



Better Local Care MCP Vanguard

Synthesis of Year 1 evaluation evidence (2016 – 2017)

July 2017

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1. INTRODUCTION

In summer 2015 Better Local Care (BLC), the Hampshire Vanguard Multi-Specialty Community Provider (MCP), began implementing a programme of change in the way out of hospital care is provided to the community in Southern Hampshire, with the aim of improving the health, well-being and independence of local people.¹

Originally, Better Local Care concentrated on a registered population of 235,000 within three initial 'fast implementer' localities: Gosport, South West New Forest and East Hampshire. The vanguard has since extended its geographic reach to provide financial support to a range of interventions within a considerably wider geographic area comprising a registered population of 839,000. This area is sub-divided into thirteen 'Natural Communities of Care' (NCCs) and five Clinical Commissioning Group (CCG) areas.

The Better Local Care Vanguard has sought to build and sustain commitment from GP practices, Southern Health, Solent NHS Trust, Hampshire County Council, Southampton City Council and local commissioners to integrate health care teams and work together at scale. The unique benefit of Better Local Care's vanguard status was the opportunity that it provided to be innovative and trial new ways of working to understand what is needed to engage local residents and health teams and to make real change happen locally. Ultimately, Better Local Care is expected to develop a scalable, Hampshire-wide approach to providing out of hospital care.

1.1 Evaluation overview

RSM was appointed in October 2016 to deliver an evaluation of the Better Local Care MCP Vanguard.

1.1.1 Evaluation objectives

The objective of the evaluation is to provide formative and summative analysis that addresses the below elements²:

- Understand the mechanisms that have led to changes in outcomes, including an analysis of factors that underpin the impact and replicability of the models of care.
- Evaluate performance of the programme against stated aims and objectives, incorporating national and local metrics, routine health service data, as well as analysis of locally collated quantitative and qualitative data.
- Undertake an in-depth evaluation of the main models of care, incorporating but not limited to the outputs and outcomes in the programme and thematic logic models.
- Evaluate the enablers and barriers to organisational change at primary care and locality level.

¹ Better Local Care Value Proposition Update, February 2016

² Sections 3.1.2 and 3.2 of the HBLC ITT Service Specification

- Evaluate the impact of the Better Local Care programme from a systems, financial and broader economic perspective.

1.1.2 Summary of evaluation approach and methodology

The evaluation uses a 'utilisation-focused' approach, acknowledging data and resourcing constraints where necessary but not allowing those constraints to prevent the provision of evaluative evidence that is 'of use' to the Better Local Care team. This utilisation-focused approach was developed by US evaluation expert Michael Quinn-Patton and has previously been used in evaluations on behalf of the US Centre for Disease Control (CDC).³ The evaluation uses mixed methods of a predominantly qualitative nature, including:

- Desk based literature review;
- In-depth semi-structured telephone interviews with internal and external stakeholders;
- Intervention specific research and case study development to inform Deep Dive reports;
- On-line survey of Better Local Care and wider Southern Health delivery teams;
- Analysis of publicly available secondary statistics;
- Analysis of routine monitoring and feedback data collected by Better Local Care / Southern Health delivery teams; and
- Telephone interviews with patients (where appropriate and when access to patients was provided).

Detailed methodologies have been produced for ten individual Deep Dive reports and these are available in Appendix 1, together with more detail on the programme level methodology.

1.1.3 Limitations

Given the 'bottom-up nature' of the programme, there have been variances in the availability and quality of data across Better Local Care interventions for use in the evaluation. This issue, as well as other limitations at the intervention level, is expanded upon in Appendix 2. Beyond these project level limitations, there have also been changes to regulations governing data protection which have affected the evaluation. Over the course of the evaluation NHS England, NHS Digital, Southern Health and local Clinical Commissioning Groups have been working together to prepare for the new EU General Data Protection Regulation (GDPR) when it comes into force in May 2018.⁴ Secondary Uses Service (SUS) data has not been available to the evaluation 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 represents a significant limitation, particularly to the economic evaluation.

³ Quinn Patton, M. (2008) *"Utilisation-Focussed Evaluation"*, 4th Edition, Sage Publishing, 2008

⁴ <https://digital.nhs.uk/information-governance-alliance/General-Data-Protection-Regulation-guidance>

1.2 Purpose of this report

This is a programme level report. As such, it seeks to synthesise key findings from the research conducted in Year 1 of the Better Local Care MCP Vanguard. The remainder of this report is structured as follows:

Section 2: Social & Clinical Context

Section 3: Organisational & NHS Organisational Context

Section 4: Aggregated Programme Data

Section 5: Analysis of National Metrics

Section 6: Analysis of Local Metrics

Section 7: Care Model Insights

Section 8: Conclusions & Recommendations

2 CONTEXT AND NEED

This section describes the social and clinical context in which the Better Local Care MCP Vanguard operates. It uses a range of indicators from publicly available sources, including the GP Patient Survey, Public Health England and the Office of National Statistics. These indicators are set out in Table 2.1 below.

Table 2.1: Context Indicators

Context	Indicator (Geography)	Source
Social & Clinical Factors	Population Age (Locality)	PHE GP Practice Lists
	Long-Term Conditions (Locality)	GP Patient Survey
	Carer Population (Locality)	GP Patient Survey
	Diabetes Prevalence (Locality)	PHE Cardiovascular Disease Risk Factors
	Smoking Prevalence (Locality)	PHE Cardiovascular Disease Risk Factors
	Stroke Prevalence (Locality)	PHE Cardiovascular Disease Risk Factors
	Health Deprivation (Lower Super Output Area)	Office of National Statistics Indices of Multiple Deprivation

Data and associated maps and charts are not presented in this report, but are available to view interactively via the RSM / Southern Health Tableau platform.

2.1 Social & clinical factors

2.1.1 Population age

The population in the Southern Hampshire is ageing. Eight of the fourteen Better Local Care localities have over 65 populations above the England average of 17.5 per cent. In addition, ten of the 14 Better Local Care localities have an over-75 population above the England average of 7.8 per cent. However, there is considerable variation in population age across the ten individual Better Local Care localities. For example, South West New Forest and Avon Valley have a higher proportion of elderly people (aged 65+ and aged 75+) in comparison to the others. Regardless of these differences, all localities have increasing over-65 populations, and most have shown growth in the proportion of adults aged 65 and over by approximately 2 per cent between 2011 and 2015.

2.1.2 Long-term conditions

Ten of the fourteen Better Local Care localities have a proportion of registered population with long-term conditions (LTCs) that is higher than the England average (53.5 per cent), the four exceptions

being Southampton Central & North, Waterlooville, Winchester and East Hampshire.⁵ The proportion of populations with LTCs in the Gosport and SW New Forest localities are also notably higher compared to the average of other localities.

2.1.3 Diabetes, smoking and stroke prevalence

There are five localities within the Better Local Care geography that have a higher estimated smoking prevalence in comparison to the national average. Both Southampton East and West have instances of smoking prevalence at almost 5 per cent above the average in England. There is greater variance in diabetes prevalence, with an almost 2:1 ratio in Gosport and Southampton Central and North respectively. A total of three localities have a higher diabetes prevalence than the England average (Gosport, SEH Havant and Waterlooville).

Five localities have a higher obesity prevalence than the national average. Gosport, Havant, Hayling Island and Emsworth have instances of obesity prevalence approximately 2 per cent above the England average, the greatest prevalence being in Waterlooville at almost 4 per cent above the national average.

A total of seven localities have a stroke prevalence above that of the national average of 1.7 per cent (New Forest & Avon Valley, SEH Havant, Totton & Waterside, Fareham, Waterlooville, Gosport and Winchester). There is considerable variability in stroke prevalence, with an almost 3:1 ratio between SW New Forest and Avon Valley and Southampton Central & North (which has the lowest stroke prevalence at approximately 1 per cent).

The Public Health England (PHE) data, highlights of which are described above, demonstrates that there are notable health inequalities in several Better Local Care areas, including premature mortality rates for major diseases that are higher than those for England as a whole.⁶ This PHE data was used by Better Local Care at the outset of the programme to define needs of the local area and the Year 1 delivery plan.

2.2 Summary of social and clinical context

The Better Local Care population is aging and older than the England average. The social profile and clinical needs of the area reflect this demographic, including above average proportions of residents with long-term conditions. The social and clinical context in local urban areas differs, characterised by younger populations, with higher instance of smoking prevalence and higher levels of multiple deprivation.

At an aggregate level, the social and clinical context suggests a need to focus system resources on providing effective care for an ageing population, and on interventions that promote prevention and self-management in respect of lifestyle risk factors and long-term conditions.⁷ There are, however, nuances within individual localities, which demonstrate that there can be few if any 'one size fits all' approaches.

⁵ GP Patient Survey, 2016

⁶ PHE FingerTips – District profile 2015

⁷ Further information can be found in the Joint Strategic Needs Assessments for Hampshire and Southampton.

3 ORGANISATIONAL & NHS CONTEXTUAL FACTORS

3.1 Fit with national strategic policy objectives

3.1.1 NHS Five Year Forward View

The Better Local Care MCP Vanguard is well aligned to the objectives outlined within the NHS Five Year Forward View. Specifically, the MCP features several alignments with three headline features of the Forward View:

- Upgrading prevention and public health to tackle major risks and prevent avoidable illness;
- Providing greater patient control over care through partnership with community and voluntary organisations;
- Breaking down of barriers in care provision across primary, hospital and community settings as well as across divides in health and social care and in physical and mental health.

The key themes of safety, efficiency and effectiveness elaborated in the NHS Five Year Forward have been built into Better Local Care's logic models at the programme level. The choice of key outcome metrics used for monitoring and evaluation purposes have been designed to reflect the Forward View's sustainability objectives, which includes a net efficiency gains target of 2 per cent annually across the system designed to address the NHS' funding gap.

3.1.2 NHS Vanguards

The Better Local Care MCP was one of the first vanguard projects established, and its operation so far indicates it has potential to contribute towards all the success factors outlined in NHS England's 'Vanguards: Developing a blueprint for the future of NHS and care services in 2016' report⁸, specifically:

- Providing more accessible, responsive and effective health care and support services;
- Reducing the number of trips to hospital and reducing the pressure on services; and
- Ensuring better co-ordination of care givers, and more effective and efficient use of health care resources.

3.1.3 General Practice Forward View

Whilst the MCP Vanguard model has potential to contribute to most primary care areas detailed within the General Practice Forward View strategy, the most significant contributions it makes are in relation to;

- Care Redesign – fundamental to the MCP model is the utilisation of community based care, provided to ensure a patient centred care model. This involves the integration and collaboration between care givers.

⁸ New Care Models: Vanguards- developing a blueprint for the future of NHS and care services (NHS England September 2016)

- Workload – the development of the MCP model aims to utilise the existing health care resources in a more efficient and effective way, which has potential to reduce the pressure on GP services.

3.2 Fit with regional and local policy objectives

Better Local Care is also aligned with the goals and aims of various regional and local policy objectives and strategy documents, the most notable of which are outlined in the below table.

