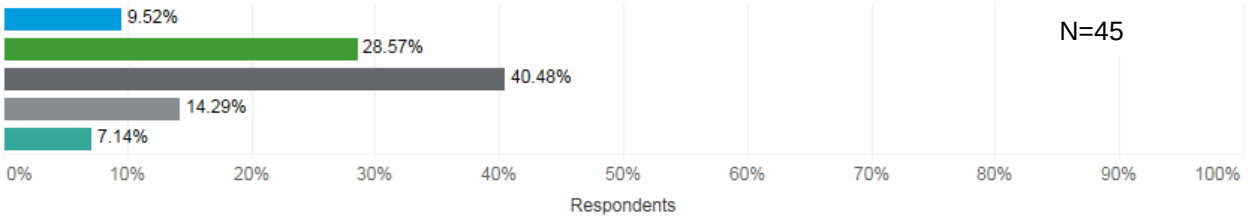
Patients in this area have more control over their own health as a result of the interventions funded by BLC



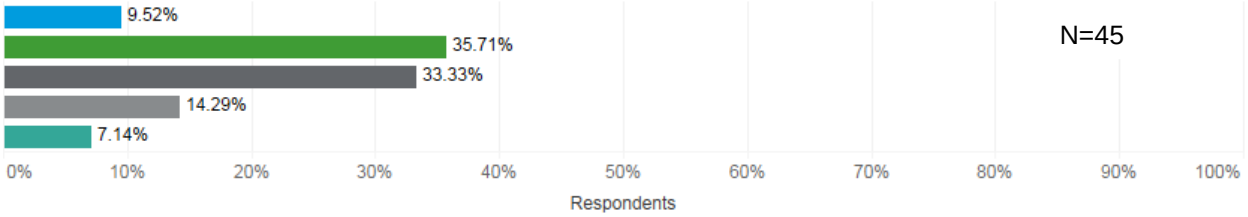
Patients in this area are more independent and better able to self-manage as a result of the interventions funded by BLC



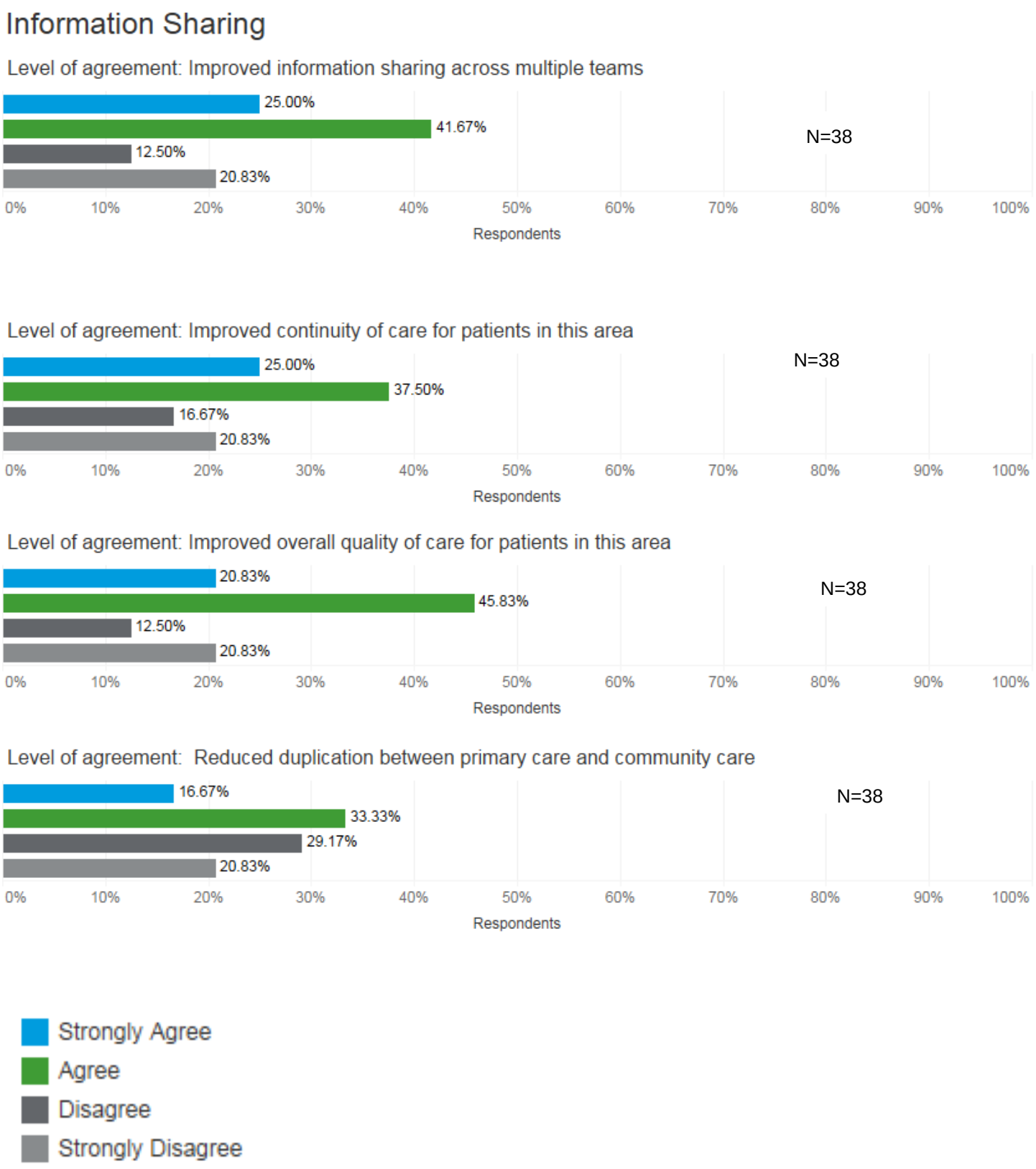
Patients in this area have better access to community based resources as a result of the interventions funded by BLC