Table 3.1: Strategic fit

Policy / Strategy	Description	Alignment of MCP
Hampshire Joint Health and Wellbeing Strategy	Produced by the Local Health & Wellbeing Boards (HWBs) to provide estimate of current and future need to assist planning of services (2012 Health and Social Care Act)	<ul style="list-style-type: none"> • Better Local Care’s development of new care models aimed at reducing barriers to health and social care services as well as improving care outcomes and patient experience could have a positive impact on the “living well”, “aging well” and “healthier communities” pillars of the strategy.
Clinical Commissioning Groups	Clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. The Better Local Care area contains five CCGs; Fareham & Gosport, North Hampshire, South East Hampshire, West Hampshire and Southampton. Each has a Five Year Strategy Plan (containing Locality Plans) and Out of Hospital strategies.	<p>CCG’s Strategic Plans</p> <ul style="list-style-type: none"> • Develops a new model of care which promotes the delivery of safe, appropriate services which are flexible and respond to the needs of each locality. • Aims to improve clinical outcomes for patients through a variety of projects which ensure the best and most appropriate care is provided and that traditional barriers to care are reduced or removed altogether. • Aims to increase effectiveness and efficiency through the introduction of the new model of care. This includes enabling the realisation of cost savings to the health care system and demonstrating the value for money of the intervention). <p>Out of Hospital Strategies:</p> <ul style="list-style-type: none"> • By designing the models of care the MCP can support the development of flexible, needs based care pathways for patients. • Shared push to improve clinical outcomes and patient satisfaction (especially patients with long term conditions). • Reducing unnecessary costs and improving efficiency within health and social care by keeping patients out of hospital care through a variety of methods.

		<p>Locality plans</p> <ul style="list-style-type: none"> The Better Local Care model will make a positive contribution to achieving outcomes under each of the locality plans as it provides a flexible model to address local needs.
The Hampshire & Isle of Wight Sustainability and Transformation Plan	Delivers a place-based plan as the first instance of local NHS planning being accompanied by significant funding from central government	<ul style="list-style-type: none"> The promotion of long-term sustainability in health and social care provision and a focus on place-based programming. The delivery of MCP through a place-based solution through its 'bottom up' approach. Orienting care models to meet locally-articulated health challenges. Deploying technology to facilitate joined up care and providing attenuated patient pathways.
Southern Health NHS Foundation Trust	<p>Operational Plan 2016/17</p> <p>Outlines a vision to 'improve the health, wellbeing and independence of the patients we serve' through the introduction of care models that integrate primary, community physical and mental health and social care functions.</p>	<ul style="list-style-type: none"> Development of a new model of care which promotes the delivery of safe, appropriate services which are flexible and respond to the needs within each locality. Aims to improve the clinical outcomes for patients through a variety of projects which ensure that the best and most appropriate care is provided and that traditional barriers to care are reduced or removed altogether. Aims to increase the effectiveness and efficiency through the introduction of the new model of care.
	<p>Strategic Plan 2015/16 2018/19</p> <p>Aims to achieve 'excellent health and care outcomes' and build 'a sustainable, person-centred health and care system'. It notes the need to move towards a health system in which 'health and social care provision are integrated,' with stronger primary care and out-of-hospital provision, supporting people to stay healthier for longer.</p>	<ul style="list-style-type: none"> Introduction of new models of care in Hampshire moving towards model in which 'health and social care provision are integrated,' with stronger primary care and out-of-hospital provision. Both aim to provide excellent health and care outcomes' and build 'a sustainable, person-centred health and care system'.

3.3 Fit with other schemes and initiatives

Better Local Care's development will inevitably be influenced by innovative care developments elsewhere. Vanguard is linked with restructuring activities such as the Sustainability and Transformation Plans (STPs) and CCG Improvement and Assessment Frameworks (IAFs). A range of other initiatives have taken place which support integrated care, wellbeing and independence in Hampshire. Most notably the Prime Ministers Challenge Fund, Area Team Transformation Fund and Hampshire County Council's Reablement and Assessment of Care Team (REACT) service all seek to contribute to similar objectives of providing better access to care, and alleviating pressure on the system.

3.4 Stakeholder views on policy alignment

3.4.1 Fit with national policy

As part of the evaluation's research, delivery staff and strategic stakeholders were asked at the outset of the evaluation (October 2016), about the strength of fit between Better Local Care and national policy drivers. Some key comments are highlighted below, and further quotations are available in the RSM Landscape Review document.

"The main strategic link is with the five year forward plan for GPs [GP Forward View]. It provides the guiding principle for the redesign of care provision in GP Practices and the MCP will make a significant contribution to achieving this in this locality." General Manager

"It is absolutely aligned to national policy. It's about shifting care closer to home and developing community and primary care services so that they are sustainable in future. Four priority areas agreed are absolutely aligned to core elements we need to deliver locally." CCG Commissioner

"Better Local Care and the Vanguard MCP has accelerated the thinking around health care systems and changed culture in Hampshire and IoW – accelerated that by 5 – 10 years. Great catalyst, has caused a lot of discussion from theoretical conversations about co-commissioning primary care to actually having to get there quickly." GP lead at pilot site

3.4.2 Fit with regional and local policy

At the outset of the evaluation, external stakeholders and delivery partners were also asked about Better Local Care's fit with the regional and local policy objectives outlined above. There was general enthusiasm about the strength of fit between Better Local Care and local policy, though not the unanimity found when discussing fit with the national policy agenda;

"The MCP system gives us sufficient flexibility to mould ourselves around local policy requirements and needs. Inevitably as the MCP becomes more embedded we anticipate greater top-down control of spending." General Manager

"There's generally a feeling that the Better Local Care vanguard is something which is much aligned with the way in which people in N Hampshire saw care developing. There's a lot of support for community and primary led transformation and care." CCG Commissioner

"Our work in 2015/16 has been to align what we're doing with CCG objectives and iron out areas of uncertainty such as long term conditions. It's about connecting their historical knowledge and

commissioning knowledge with what we know about delivery". Internal Better Local Care Stakeholder

Interviewees also suggested that while the Hampshire & Isle of Wight Sustainability and Transformation Plan is becoming a stronger driver of activity, there is still a need for a narrower focus on the projects that are being proven to deliver results.

3.4.3 Other Schemes and Initiatives

At the baseline stage of the evaluation, a notable minority of interviewees identified aspects of Better Local Care where greater clarity could be provided, particularly regarding the roles and responsibilities of staff within a relatively complex environment. This includes the role of General Managers, who perform a dual role leading Southern Health's current integration work whilst simultaneously developing the design and ongoing delivery of Better Local Care-specific work. Interviews at the baseline stage also identified several issues surrounding the role and function of commissioners, and the extent of overlap and duplication in their work spearheading integrated care initiatives.

3.4.4 Views six months on

The evaluation team contacted many of the same external stakeholders and delivery partners again in March 2017 (6 months after original interviews were conducted). In total 15 interviews were conducted with staff across the Better Local Care area, including:

- CCG Representatives;
- MCP Representatives; and
- Southern Health Representatives (incl. General Managers).

The paragraphs below summarise interviewer's views on how the policy landscape has changed within those six months, and the implications that those changes have for Better Local Care.

Interviewees were asked whether the changing political landscape of the last six months has had any impact on Better Local Care. Interviewees reported that generally there is a greater alignment now between CCGs, Better Local Care, and national policy than there was at the outset of Better Local Care. Six interviewees stated that there was greater alignment between the objectives of commissioners and primary care providers, and stronger relationships between key actors. Specifically, interviewees cited:

"More collaboration regarding long-term care, including meetings between the Acute Trust and Better Local Care";

"Better alignment of the four CCGs";

"Reduced duplication between the Acute Trust, the MCP and the Integrated Care Board".

During follow-up interviews, four interviewees referred to the Sustainability and Transformation Plan footprint, suggesting there was increased integration and alignment across the Vanguards. Comments included;

"There is more alignment within the area following the publication of the Sustainability and Transformation Plan (STP), which, like Better Local Care, has an emphasis on non-medical care"

“The STP should act as the delivery oversight vehicle, and should bring both providers and commissioners together. Within this context Better Local Care should act as “enabler” rather than a system within itself.”

Overall, interviewees indicated that the changing strategic landscape was likely to have a positive impact on infrastructure within the Better Local Care area but that the current reality is that Better Local Care is operating in a highly fluid organisational context.

3.5 Organisational and NHS context in summary

The NHS has faced sustained financial pressures for almost a decade. These pressures are reflected in strategic policy documentation at all levels, from the national 5 Year Forward View and General Practice Forward View, to regional and local policies referred to in this section.

Ultimately, the drive for improved efficiency and effectiveness has had a significant influence on the focus of Better Local Care resources towards addressing system issues such as access to primary care and prevention of secondary care use. As discussed in Section 4, these drivers have taken a prominent role alongside improved patient care in the allocation of Better Local Care resources. Locally, severe pressure on primary care, particularly in more deprived localities, has also been a key feature of decision making. Internal and external strategic stakeholders believe that there is a greater alignment now between CCGs, Better Local Care, and national policy than there had been at the vanguard’s outset. Several strategic stakeholders also believe that there is better alignment between the objectives of commissioners and primary care providers because of Better Local Care.

Interviewees indicated that the changing strategic landscape (towards a more regionally focussed STP) was likely to have a positive impact on infrastructure within the Better Local Care area although Better Local Care currently operates in considerably fluid organisational context. This fluidity has exacerbated what is already a challenging resourcing landscape, and there has been recognition via strategic stakeholders and delivery teams that the MCP Vanguard has been subject to staff capacity constraints. More certainty regarding the organisational context in Year 1 may have facilitated stronger relationships with, for example, CCGs, Acute Providers, and other key system providers such as SCAS. To ensure that the Vanguard learning is not lost, Better Local Care should be positioned in Year 2 as an ‘enabler’ for bringing commissioners and primary care providers together under the new Sustainability and Transformation Plan Footprint.

4 AGGREGATED PROGRAMME DATA

This section aggregates data at the programme level to provide:

- An overview of expenditure across the four care model themes within Better Local Care (access, layering, extended primary care team and prevention).
- An overview of expenditure across each segment of the care triangle (whole population, urgent, ongoing and highest care needs).
- A summary of Better Local Care’s reach across GP practices and patient populations.

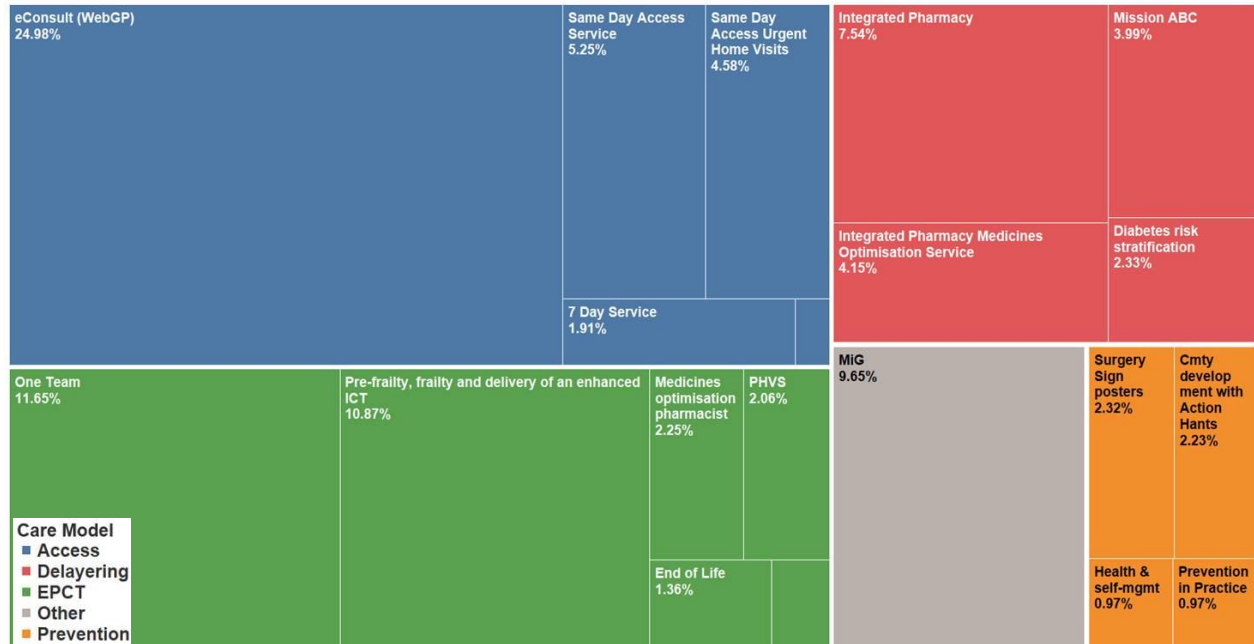
4.1 Programme overview

4.1.1 Vanguard investment by Better Local Care theme

The approved aggregate budget for 21 projects carried out under Better Local Care was £2,574,408. The figure below shows a breakdown of projects and budget allocation (by percentage) under the new models of care.⁹ The data in Figure 4.1 below shows approved budgets except in the case of eConsult (WebGP), which is recorded as two separate packages of £21,000 and £26,531 in the project budget list against an actual spend of £643,131.

The largest budget is allocated to projects under the ‘Access’ theme, totalling £870,371. This is followed by Extended Primary Care Teams (EPCT) with a budgeted £742,603, then Delaying at £463,685. The ‘Prevention’ theme had a lower allocated budget, totalling £309,416.

Figure 4.1: Budget Allocation against each Better Local Care model of care



Source: Hampshire Vanguard Finance report 2016 – 2017 financial year^{10,11}

⁹ Please note this does not include all Better Local Care funded projects

¹⁰ * = EMIS ; ** = Diabetes risk stratification; *** = Prevention in Practice, **** = Medication reviews, Clinical pharmacist

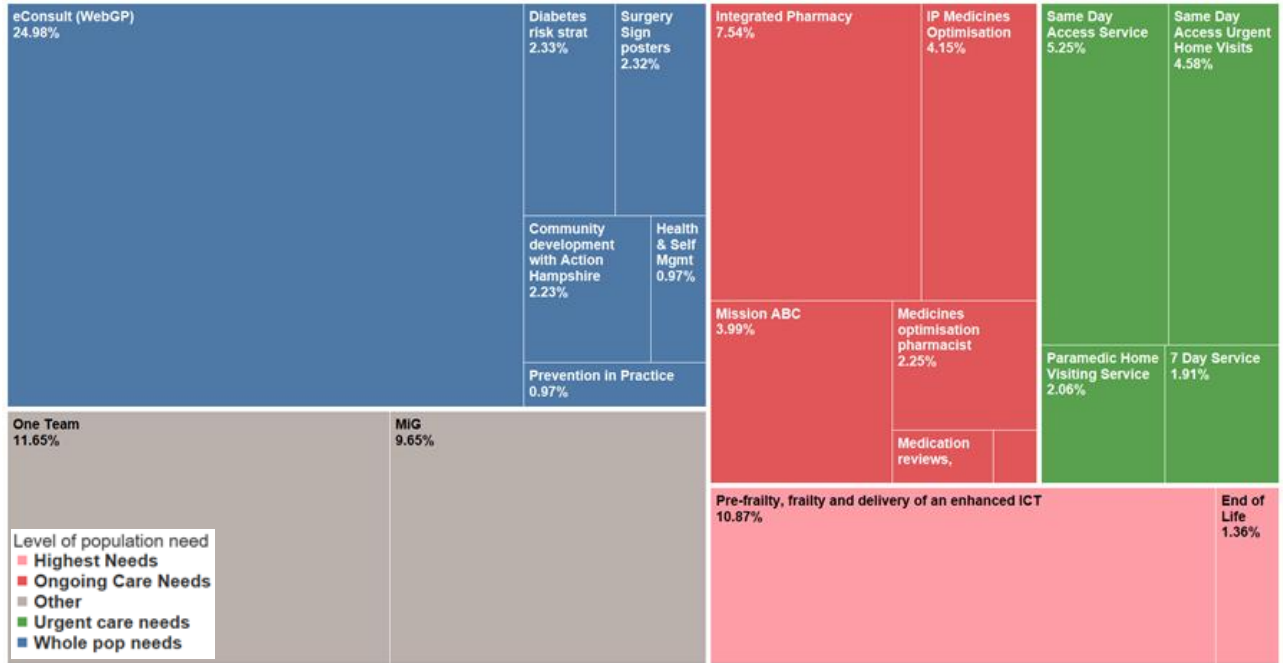
¹¹ A three year budget was allocated for MiG, therefore the figure includes an approximate budget for the first 2 phases of the project

Figure 4.1 above displays the relative size of each project’s budget, with projects grouped by colour depending on their assigned care model. The Medical interoperability Gateway (MiG) project, as a ‘technology enabler’, is classified separately. At a high level, budget allocations are logical given the context and need presented in Section 2. For example, East Hampshire has a comparatively high elderly population, which provides a basis for expenditure on pre-frailty, frailty and delivery of an enhanced ICT. Similarly, investment in Integrated Pharmacy and Medicines Optimisation is commensurate with the comparatively high LTC populations within several localities across Hampshire. However, as discussed in Section 3, Better Local Care has also been tasked with responding to significant system pressures. On balance, the focus of Better Local Care resources has oriented more towards addressing pressures in primary care, with a view to also addressing wider system pressures. This is reflected in comparatively high levels of investment targeted at improving access (evidenced above) and responding to urgent care needs. This is explained in more detail below.

4.1.2 Vanguard investment by care needs triangle

As well as being organised by care model, Better Local Care pilot projects are also classified by the level of health need of their target population segments. Figure 4.2 below shows the proportional size of individual project budgets organised by their position within the care needs triangle. Projects are grouped by colour depending on population segment: highest needs, ongoing care needs, urgent care needs and whole population needs. The two projects in grey fall under ‘other’: MiG is recognised as a technology enabler, and One Team is recognised as a team development initiative.

Figure 4.2: Budget allocation against the MCP Care Model



Source: Hampshire Vanguard Finance report 2016 – 2017 financial year ¹²

¹² * = EMIS; ** = Medication reviews, Clinical pharmacist; *** = Prevention in Practice, **** = Health prevention and self-management

The total allocated budget by population need is outlined below (A detailed breakdown of allocated budget and funding by project can be found in Appendix 3.)

- Highest needs: £314,953
- Ongoing care needs: £485,494
- Urgent care needs: £355,257
- Whole population needs: £870,371
- Other: £548,333

4.1.3 GP practices engaged in Better Local Care interventions

Background documentation and evaluation research to date indicates that there are at least 72 practices across Hampshire engaged in one or more Better Local Care projects. The table below outlines the number of localities and practices involved in Better Local Care interventions for which data was available at the time of writing.¹³

Table 4.1: Number of localities and GP practices engaged in Better Local Care projects

Project	Localities engaged	Target no.of practices	Number of GP practices engaged	Total registered population (approx)
One Team	9	No target set	38	384,237
Frailty Clinic	1	1	1	14,952
Integrated Pharmacy	1	11	7	68,950
Paramedic Home Visiting Service	1	6	6	55,195
Same Day Access Service	1	4	4	35,223
Surgery Signposters	3	5	5	54,457
WebGP	8	150	130	391,655
Total	24	177	191	1,004,669¹⁴

Source: Deep Dive Evaluation Reports, RSM

GP practices and list sizes arranged by locality can be found in Appendix 4. Based on our Deep Dive evaluation research, we estimate at least 70,000 patients across Hampshire have been users of *physical* Vanguard funded services i.e. excluding technological enablers such as WebGP and MiG.¹⁵

¹³ Please note this table does not include all Better Local Care funded projects in Hampshire

¹⁴ Note that these figures double count localities and registered populations that are involved in two or more BLC interventions.

¹⁵ This figure is based on aggregating activity data in Deep Dive reports and caveating gaps where data is unavailable. We approximate 50,000 patients to have been users of Vanguard funded services that were selected for Deep Dive evaluation, and estimated a further 20,000 based on projects such as MSK Physio, MECC, EPCTs, etc.

5 ANALYSIS OF NATIONAL METRICS

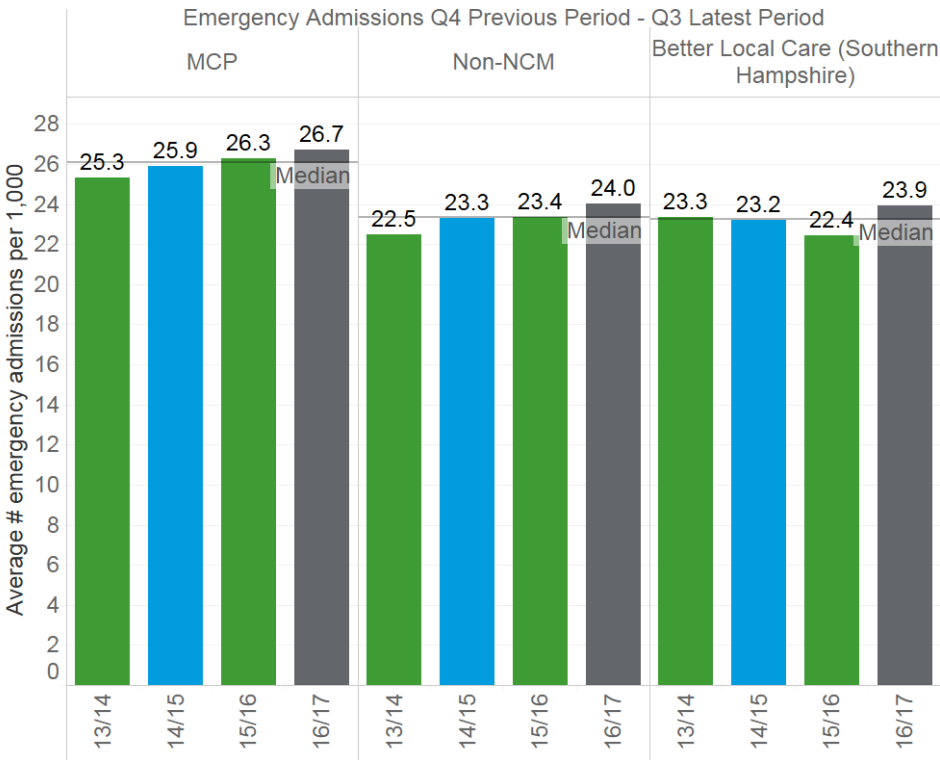
This section uses data from the NHS England New Care Models (NCM) Dashboard to discuss trends and make comparisons in Emergency Admissions and Non-Elective Bed Days between the Better Local Care area, other MCP Vanguard areas, and non-New Care Model (non-NCM) areas. For both measures (Emergency Admissions and Bed Days) the analysis focusses on i) rates per 1,000 population and ii) raw activity data compared to a synthetic region. Note that logic models at the local level preceded the New Care Models dashboard, and therefore local Better Local Care interventions were not originally designed to attach priority to these national measures.¹⁶

5.1 Emergency Admissions

5.1.1 Emergency Admission Rate

Pre-Vanguard data (Q4 2013 – Q3 2014) shows an average emergency admission ratio within the Hampshire Better Local Care area of 23.3 per 1,000 population, below the average ratio of all other MCP areas combined (25.3) but slightly higher than other non-new care model areas (22.5). Figure 5.1 shows how the average rate of Emergency Admissions per 1,000 population has changed since the 2013/14 period in the Better Local Care area, compared to the average rate in other MCP areas and to non-NCM areas.