Patients in this area benefit from better joined up care as a result of the interventions funded by BLC



1.2.5 Information Sharing

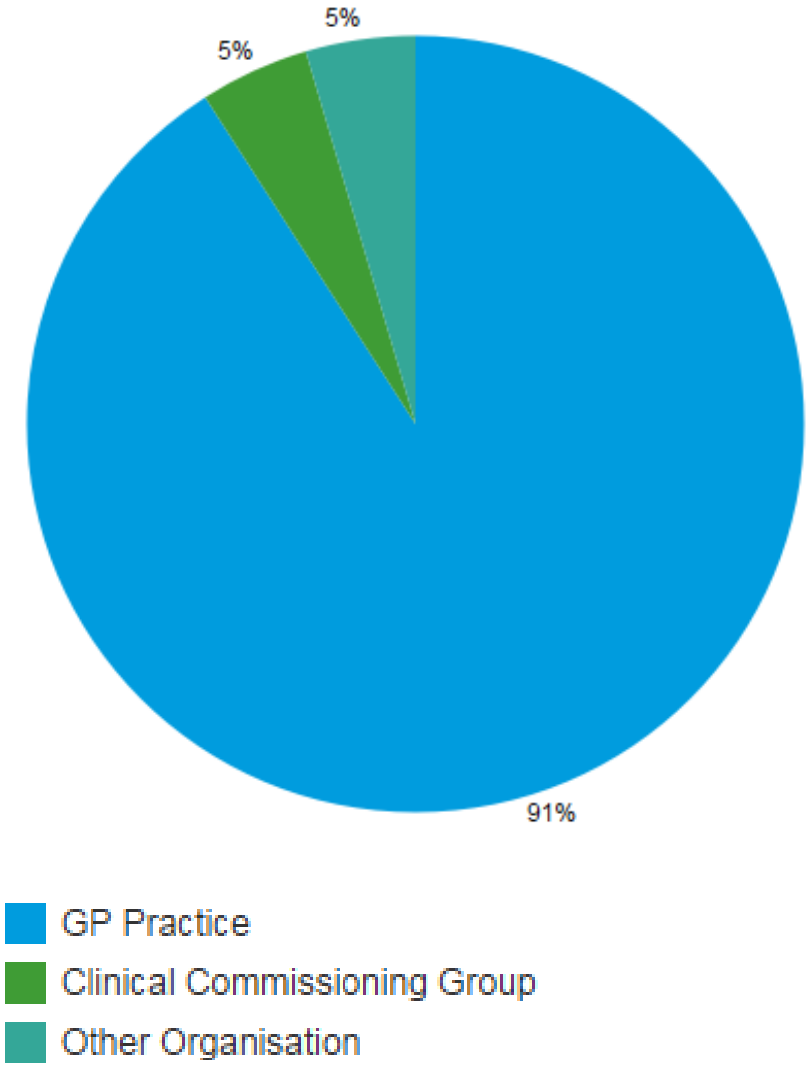


1.3 Staff Survey: General Practitioners

N=22

1.3.1 Organisation Details

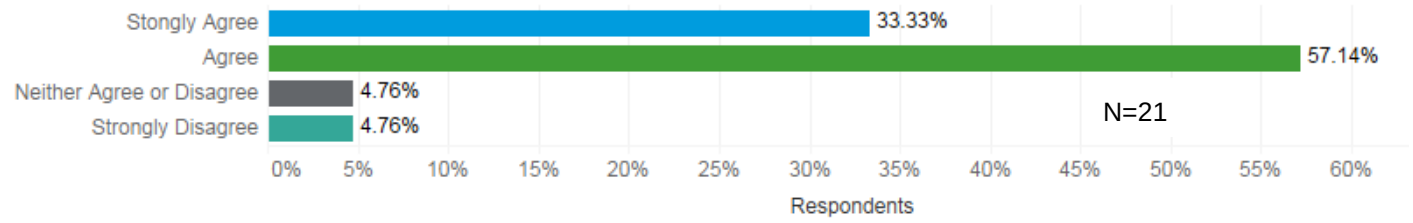
Which Organisation do you Work For?



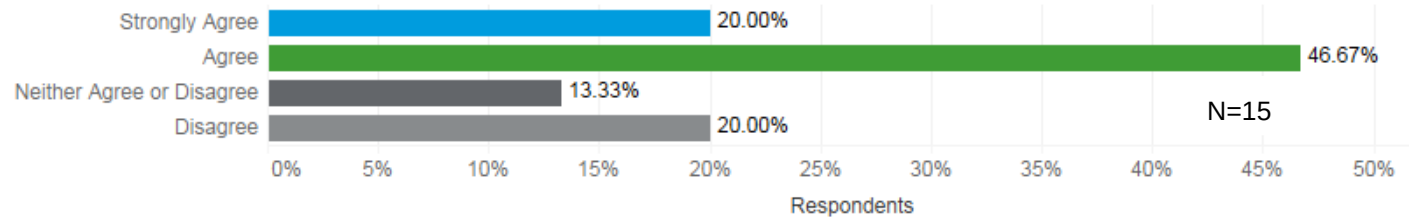