Figure 5.1: Emergency Admissions 2013/14 – 2016/17 (per 1,000)



Source: NHS England NCM National Metrics Dashboard

¹⁶ Synthetic regions have been constructed by the NHS England NCM team and use estimates of Emergency Admission and Bed Day activity in non-NCM areas, based on the profile of the Better Local Care region between April 2012 and March 2015. The members of these regions are selected to provide a best fit¹⁶ to the profile (using a simulated annealing algorithm). These regions are then projected forward to allow for comparison with NCM areas.

Key takeaways from the data are:¹⁷

- The median rate of Emergency Admissions in the Better Local Care area (2013/14 – 2016/17) is equivalent to the median rate in non-NCM areas, and lower than the median rate in other MCP areas.
- The average rate of Emergency Admissions in the Better Local Care area fell in 2014/15, and again in 2015/16 to a low of 22.4 admissions per 1,000 population (Vanguard Year 1). It increased notably in the 2016/17 period, to above 2013/14 levels at 23.9 admissions per 1,000 population (Vanguard Year 2). Note that there is a potential danger of over-interpreting fluctuations in the Emergency Admission rate from one time point to the next due to the background variability in these indices.
- The reduction in the Emergency Admission rate between 2013/14 and 2015/16 contrasts with the trend in other MCP areas, and in non-NCM areas, which have both seen steady increases in Emergency Admission rates.
- The notable increase in the Emergency Admission rate within the Better Local Care area in 2016/17 brings it in line with the average rate in non-NCM areas. This may, however, reflect natural variation in the Emergency Admission rate.

5.1.2 Overall Emergency Admissions activity

Attributing changes in Emergency Admission rates to Vanguard interventions is highly challenging. In an attempt to establish a counterfactual against which changes to key performance indicators could be measured, the NHS England New Care Models evaluation team constructed 'synthetic regions'.

At the start of the overall measurement period (Q1 2012) the Better Local Care area closely matched trends within the synthetic region, as would be expected.

In 2015/16 the synthetic region saw an average of 5,581.75 admissions per quarter, roughly 385 higher than the average of 5,196.5 in the Better Local Care area. Since then, the number of emergency admissions in the Better Local Care area has increased by more than the synthetic region.¹⁸ The average number of emergency admissions between Q1 and Q3 2017 for the synthetic region was 5,697.3, compared to a Better Local Care average of 5,568 (a smaller difference of 129).

The Better Local Care area's performance in Emergency Admissions compared to the synthetic region mirrors the per 1,000 population data, reflecting a notable increase in admissions in Year 2 of the Vanguard.

¹⁷ Given challenges in attributing these data to local interventions, the evaluation has not performed formal statistical testing to inform the narrative in this section.

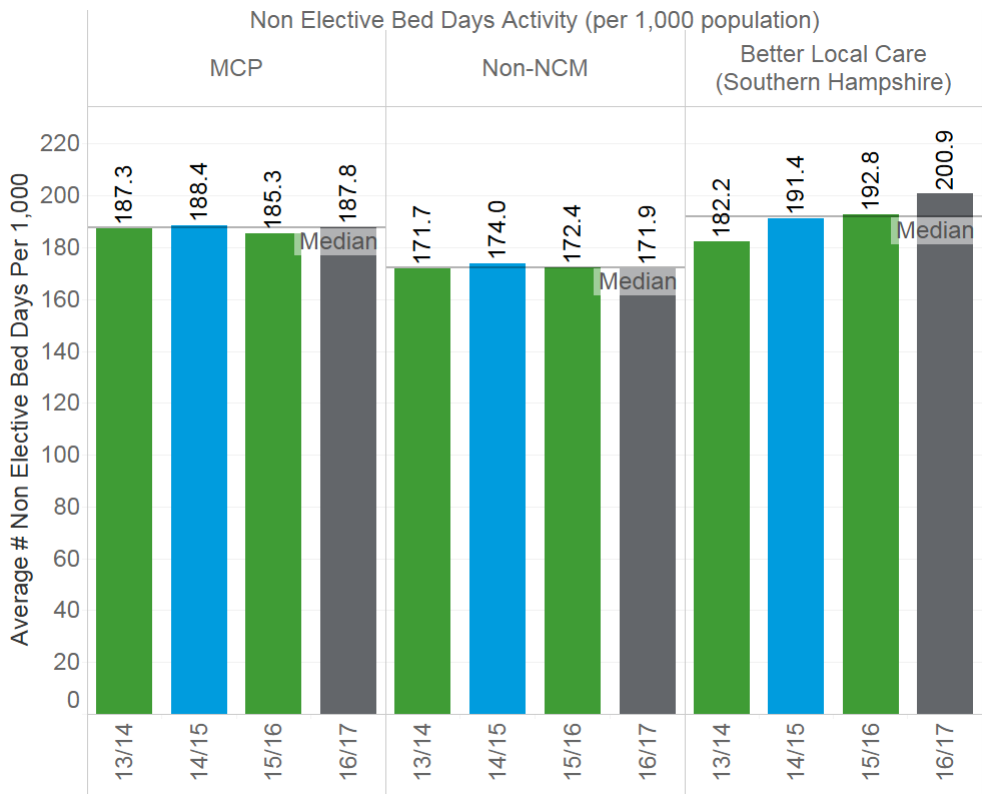
¹⁸ Again, caution is needed in comparing these changes without considering the background variability in these numbers.

5.2 Bed Days

5.2.1 Bed Days per 1,000 population

Pre-Vanguard data (Q4 2013 – Q3 2014) shows an average bed day rate within the Hampshire Better Local Care area of 182.2 per 1,000 population, which was below the average ratio of all other MCP areas combined (187.3) and above other non-NCM areas (171.7). Figure 5.2 shows how the average rate of Bed Days per 1,000 population has changed since the 2013/14 period in the Better Local Care area, compared to the average rate in other MCP areas, and to non-NCM areas.

Figure 5.2: Bed Days 2013/14 – 2016/17 (per 1,000)



Source: NHS England NCM National Metrics Dashboard

Key takeaways include:

- The median rate of non-elective (NEL) bed days in the Better Local Care area (2013/14 – 2016/17) is marginally higher than the median in other MCP areas, and considerably higher than the median in non-MCP areas.
- The average rate of NEL bed days in the Better Local Care area rose marginally between 2014/15 and 2015/16 (despite declining Emergency Admissions), and much more steeply in 2016/17, by 8 NEL bed days per 1,000 population.
- The increase in NEL bed days is in contrast to the trends in other MCP areas, and in non-NCM areas where the average rate has remained flat over the period.

5.2.2 Overall NEL Bed Days Activity

Comparison with the synthetic region shows that with the exception of Q1 2015-16, the synthetic region had consistently lower levels of NEL bed days activity compared to the Better Local Care area.

5.3 Summary

- Better Local Care performed better than the synthetic region on Emergency Admissions in Year 1 of the Vanguard, before seeing a notable increase in Emergency Admissions in Year 2.
- The Better Local Care area underperformed against the synthetic region, non-MCP and other MCP areas on the NEL bed days measure, which is evidence of the ongoing pressures faced in the local health system.
- The ability to compare Better Local Care performance to a synthetic region provides insight that would not otherwise be possible. However, data at this level of geography provide limited insight into the contribution that MCP funded interventions have on either Emergency Admissions or NEL bed days, particularly given the local focus of Vanguard funded interventions, and the wide range of other factors at play.
- Crucially, the data is also unable to show whether or not the increases in Emergency Admissions and NEL bed days in 2016/17 would have been more severe in the absence of Better Local Care interventions.
- In the absence of a control group that would allow quantitative assessment of the counterfactual scenario, subsequent sections of this report provide qualitative opinion from a range of internal and external stakeholders regarding the likely counterfactual position.
- In an attempt to provide more granular insights, the Chapter 6 overleaf analyses local metrics compiled by the South Central and West Commissioning Support Unit (SCW CSU) in quarterly dashboards that have been routinely submitted to NHS England via quarterly reporting.

6 ANALYSIS OF LOCAL METRICS

South Central and West CSU were tasked with gathering monitoring data from pilot sites and subsequently populating a local metrics dashboard on a quarterly basis for review by programme stakeholders.

RSM reviewed the scope and quality of local metrics as part of the evaluation process. A full table detailing these metrics for Quarter 3 and 4 is displayed in Appendix 5 accompanied by commentary on the data. At the time the local metrics dashboard was compiled, the Better Local Care programme was organised around four key 'themes'. While the programme has since re-organised its focus towards a whole system intervention, the findings presented in this section remain organised by theme.

6.1 Theme 1: Access

Better Local Care's key short-term outcomes for the 'Access' theme were to a) improve overall satisfaction with primary care services, and b) to reduce A&E attendances. At programme level there are five local metrics designed to measure changes in access to care. The core project aimed at improving access to urgent primary care services is the Same Day Access Services (SDAS) which has been piloted in Gosport (see Section 7.3.1 for more detail). Most localities also piloted the 'eConsult' online appointment and diagnosis system under Better Local Care. A fuller break down of Access Metrics are listed in Appendix 6.

Theme 1: Access – Local Metrics

1. Percentage of patients have their issues resolved on the same day following contact with primary care.
2. Percentage of patients 'satisfied' or 'very satisfied' with the service.
3. Number of first attendances at A&E.
4. Percentage of attendances coded VB11Z - no investigation with no significant treatment.
5. Percentage of patients who say they no longer needed a face-to-face GP appointment.

6.1.1 Same Day Resolution

The percentage of patients having their issues resolved on the same day (1) reflects the performance of same-day primary care services in providing the right level of primary care response to patients' urgent care issues. Data gathered from EMIS (GP record management system) for the SDAS shows that 73.4 per cent of patients during Q3 had their issues resolved on the same day, well above the initial guideline target of 40 per cent. In South West New Forest 45.6 per cent of patients indicated that they had their issue resolved on the same day, suggesting the 40 per cent target is appropriate for early-stage interventions.