1.3.2 Making Changes and Work Demand

Based on your experience in the primary care and community setting:

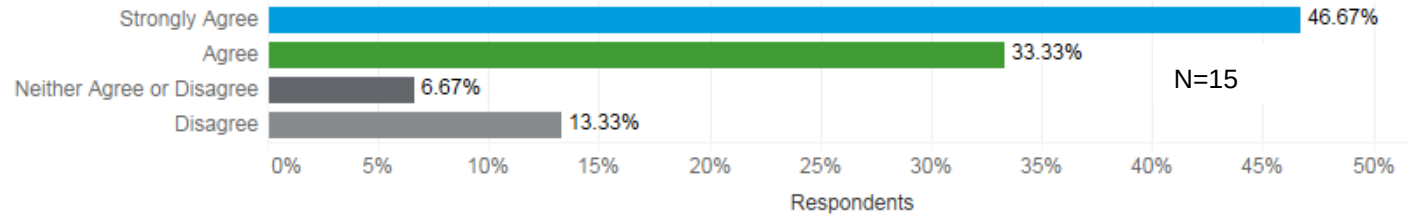
Non-clinical staff input is encouraged for making changes and improvements.

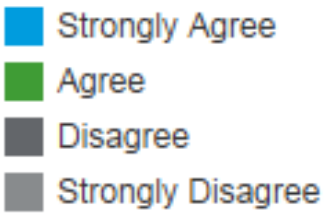


Staff are appropriately involved in developing plans for improving quality.

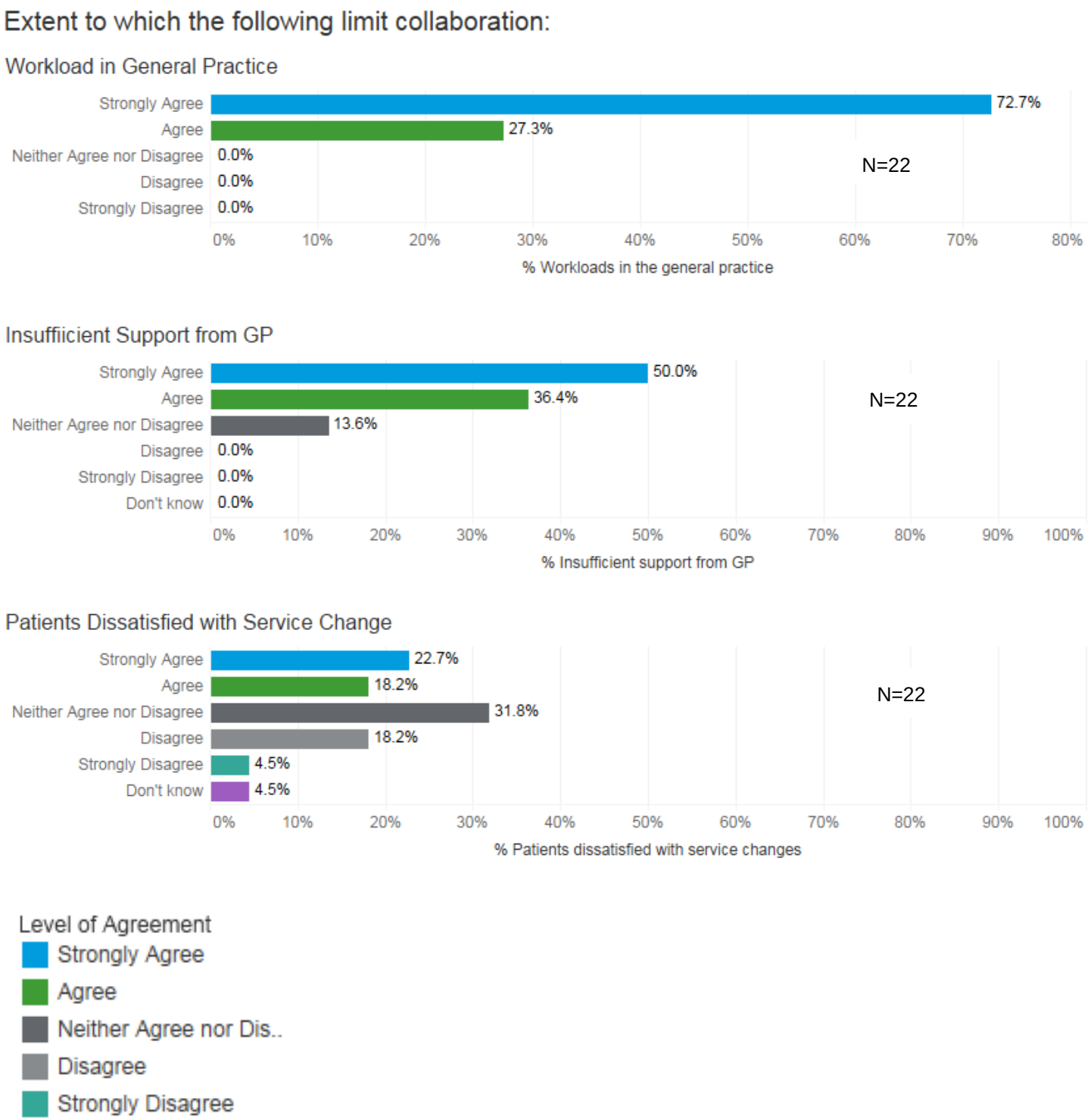


Staff very frequently feel overwhelmed by work demands.