6.1.2 Patient Satisfaction

Patient satisfaction (2) measured using SDAS patient surveys is suggested to have improved over the course of the service at six monthly intervals (May – Dec 2016). Satisfaction measures across other localities taken in separate surveys (e.g. in SWNF) show high satisfaction levels.

Further data regarding patient satisfaction with individual Vanguard funded services is available in project specific Deep Dive evaluation reports. For example, the Paramedic Home Visiting Service saw very high levels of patient satisfaction. One hundred percent of patients (n=38) reported they were treated in a kind / caring manner; and the same number reported that they were either 'satisfied' or 'very satisfied' that their issue had been resolved.

In Year 1 of the evaluation, patient satisfaction data was gathered predominantly by service delivery staff (across different interventions) and is therefore subject to participation bias. In Year 2 the evaluation team will conduct an independent survey with patients which will serve to validate patient experience and capture additional patient outcome data.

6.1.3 A&E Attendance

A&E data on total attendances (3) can feature wide fluctuations making comparison difficult to achieve without segmented populations/control groups. The data suggest that no single locality met the target of a 3 per cent decrease on year-to-date, though information governance issues prevented reporting of SUS data in quarters 3 and 4. The external evaluation team is working with SCWCSU and South Eastern Hampshire CCG to enable use of patient level SUS data in Year 2.

6.1.4 Attendances coded VB11Z

The fourth access measure (4), VB11Z ('No investigation with no significant treatment') is one of 11 A&E codes and can act as a proxy for perceptions of access to primary care. Table 6.1 shows the percentage change in A&E attendances coded VB11Z by locality between Q2 of 2016 and 2017.

Table 6.1: Percent change in A&E attendances coded VB11Z (Q2 2016 to Q2 2017)

Locality	VB11Z %
Gosport	6.3
Fareham	13.8
East Hampshire	-12
Havant, Hayling Island and Emsworth	-1.5
Waterlooville	0.4
Andover	-52.6
Eastleigh	11.2
Eastleigh Southern Parishes	28.2
Mid Hants	-0.9
SW New Forest	1.5
Totton and Waterside	5.2
Southampton Central	5
Southampton East	25.8
Southampton West	4.4

Source: Better Local Care Dashboard

The data does not appear to show any detectable trends across the participating Better Local Care localities and there are large fluctuations across the different areas. This is likely a result of the data being limited to quarterly measurements as opposed to a more frequent interval (e.g. monthly), therefore results are represented through a restricted number of data points used to make up the sample. In Gosport, a key target area, the percentage change was 6.3 per cent growth from a year earlier, with longitudinal data on VB11Z suggesting steady levels of A&E admissions coded as VB11Z over 2 years.

6.1.5 Need for Face-to-Face GP appointments

Changes in the percentage of people no longer needing a face-to-face GP appointment (5) can be used to reflect changes in urgent care provision. However, there is no general or routine source used for this data, and it has been reported manually at locality level. The data collection method for this metric in Year 1 is therefore somewhat unreliable and cannot be used to infer changes in provision of urgent care. In Year 2 of the evaluation, this indicator is to be supplemented by proxy indicators from the GP Patient Survey, such as patient use of telephone and / or online consultations.

6.2 Theme 2: Delayering

‘Delayering’ refers to the simplification of diagnosis and care pathways to subsequently reduce the length and complexity of patient journeys. Better Local Care’s key short-term outcome under this ‘Delayering’ theme has been to improve management and self-management of diabetes, respiratory conditions and Cardiovascular Disease (CVD). The Table below provides a summary of Better Local Care interventions that were funded under the delayering theme.

BLC Funded Intervention	Summary	# Patients Reached
MSK Practitioner	An intervention designed to improve clinical and care outcomes with two Musculoskeletal (MSK) practitioner clinics per week, which delays the path to specialist care. Patients can directly refer to a physiotherapist rather than a GP. The intervention involves the introduction of two MSK practitioners for 4 hours a week divided into 12*20 minute clinics, an IT infrastructure (booking systems and processes), financial resources, clinical leadership and a shared IT platform and access.	239
Mission ABC Carousel (Respiratory, East Hampshire, South West New Forest)	An intervention that builds on the recommendations of the National Review of Asthma deaths (NRAD) (RCP 2014) and the GOLD (2015) guidelines as well as given successes of previous projects that demonstrated a decrease in measures of healthcare utilisation. The project involves hospital staff, provision of access to GP lists to carry out searches, project	1,000 (Hampshire wide)

	funding and PM resource from Wessex AHSN, MCP funding, technology support from innovators and support from third sector organisations.	
Mission ABC Carousel (Breathlessness, Totton)	This intervention is a community based 'One-stop Breathlessness clinic' which intends to speed up the assessment process for patients with breathlessness of an unknown cause. The clinic involves respiratory and cardiology consultants with portable equipment, IT support in primary care and Respiratory, Heart failure and Palliative Care teams.	77
LTC Risk Stratification (East Hampshire)	By introducing care closer to home in a primary care hub, this project focuses on delayering specialist support and promoting health, specifically targeting an improvement in diabetes management. It includes a specialist nursing team, GP, health care assistants, dietetics, podiatry and therapy staff.	Did not proceed.
Integrated Pharmacy (SWNF)	This intervention takes the opportunity to integrate seven practices with support provided by two pharmacy teams that did not previously work together, introducing scope for integration and for pharmacy teams to focus resources on supporting the frail.	4,000 patient queries

The local metrics measured under the 'delayering' theme are presented below in a highlighted form. A fuller breakdown of the metrics being summarised can be found in Appendix 7. Detailed data and analysis was not available to the evaluation for all of these metrics.

Theme 2: Delayering – Local Metrics

1. Number of new care pathways developed and implemented for long-term conditions.
2. Long-term condition (LTC) population identified and risk-stratified including diabetes, chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD).
3. Number of people have their complex clinical needs optimised.
4. Percentage of complex needs patients with improved quality of life post-intervention.
5. Percentage of patients with long-term conditions who feel 'very confident in managing their own health'.

6.2.1 Number of new care pathways for LTCs

This refers to pilots which were intended to create new pathways for patients with particular long-term issues, such as diabetes or respiratory-related conditions. The outcomes are concentrated in areas where these pilots were featured such as East Hampshire (new respiratory model) and New Forest (new diabetes pathway). Returns for Q3 suggest that 24 new pathways had been developed, compared to the same period a year earlier. The utility of this particular metric is questionable and will be revisited in Year 2.

6.2.2 Long-term condition (LTC) population identified and risk-stratified

This metric includes Diabetes, Chronic obstructive pulmonary disease (COPD) and CVD. In cases where large populations were involved (e.g. the population of those with long-term conditions risk-stratified) the resulting data that was made available to RSM PACEC appears to have been estimated and rounded. Three different localities returned a value of 23,000 for this particular metric and only the South West New Forest locality appears to have monitored this data from the outset rather than providing estimates.

6.2.3 Number of people having their complex clinical needs optimised

The cumulative number of individuals with complex clinical needs whose care has been optimised was 855 in Q3 2016, up from ~600 identified in RSM's landscape review in late 2016. Again, this indicator should be more closely defined in Year 2.

6.3 Theme 3: Extended Primary Care Teams (EPCT)

Rolling out extended primary care teams is one of the two overarching objectives of the Better Local Care vanguard which were set out in its initial value proposition document. Better Local Care's key short-term outcome for the EPCT theme is the reduction of acute hospital activity for case managed populations. Five measures were used to assess performance in developing the Vanguard's EPCTs (the selection of metrics are designed around the care of elderly populations). A full breakdown of this EPCT metric data can be found in Appendix 8.

Theme 3: Extended Primary Care Teams

1. Number of primary care practices live with MiG (technology platform for patient data exchange).
2. Number of care homes receiving regular structured in-reach.
3. Number of emergency admissions by residents of care homes.
4. Number of people identified as pre-frail and frail with a care plan.
5. Number of emergency admissions for falls.

6.3.1 MiG live practices

As of March 2017, 103 out of 112 practices under Better Local Care had signed up to implement MiG, and 92 were 'live', leaving 11 practices set to go live. The use of MiG across practices grew quickly from 29 practices (22 per cent) in Q1/Q2 to 69 (53 per cent) in Q3. However, as explored in more detail in the MiG Deep Dive report, this data relates only to 'Phase 1' of the MiG implementation i.e. where functionality is one-way, allowing Southern Health staff to access primary care records. More information regarding the roll out of MiG, including Phase 2 plans, is available in the Deep Dive evaluation report.

6.3.2 Number of emergency admissions by residents of care homes

The number of emergency admissions by residents of care homes was recorded for Q2 only against the previous quarter a year earlier, providing little scope for comparison. The data shows that six

localities performed better and eight performed worse compared to a year earlier. This trend is in keeping with the national metrics dashboard which shows a notable spike in emergency admissions in 2016/17.

At this stage, it does not appear that projects such as the Paramedics Home Visiting Service (Waterlooville locality) have impacted care homes admissions data, as the number of admissions grew slightly from 49 to 58 compared to the same quarter one year earlier. The overall vanguard-level data suggest a minor increase in admissions from care homes, up 1.4 per cent over the year.¹⁹

There were some reductions in emergency admissions from care homes in areas with targeted pilot activity. In the Havant, Hayling Island and Emsworth locality, where the targeted Care Homes Team pilot was focused, the data show a reduction in admissions from 87 to 72, a total reduction of 17.2 per cent. In Totton and Waterside, where respiratory management programmes were piloted, there was similarly a reduction, this time of almost a quarter from 108 to 82.

6.3.3 Number of emergency admissions for falls

The number of emergency admissions for falls varied, with 8 BLC localities seeing reductions and 6 experiencing increases. Across the entire vanguard area, the data suggest considerable reduction in falls over the monitored period, down by 5.7 per cent.

There were notable decreases in falls-related admissions within localities that have introduced care plans and frailty management work. Eastleigh Southern Parishes provided care planning for 32 frail patients in co-ordination with local authorities, carers and community providers and saw a 14.5 per cent decrease in falls-related admissions, from 83 to 71. In Waterlooville, where home visiting was followed up by GP planning work, there was a decrease of 12.6 per cent. There was also a decrease of 23.1 per cent in the Havant, Hayling Island and Emsworth locality, where specific activities were undertaken to target a reduction in falls through five training modules across homes. No data was submitted to RSM PACEC on the number of pre-frail or frail persons or those with a care plan.

6.4 Theme 4: Prevention

Prevention metrics focus on larger population segments that reside at the lower end of the care needs pyramid. Better Local Care's key short-term outcome for the 'Prevention' theme was an increase in instances of signposting and utilisation of self-help as well as provision of structured support for risk factor modification and social support. As discussed in Section 4, the Prevention theme received the smallest proportion of Better Local Care funding (four interventions representing approximately 7 per cent of total investment). While the smaller number of prevention oriented interventions is understandable given the programme's priority focus on relieving pressure within primary care, Better Local Care may wish to consider rebalancing spend to focus more on prevention in Year 2.

Due to these focuses of BLC the indicators used at local level are more focused on capacity-building for intervention. The three thematic indicators are:

¹⁹ Note that this data is difficult to measure accurately.