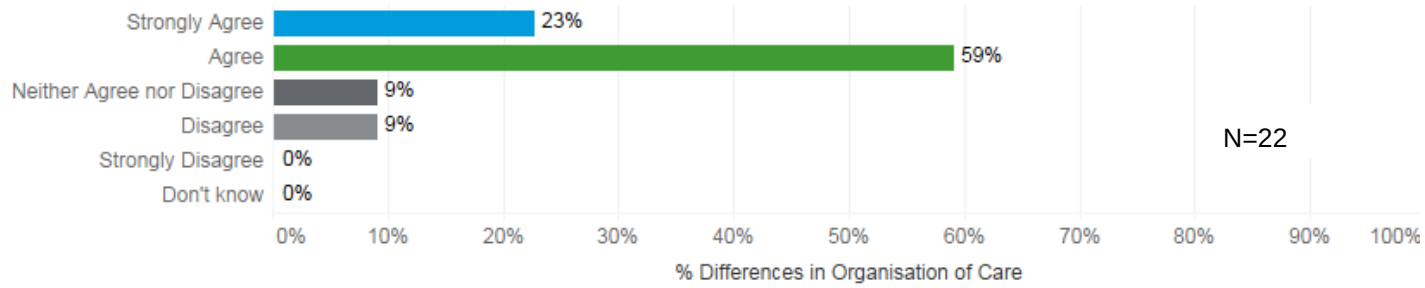


1.3.3 Limitations of Collaborative Working

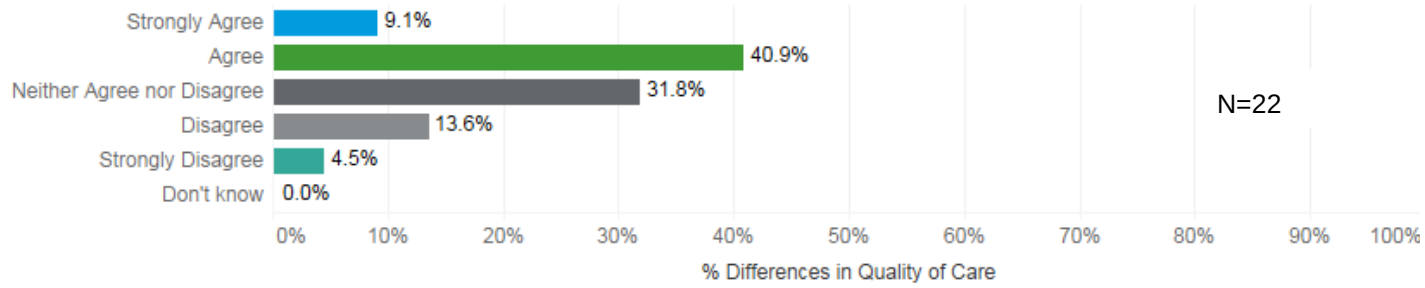


Extent to which the following limit collaboration:

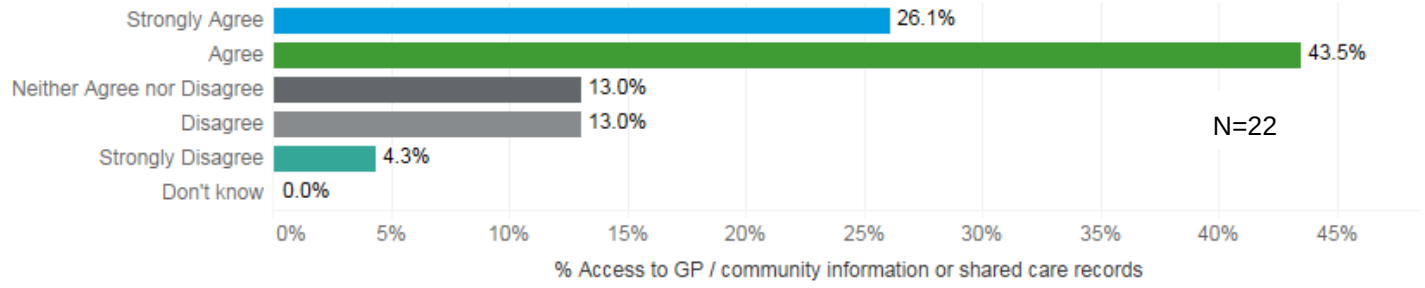
Differences in Organisation of Care

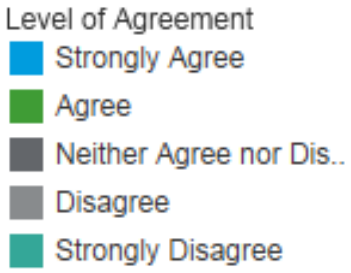


Differences in Quality of Care



Access to GP / Community Information or Shared Care Records

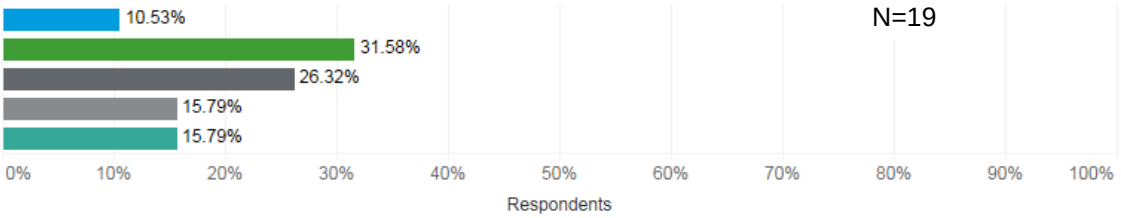




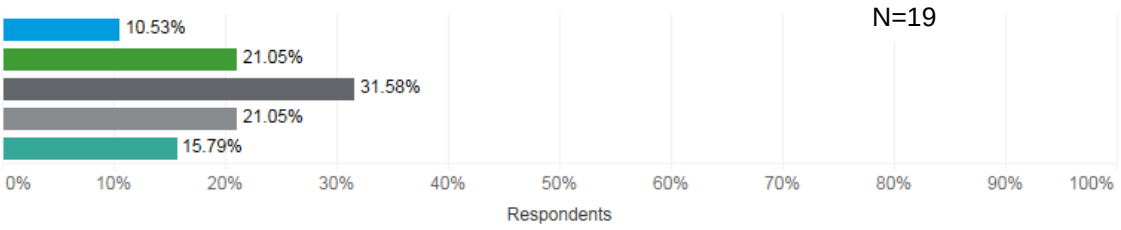
1.3.4 Patient Outcomes

Patient Outcomes

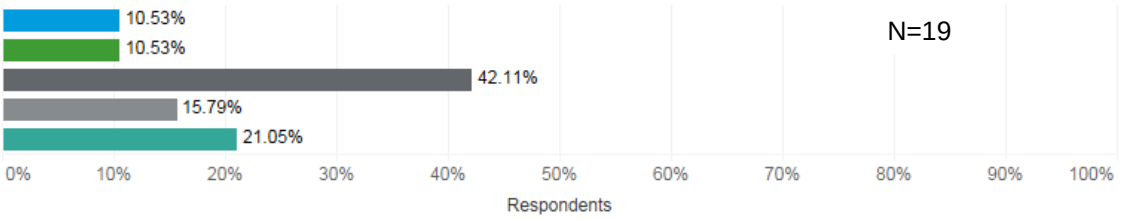
The health and wellbeing of patients in this area is better as a result of the interventions that have been funded through BLC



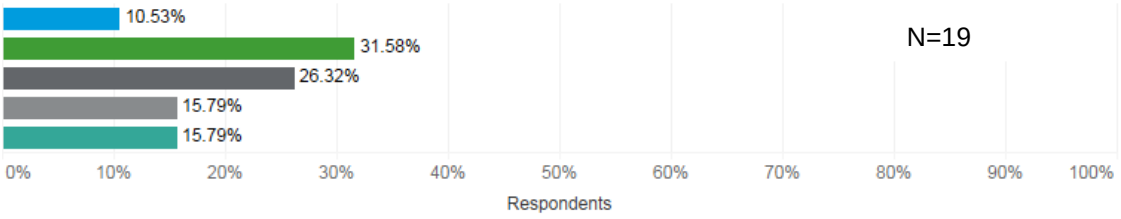
Patients in this area have more control over their own health as a result of the interventions funded by BLC



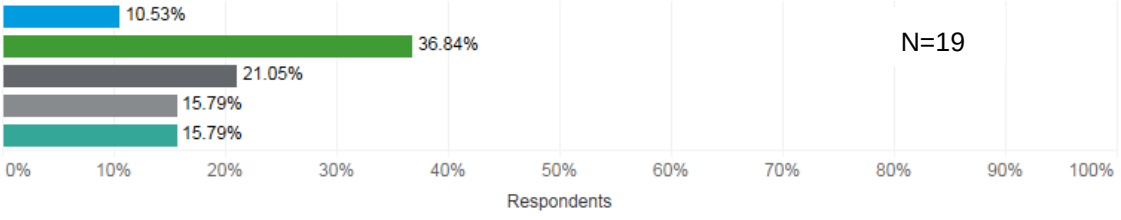
Patients in this area are more independent and better able to self-manage as a result of the interventions funded by BLC