Theme 4: Prevention

1. Number of lifestyle behaviour change outcomes (smoking quitters, 5 per cent weight loss)
2. Number of frontline workers trained in MECC through the MCP programme
3. Number of patients signposted to social support by Surgery Signposters / Care Navigators


Evidence based on the first two indicators was unavailable to the evaluation, likely because the indicators are aimed at activity confined within Gosport. The number of individuals assisted through signposters/care navigators (indicator 3) grew from 214 in Q2 to 428 in Q3. It should be noted that this figure is slightly higher than the figure of 358, which was provided to the external evaluation team in January 2017, once again highlighting the need for greater consistency in data collection and reporting under BLC interventions. As discussed in greater in Chapter 7 overleaf, the signposters service is somewhat under-utilised currently.

6.5 Summary

Based on the data available, performance against local metrics has varied. In broad terms, the programme appears to have performed better on measures relating to access to primary care and in rolling out technological enablers such as MiG, showing less success on measures relating to the delayering of specialist care or prevention oriented initiatives. However, the analysis presented here is skewed towards indicators that are comparatively easy to capture, and it must also be caveated due to the coverage and quality of data currently available, as discussed in more detail below.

The process of gathering and monitoring programme data over the lifetime of the vanguard provides important learning. Evaluation providers at all levels, from the NCM central team, to local external evaluators and internal evaluation leads have been refining their approaches to deliver more useful data, putting in place the processes and resource required to generate credible evidence and subsequently meaningful evaluation. There are several related points emerging from the analysis of the Better Local Care national and local metrics, notably:

- In most cases, data gathered centrally by the NCM team is at too high a level of geography to show effects generated by the type (scope and scale) of projects that the Vanguard has funded. It is also not specific to targeting populations. In Year 2 the Better Local Care evaluation team will invest more time in supporting local data collection. Additional focus by the central NCM team would be beneficial (e.g. in identifying and / or validating metrics, supporting the Information Governance processes necessary to enable more robust local evaluation, and establishing locally viable control group data).
- Data coverage and data quality in Year 1 of the evaluation have been negatively affected by several factors including most notably a) information governance restrictions and b) limited capacity of delivery staff to devote time to monitoring and evaluation activity. Year 2 of the Vanguard will focus on a narrower geographic area (Gosport & Fareham) and the external evaluation team will be more closely involved in designing and assisting data collection.
- The rationale for selection of the individual local metrics is not clear in all instances. For example, reporting the number of 'new care pathways' developed is of little value in



understanding either system or patient effects. Again, the narrower focus in Year 2, and the external evaluation team's involvement in evaluation design should deliver a smaller set of useful indicators and measures.

- A focus on additional patient experience and outcome data will be required in Year 2, as data has been limited in Year 1. The external evaluation team will agree processes that enable an independent patient telephone survey to be conducted across multiple Year 2 interventions. The telephone survey will be used to validate patient experience data and capture data on patient outcomes to the greatest extent possible.

7 CARE MODEL INSIGHTS

This section provides a brief commentary on evidence that was made available to RSM PACEC for its individual Deep Dive evaluation reports, before providing a synthesis of key findings. The deep dive projects are listed under several categories of intervention type.

7.1 Quality and strength of monitoring and evaluation data

Each of the individual projects which were subjects for Deep Dive evaluation featured different monitoring and data capture practices. This resulted in considerable variation between each report in the quality and scope of evidence generated and subsequently the strength of that evaluation's evidence. Each Deep Dive report (made available separately to Southern Health NHS Foundation Trust) includes a detailed methodology and associated study limitations detailing these considerations as well as recommendations from the RSM PACEC team for further improvement of the intervention monitoring. The most common area identified for improving the strength of evidence across the range of projects was in the 'design' category, such as in the ability to control sample bias and explain effects due to a lack of valid comparator groups.

7.2 Whole population interventions

Better Local Care supported seven interventions which sought to address whole population care needs. These included the following projects that were the subject of Deep Dive evaluation reports:

Making Every Contact Count (MECC): A national approach to behaviour change, supported by local government and the NHS, that aims to develop the workforce to promote healthier lifestyles through interactions that individuals have within healthcare.

Web GP / e-Consult: An online service that gives adults access to a range of services including online 'e-Consults' which provide access to their GP Practice and medical advice without having to attend.²⁰

Surgery Signposters: An initiative aimed at reducing pressure on GP services by using trained volunteers to 'signpost' individuals to relevant voluntary and community sector services.

The key evaluation findings for these interventions are presented in the sub-sections below.

7.2.1 Making Every Contact Count (MECC)

Making Every Contact Count (MECC) is a national approach to behaviour change, designed by Health Education England and supported by the NHS. It is a long-term national strategy which aims to ensure that staff from the NHS and from other organisations take every opportunity to help patients and visitors make informed choices about their health-related behaviours, lifestyle and health service utilisation. It aims to train a wider public sector workforce (local authority, community and voluntary sector staff) to promote a healthier lifestyle through brief intervention 'healthy conversations'.

²⁰ Note that the external evaluation team produced an interim evaluation report on the e-Consult service but the final evaluation was conducted and produced internally by Better Local Care staff.

7.2.2 Activity to date

The intervention is led by the Gosport Borough Council and the Better Local Care localities are participants. At the time of writing, 11 public and community sector stakeholders had undertaken Train the Trainer training after becoming involved in the network. They represent organisations and teams across various sectors and include three staff from Gosport Borough Council (from the Housing Service, and Corporate Policy & Community Safety Section), one staff member from the Hampshire County Council Library Service, three third sector staff members, three individuals from the Places for People Leisure centre in Gosport and one individual from the Fareham & Gosport Clinical Commissioning Group, who holds the same remit across the South East Hampshire CCG.

In addition to 'Train the Trainer' sessions, a total of 39 people had completed 'Healthy Conversation Skills' training via the Gosport MECC Network. The training has been delivered to mixed delegate groups so that people had the opportunity to network and gain knowledge of other sectors and roles. The profile of participants to date has been varied, including staff and volunteers from across sectors including local council services, primary care, commissioned sexual health service, voluntary sector groups supporting older people, an armed forces charity, and a mental health support charity. Further training sessions are planned on a monthly basis throughout the second quarter of 2017. At the time of writing a total of 21 participants had signed up to two of the three training sessions.

7.2.3 Participant outcomes

In total, there were 15 full (pre and post) responses to a MECC trainee competency questionnaire. The questionnaire was ranked on a scale of one to ten, with ten being the most positive rating. Figure 8.1 below illustrates the change in participant ratings regarding their confidence to support individuals in making lifestyle changes before and after MECC training.

- On average, participants gave a rating of 6.4 [95 per cent CI (5.7, 7.2)] before MECC training, and a rating of 8.1 [95 per cent CI (7.4, 8.7)] having completed MECC training;
- 11 of the 15 participants denoted a positive change in their confidence to support lifestyle changes following MECC training;
- The difference in pre and post training scores ranged from -1 (one participant) to +5. The median change in pre and post confidence levels was 1.8 [95 per cent CI (0.9, 2.7)].

Figure 8.1: Pre and post training average scores for confidence and skills (n=15)



Source: MECC in Gosport monitoring data,

MECC participants were also asked to rate how important they believe it is for them to support individuals to make lifestyle changes. On average, participants gave a rating of 7.4 [95 per cent CI (6.6,8.3)] before MECC training and a rating of 7.7 [95 per cent CI (6.9, 8.6)]. Seven participants denoted a positive change in their rating of how important it is to support individuals to make a lifestyle change. This is unsurprising given that MECC trainees are first and foremost providers of either public or community services, and therefore predisposed to attaching relatively high degrees of importance to supporting members of the public generally;

Lastly, MECC training participants were asked about how useful they felt 'conversations' were in supporting individuals to make lifestyle changes. On average, participants gave a rating of 6.5 [95 per cent CI (5.8,7.5)] before MECC training and a rating of 8.1 [95 per cent CI (7.42,8.84)] after MECC training. A total of 11 out of 15 participants denoted a positive change in their rating of how useful conversations are in supporting individuals to make lifestyle changes.

Wider outcomes

While no data was available from public service users regarding the effect of MECC on their health-related behaviour (a gap that also exists in the wider MECC evaluation literature), in-depth interviews with members of the MECC in Gosport network provide some insight into perceived benefits beyond participant outcomes, including:

"I think that the research shows that just giving someone a leaflet doesn't encourage them to take up a service. If we can give the patient a bit more detail, and talk to them about their decision, and then signpost, rather than just signpost then they are more likely to take it up."

"I think it quite often saves time – you can bring them down fairly quickly because they understand that you're listening to them, and you get to the issues quicker. MECC guides you into asking those questions."

Interviewees were asked to describe what in particular about MECC training derived these benefits. Responses consistently pointed to both the content and format of MECC training:

"The role play aspect of training is particularly beneficial. That was good because we had people from different organisations. You got to see an insight into how other organisations deal with things e.g. Council Environmental Department who deal with people who hoard stuff."

"I think you get more out of this type of training face to face, particularly the role plays and the interaction with the people in the room."

Group consultation with the MECC in Gosport Network highlighted that to date (albeit at an early stage) it has been more difficult to engage primary care staff. When interviewees were asked if they could suggest any reasons for lower levels of engagement by primary care staff the availability of alternative provision within Gosport GP practices in the past, and logistical issues were noted.

"In the practice we do have training for dealing with difficult patients, but MECC isn't just about patients, it's about everybody. The Practice I worked in before had the Medical Defence Union provided free training, the trainer was bought in. Under Southern Health a lot of their training is online, so I'm not sure the practice training will be available in future."

"It requires a bit more organising to get practice staff there. If you're going to make it worthwhile for practices you'd need to do it on a bigger scale. Four times a year practices have target afternoons

which is an opportunity for in house training – you would have to arrange it around that (tailoring so it could be completed in a 4-hour slot) and it would be a good opportunity to get that in.

“There has been a good take up from different sources, but I’m wondering whether that is going to continue and whether it is wide enough. At the end of the day it comes down to organisational decisions on whether cost is beneficial. There is a risk there, while not theoretically costing anything, it is still going to be 6 – 7 hours pay per member of staff which is not insignificant in a small business.”

Conclusions

- Evidence on the health profile of the local population indicates a need for intervention.
- MECC presents a strong fit against the objectives of the Hampshire and Isle of Wight Sustainability and Transformation plan.
- The MECC Network has successfully delivered TtT training to relevant staff in the public and community sectors. This training has been cascaded to just under one third of the Year 1 target participant number within the first quarter of the year. As such, the MECC in Gosport Network is on track to meet its participation target.
- While sample sizes are small, early evidence suggests that MECC has led to an increase in trainee confidence, skill level, and belief in their ability to influence lifestyle.

Recommendations

- The evaluation does not include evidence from patients / service users who have been supported by MECC trained staff. While this evidence can be considered difficult to capture, it should be considered as part of future evaluation activity.
- Health Education England – Wessex Team, working with Better Local Care and the MECC in Gosport Network, should consider whether MECC training can be tailored to be delivered in 4-hour slots locally in Gosport E - consultation²¹

7.2.4 E-Consult (WebGP)

e-Consult (WebGP) is an online service that gives adults access to a range of services including online ‘e-Consults’ that allow them to obtain medical advice without the need to attend their practice. Some functions (self-help and sign-post information) are available 24 hours a day, 365 days a year, whilst access to medical advice is provided by the end of the next working day for non-urgent consultations.

Activity to date

The e-Consult (WebGP) project is the first large scale roll-out of this size and provides an opportunity to test the associated issues and lessons associated with projects of this type i.e. across Hampshire and its 10 individual Multispecialty Community Provider (MCP) localities.

²¹ Information taken from the final internal Better Local Care evaluation report, Christison. N., (2017) “Evaluation of e-Consult (WebGP), 20th March 2017.

A total of 130 (87 per cent) of the 150 Practices in scope were recruited across Hampshire, with a registered patient population of approximately 1.2 million. This means that the project is about 10 times bigger than the original Hurley Group pilot completed in 2015 (this figure includes 34 Practices recruited in Southampton).

Service Outcomes

The new online e-Consult service is well used and Practices have reported that it is helping to manage demand without impacting significantly on the Practice's or the wider health economy workloads. Key outcomes include and takeaways include;

- Patients reported that they were satisfied with the service, that got the help they needed and would recommend it to others i.e. between 80 – 95 per cent (n=851).
- e-Consult is available to 810,000 patients registered in the 73 Practices that have already launched the new service.
- Almost 44,000 'unique' individuals have used it, saving an estimated 11,200 GP appointments since July 2016.
- Sixty-six percent of all e-Consults were managed remotely meaning, potentially, that more appointments were saved than estimated (12,318.8 of 18,680 e-Consults received).

However, some issues remain.

- Investment in about one third of Practices (24) has not been realised. Of these 13 have decided to withdraw and has a value of about £69k. Whilst the contract does not allow for a refund, the provider has agreed to a free extension of two MCP locality contracts to align renewal dates in East Hants, which equates to a similar value – meaning the investment has not been wasted.
- Only 73 of the Practices outside Southampton signed up have launched the new service, meaning that project support is needed for the 11 remaining Practices and if approved, will slip into 2017/18.
- Most Practices have only been using e-Consult for a few months, which is not long enough to fully assess if it is helping to manage demand – although aggregated data to date would suggest that it is.
- The percentage registered population using e-Consult needs to increase from 5 per cent (YTD) to 20 per cent to ensure full benefits are realised. Practices using e-Consult the longest are already exceeding this target (Jubilee Practice).

Recommendations

Evidence to date supports the roll out of the e-Consult service. RSM PACEC recommends going forward;

- Retest the market provision for an e-Consult solution to ensure the best quality and value solution continues to be procured.
- Update or develop a local directory of services and work with the provider to ensure that e-Consult directs Hampshire residents to local services.

- Work with patients and the provider to improve the e-Consult patient feedback function.

7.2.5 Surgery Signposters

Surgery Signposters is an initiative aimed at reducing pressure on GP services by using trained volunteers to ‘signpost’ individuals to voluntary and community sector services. The pilot began in four sites, covering 13 GP practices.

Activity to date

A total of 372 patients have been referred to the service through a GP, nurse or self-referral. Approximately 20 volunteers have received training to ‘Signpost’ patients.

Table 7.1: Surgery Signposter practices

Practices	Registered population
Westlands Medical Centre	10,164
Bosmere Medical Centre	17,918
Brune Medical Centre	8,838
Gosport Medical Centre	9,107
Waterside Medical Centre	8,430
Total	35,223

Service use data

Three hundred and fifty-eight patients were seen between November 2015 and January 2017. This is lower than the original target of 500, due to lower than anticipated uptake of the service in some localities. The first phase of the pilot involved Waterside Medical Centre only, the service was then rolled out to Brune Medical Centre, Gosport Health Centre, Westlands Medical Centre and Bosmere Medical Practice later in 2016. A total of 173 individuals used the service in Phase I (November 2015 – June 2016). A further 185 patients were seen during Phase II, however the average number of patients seen per month in practices taking up the service more recently is lower than the numbers seen in Phase I.

Patient confidence and wellbeing (R-Outcomes)

The Surgery Signposters intervention uses a research tool called R-Outcomes to capture feedback from patients on an ongoing basis. A total of 99 patients completed a baseline R-Outcomes survey, and at the time of writing 15 follow-up surveys had been completed. Follow up surveys are given to patients 4-6 weeks after referral in to the service. The R-Outcomes survey has four measures; experience, health confidence, personal wellbeing and health status. Scores are between 0 and 100, with 0 being the lowest and 100 being the highest. The overall scores indicate an improvement across all four measures.

R-Outcomes data suggests improvements in patient experience (up 5 points within the follow-up data); health confidence (up 20 points within the follow-up data); health status (up 8 points in the

follow-up data); and personal wellbeing (up 10 points within the follow-up data). Note that baseline scores on the latter two measures (health status and personal wellbeing) were notably lower than baseline figures for patient experience and health confidence. These results should be treated with caution due to a small sample size and potential selection bias in the follow-up sample.

Staff outcomes

The service set a qualitative measure for staff outcomes, described as 'positive feedback from primary care'. Data against this measure was gathered via an online survey administered by RSM PACEC to both administrative and clinical staff within participating practices. A total of 25 complete responses were received. While in-depth interviews and survey responses often pointed to the comparatively low cost of the service, just forty-four percent of respondents to the staff survey (n=11) believed that the project could be sustainable in the longer term. One third of staff (36 per cent, n=9) were unable to comment on the sustainability of the intervention. Respondents provided several possible learning points for future roll out. These include:

- Improving advertisement locally outside of GP practices; advertisement is inconsistent across practices;
- Providing more clarity on how to use the service in the area and increasing utilisation;
- Upskilling the team on knowing the types of patients who would benefit; and
- Possibly changing location for signposting, patients can feel that if they are coming to the practice their time is best spent seeing a GP or nurse.

Respondents were generally less certain about the extent to which the service had reduced demand for primary care services. Fifty-three percent (n=11, base=21) [95 per cent CI (33 per cent, 73 per cent)] of respondents to the staff survey stated that the service supports better use of resources across primary care, and the voluntary and community sectors. However, approximately one third (36 per cent, n=9, base=25) believed that the service had reduced demand on primary care services²².

Reduction in unplanned hospital attendances

Among Surgery Signposters service users there were a total of 27 A&E admissions (20 patients) in the 6-month period prior to their use of the service, and 17 admissions among the same cohort (10 patients) in the 6 months following their use of the service. The evaluation cannot determine whether any reduction in admissions is due to the service or other factors. For example, seven admissions in the 6 months after using the service were multiple admissions by just two patients.

Reduction in GP appointments

Six months prior to signposting, there were a total of 41 GP visits among the patient cohort, at an average rate of 6.8 per month. Following signposting, the total number of appointments fell to 25. However, this number does not include a full 6 months "post intervention" period, and the rate of visits per month is higher in the post intervention period (12.5 GP visits per month).

²² Note: these results should be treated with caution due to the small sample size.

Conclusions

- There is a clear rationale within national and regional policy for this intervention, which has led to a proliferation of care navigation, signposting and / or social prescribing schemes across England in recent years. The project demonstrates strong alignment with objectives set out in the Five Year Forward View – particularly in providing patients with access to information relating to wellbeing, and supporting them to manage their own health, with the help of voluntary sector partners.
- Research on the clinical effectiveness of social prescribing is limited. Early indications are that much of the benefit is derived from patient experience and wellbeing impacts, and more effective linkages with the voluntary sector to support delivery of health and care in future.
- Service data shows that uptake of the service by patients has been lower than anticipated with 358 patients assisted patients between November 2015 and January 2017 against a target of 500. This may be because the service has recently spread to new localities, in which awareness and understanding of the service is still being raised.
- Surveys of staff at participating practices indicated scope to improve levels of awareness about the service among staff in participating practices. Approximately one third of staff (n=9) cited lack of knowledge about the service as a key constraint to implementation. Improving the level of awareness may help to increase utilisation of signposting volunteers in future.
- Health and wellbeing surveys completed by patients who used the service indicate an increase in health confidence and self-management ability (specifically self-management confidence in patients grew by c.20 points after 6 weeks)²³, though the number of patients completing follow-up surveys (around 15 per cent) for before-and-after comparison remains low.

Recommendations

- Create a clear publicity plan that will be delivered at the outset and supported by buy-in from all practice and voluntary groups.
- Review the service in six-months, focussing particularly on utilisation of signposting volunteers and health and wellbeing outcomes among a more substantive patient population.
- Ensure primary care staff are aware of read codes and the importance of issuing them to signposted patients. This would permit easy search and analysis and help demonstrate the benefits to external stakeholders.

²³ R-Outcomes question: 'I can look after my health', percent who strongly agree.

7.3 Urgent care interventions

Better Local Care supported several interventions that sought to address urgent care needs. These included, but were not limited to, the following projects which were the subject of Deep Dive evaluation reports:

Same Day Access Service: an urgent primary care hub based in Gosport War Memorial Hospital, that seeks to provide patients from four Gosport practices with easier access to same-day consultations with a healthcare professional.

Paramedic Home Visiting Service: an online service that gives adults access to a range of services including online 'e-Consults' which provide access to their GP Practice and medical advice without having to attend.²⁴

Key evaluation findings regarding each of these interventions are presented in the sub-sections below.

7.3.1 Same Day Access Service (SDAS)

The Same Day Access Service (SDAS) is an urgent primary care hub based in Gosport War Memorial Hospital. It provides patients from four Gosport practices with easier access to same-day consultations with an appropriate healthcare professional.

Table 7.2: SDAS practices

Practices	Registered population
Forton Medical Centre	9,497
Stoke Road Medical Centre	8,458
Brune Medical Centre	8,838
Waterside Medical Centre	8,430
Total	54,457

The SDAS was first introduced in January 2016, and is intended to help address growing demand for urgent primary care, and increase the proportion of cases dealt with through means other than face-to-face GP appointments such as non-GP appointments, use of community providers and self-management solutions. A key objective is to filter routine cases and provide GPs more time with patients who have complex clinical needs or long term conditions (LTCs).

The service comprises one full-time, core GP (supported by Southern Health) with input from several locums and GPs from participating practices providing specialist sessions. Specialist non-GP support is also provided by a physiotherapist (0.4 FTE), several practice nurses and a paediatric

²⁴ Note that the external evaluation team produced an interim evaluation report on the e-Consult service but the final evaluation was conducted and produced internally by Better Local Care staff.

nurse practitioner. Specific system and healthcare drivers of demand in Gosport, to which the service seeks to respond, include:

- Relatively high levels of health need when compared to the England average: Public Health England data for Gosport shows above average levels of premature mortality and major diseases such as cardiovascular and smoking-related conditions.
- GP workload and associated retention issues: GP retirement and significant recruitment challenges, the number of patients per WTE GP in SDAS practices in 2015 (3,457) was higher than the national average (2,553 patients per WTE GP).
- Growing dissatisfaction among patients with all aspects of GP access: Largely facilitated by the above points.