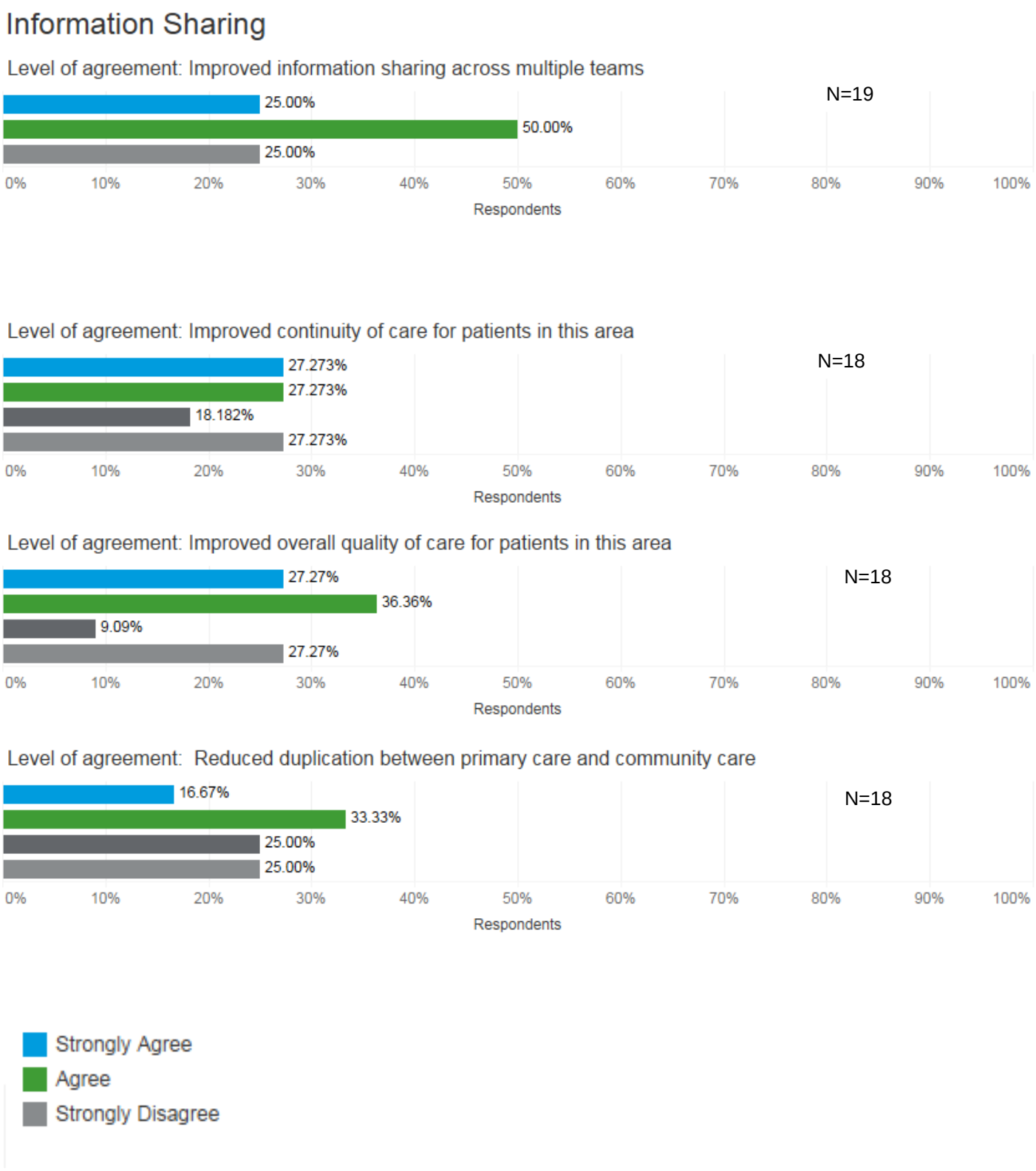
Patients in this area have better access to community based resources as a result of the interventions funded by BLC



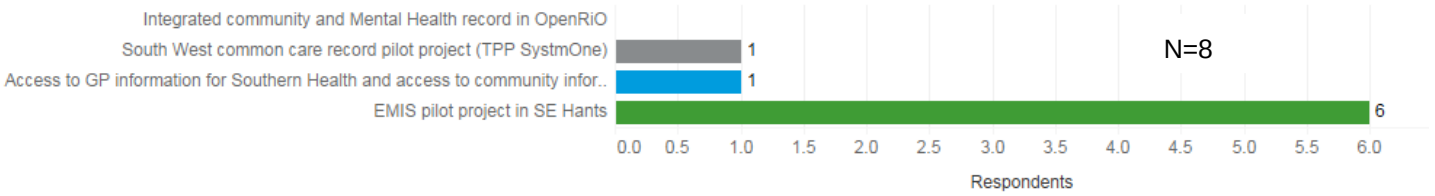
Patients in this area benefit from better joined up care as a result of the interventions funded by BLC



1.3.5 Information Sharing

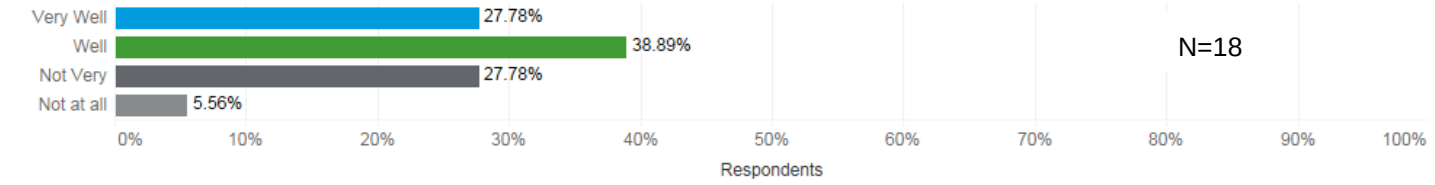


How do you access patient data?



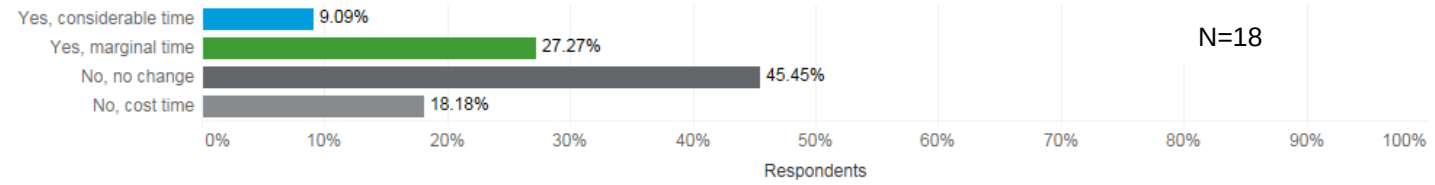
N=8

How well equipped are you at using data systems in the future?



N=18

Has the use of these mechanisms for accessing shared patient information saved you time?



N=18

Appendix 12: Stakeholder interview topic guide

1. HAMPSHIRE STRATEGIC STAKEHOLDER INTERVIEW GUIDE

1. Your involvement in BLC

2. In your view, how is BLC making a positive contribution to national health policy objectives?

3. How (if different) do you see BLC fitting with regional / local health objectives?

4. What you would point to as being particular successes to date?

5. What you would point to as being particular challenges to date, and how have or could these be overcome?

6. What you expect the programme to achieve / what does good look like?

7. Counterfactual?

8. From a commissioning perspective, what are the key metrics you need to have sight of?

9. Anything else?

Appendix 13: Follow up interview topic guide

HAMPSHIRE STRATEGIC STAKEHOLDER: FOLLOW UP - INTERVIEW GUIDE

1. Your involvement in BLC

2. Has the national policy landscape changed in the last 6 months, and if so what does that mean for the BLC contribution?

3. Has the local policy landscape changed since Q4 last year, and if so what does that mean for the BLC contribution?

4. What tangible outcomes would you point to that have emerged from the increased GP co-operation and resilience?

5. To what extent have these issues been addressed?

6. If so, how have they been addressed?

7. To what extent has BLC been able to deliver against these expectations to date?

8. What are your priorities for BLC over the next year?

9. What about the counterfactual position now?

10. Value for Money is a difficult term to assess qualitatively, but if you had to give your view, to what extent has BLC represented value for money, and why?

11. What will be key to sustaining the more mature / effective BLC interventions?

12. Anything else?

Appendix 14: Staff Survey