SDAS Activity

Key points to note from a review of SDAS activity data include:

- The number of calls triaged by the service between January and December 2016 was 44,793 (with an average of 3,700 per month);
- In total, 28,331 (63 per cent) of patients triaged had their issue dealt with over the telephone and 16,462 (37 per cent) had their issue dealt with through face to face appointments;
- The proportion of GP face-to-face calls fell sharply after the first two months and remained low for the rest of the year so that by December, GPs were dealing with less than one quarter of face-to-face appointments arranged;
- The time taken for call-backs to occur fell gradually throughout the year; and
- As the service has progressed the proportion of face-to-face appointments has decreased.

Service Outcomes

The SDAS has also seen progress towards other outcomes outlined in its Logic Model (listed within the SDAS Deep Dive report and Appendix 1). For example, 74 per cent of patients surveyed in December 2016 said they were called back within one hour of initial contact (n=96, base 129). This was an improvement from findings in May 2016 of 61 per cent (n=84, base=137).

The service originally also sought to measure changes in locum use to assess the extent to which the service was freeing up GP time. Data on locum numbers was not available to the evaluation, although the evaluation team has been able to analyse changes in locum allowance spending. The average locum allowance among those practices involved in SDAS decreased by £3,528 between the financial years 2014/15 and 2015/16. This impact is likely to be largely attributable to the merger of SDAS practices, but would not have been possible in the absence of SDAS. In comparison, those practices in the Fareham and Gosport CCG and those locally in Gosport which were not involved in SDAS experienced an overall increase in average locum allowance between the financial years 2014/15 and 2015/16.

Conclusions

- Evaluation findings suggest that the service has performed well against numerous targets. Limited access to key data due to changes in rules governing Secondary Use Statistics has limited the extent of analysis regarding some logic model outcomes, including A&E attendance.

- It is notable that an analysis of practice's locum allowances shows that there has been a considerable decrease in the value of allowances among SDAS practices, especially when compared to large increases seen in other Gosport practices which have remained uninvolvement.
- A basic analysis of costs and cost savings shows cost per patient falling by approximately 15 per cent as the ratio of nurse to GP cases has reduced. This is assuming that all people who weren't seen by GPs would have gone to their practice and been seen by GPs at the same unit cost or cost per consultation. Under this assumption SDAS delivered approximately £56,359 in savings in the 2016 financial year.

Recommendations

Based on the findings of this evaluation, feedback from staff and patients and obstacles encountered within this analysis RSM has outlined some key recommendations to facilitate the continued improvement, uptake and monitoring of the SDAS service in the future.

- Based on staff feedback of implementation issues upon service launch, the evaluation evidence suggests a need for extensive consultation on non-cost factors prior to any escalation or growth in participating practices. This would require a full understanding of the relationships between clinicians and administrators in both the practices and the hub, as well as prior consultation with staff to ensure any necessary equipment or resources are available as expected.
- While the SDAS patient survey found that patients were happy to travel further for a GP appointment, before any wider roll-out the service should model the travel and distance effects of future services in advance. There is a risk of in the distances patients are willing to travel to receive a same-day appointment, which could dramatically affect assumptions regarding scalability.
- Development of an interoperable record system to allow rapid analysis and comparison between the hub and services delivered in practices will be key to ensuring sufficient evidence regarding the benefits of replication and roll-out elsewhere. This should include development of more robust service monitoring and evaluation within practices to better understand the impact and service trends. There should be clearer ways of tracing the impact on GP time (i.e. proportion of cases in practices taken by non-GP staff, amount of and changes in locum use).
- SDAS should continue to monitor service demand, and understand reasons for reduced call volumes over time. In addition, SDAS staff should set up methods to monitor any possible adverse impacts on healthcare delivery and continuity of care at the individual practice level due to the reallocation of staff for the service (i.e. displacement risks).

7.3.2 Paramedic Home Visiting Service

The Paramedic Home Visiting Service (PHVS) began in May 2016 in Waterlooville as a pilot site Better Local Care. The service involves six practices with a patient population of roughly 55,200, and is delivered by one specialist paramedic and one specialist nurse practitioner, seconded from the South Central Ambulance Trust (SCAS), who complete home visits on behalf of GPs from local practices in the locality.

The goal of the PHVS is to save GP time, deliver better and more convenient patient care, and improve caseload management in response to cost and capacity issues. It seeks to deliver improved

access to care for registered patient populations by seeing increasing proportions of patients on the morning that a home visit is requested, and visiting higher proportions of patients within 2 hours of a home visit request. In theory, where patients ultimately do need to attend hospital, seeing them earlier in the day could lead to a reduced NEL bed days.

PHVS Activity

- Over 1,000 patients were seen by the PHVS over a 10-month period, approximately 113 per month on average. Just less than 60 per cent of issues addressed by the PHVS related to respiratory symptoms, swelling / joint pain, urinary symptoms, diarrhoea and vomiting.
- Overall, activity data shows variable utilisation of PHVS slots by individual practices, ranging from 60 per cent (Queenswood), up to 93 per cent (Vine Medical Group). There is scope to improve service utilisation among some participating practices.
- In-depth interviews with GP leads and PHVS visiting team members identified strong communication between the paramedics and practices as a key enabler of the PHVS.

Service Outcomes

- Between June 2016 and March 1st 2017, from a total of 990 recorded visits, 474 occurred before 12pm (c.48 per cent) and 516 recorded visits have occurred after 12pm.²⁵ This is just short of the key short-term outcome outlined in the logic model to have most home visits completed before noon (although the proportion of patients seen before noon grew as the service matured).
- The majority of patients are seen within two hours of a slot being claimed, with 39 per cent (n=389) of patients seen within an hour and 28 per cent (n=273) seen between 1 and 2 hours. However, there was a notable lag early in the day between patients requesting a home visit when practices opened (at c.8am) and GPs allocating those cases much later in the morning, which suggests scope to further increase the proportion of patients seen before midday.

Patient outcomes

- Ninety-five percent of PHVS patients (n=38) reported that their visit occurred at the expected time and 100 per cent of patients stated that everything was clearly explained to them.
- One hundred percent of patients (n=38) reported that they were either 'satisfied' or 'very satisfied' that their issue had been resolved; and the same number reported that they were either 'happy' or 'very happy' with the service. A small minority of patients remain keen to see their GP.
- For those patients that were seen via a home visit, 247 resulted in an intervention (24 per cent of the total patients visited).

²⁵ Please note 24 records were removed in this count due to recording errors.

GP Feedback and Workload Impact

- A total of 19 out of c.37 GPs (51 per cent)²⁶ at the four participating practices responded to a RSM PACEC's February survey and a majority (n=16) indicated that the PHVS had freed-up time and reduced their existing workload.
- Seventeen GPs were asked to estimate the additional staff time required to deliver the service, and time savings as a result of the service. Survey responses indicate that on average, 1.5 hours per week of GP time were spent on the service, and 4.5 hours of GP time were saved. This would represent a theoretical net effect of 3 hours (CI 95 per cent [4 hours 41 mins, 1 hour 18 mins]) saved per week for each GP involved in the service²⁷.
- Five GPs commented that there were additional job satisfaction benefits such as the reduction in stress from knowing they wouldn't have to leave mid-surgery to attend to patients at home.²⁸ One GP respondent claimed;

"The pressure on time during on-call days is now more manageable. It had previously been "retiring early soon" levels of manic!"

- Almost half of respondents to the GP survey indicated that longer appointments had been provided to deal with more complex patients as a result of the PHVS.
- A total of 17 out of 19 GP survey respondents (89 per cent) stated that the PHVS had been 'very beneficial' for non-complex patients and Thirteen (68 per cent) suggested that the service was either 'very beneficial' or 'slightly beneficial' for patients who have complex care needs.
- A total of 5 out of 19 suggested that the PHVS resulted in 'No change' or was 'Slightly disadvantageous' to the quality of care received by complex patients. Comments included;

"Can be useful to get baseline observations, but decision making can be more difficult with more complex patients (respondent reporting 'No change')";

"I don't think the quality of care has gone up or down - the service is just delivered in a slightly different way (respondent reporting 'No change')".

Sustainability in primary care

- Eighteen of the 19 GP staff surveyed via RSM's online questionnaire stated that the service should be rolled out to other localities in the future, which suggests that the PHVS has had a positive effect on sustainability for the practices involved. However, when asked to identify "any significant issues associated with scaling up / rolling out the service" four out of seven respondents to that question noted shortages of appropriate staff. SCAS representative interviewees similarly noted that there are currently 65 Specialist Practitioners across the trust,

²⁶ Respondents were asked to state the number of GPs employed at their practice. The numbers returned for each practice varied slightly. The 37 figure uses lowest estimates for each practice.

²⁷ Although answers were given at GP level, please note the survey questions addressed both the GP level and practice level. These time estimates are subjective.

²⁸ Note that reductions in stress and / or improved job satisfaction were not quantified through the survey.

with internal estimates suggesting that to expand the service to the wider Southern Trust area more than four times that number would be required.²⁹

- Cost and future funding sources were also identified as challenges for future sustainability in the online GP practice survey (one respondent) and in interviews with local GPs, CCG, and SCAS representatives (five interviewees in total). Current funding for training and resources is provided by the Vanguard (Better Local Care), with the cost of the paramedics borne by SCAS through the 999 contract, rather than through practices. Commissioning discussions suggest that this funding model is not expected to continue in future, since patients using the service are not those that would typically call 999.
- Overall costs and cost savings (estimated on a 'per appointment saved' basis) suggest a net value of in-practice appointments of £188,160 against non-overhead projects costs of £252,070 – a difference of -£63,910. When calculated on a 'unit cost' basis i.e. not reflecting initial overhead costs, the PHVS could be considered as having the potential to generate net savings of between £25,755 and £71,411.³⁰

Recommendations

- Disseminate findings widely given that the evidence could contribute to the strategic need for a clearer, more varied Paramedic career path, and may provide learning for other Home Visiting interventions.
- Options for spread should be considered, with a particular focus on overcoming staff resourcing and financing issues, including the option of widening the pool of staff that can conduct home visits beyond the SCAS paramedics.
- Develop and implement common case allocation protocols to ensure clinical decisions are made earlier in the day, so that paramedics are dispatched as soon as cases come in, thus providing a shorter time between initial call and home visit.
- Explore the potential for applying research funding to conduct a larger evaluation study addressing robust evidence of effectiveness and cost-effectiveness of the pilot.
- PHVS staff that were interviewed stated that better communication, and a more standardised booking process in line with high use PHVS practices, would reduce the lag in case allocation and allow an even higher proportion of visits to be completed within 2 hours.

7.4 Ongoing care interventions

Better Local Care supported six interventions that sought to address ongoing care needs. Most projects focussed on either integrated pharmacy / medicines optimisation, or carousel clinics for people with LTCs. The interventions supported by Better Local Care that were the subject of Deep Dive evaluation research were:

Integrated Pharmacy: a range of pharmacist services delivered by Medicines Optimisation Pharmacists (3.3 WTE) and Technicians (0.5 WTE), including practice based medicines optimisation reviews, domiciliary care and care home visits, clinical appointments and telephone consultations.

²⁹ Figure drawn from consultation with SCAS representatives.

³⁰ Key assumptions and limitations to the economic analysis are provided in the Deep Dive evaluation report.

The service seeks to supplement and complement the current pharmacy services, to develop a fully integrated service, embedded in primary care, across the South West New Forest Area.

Mission ABC: Modern Innovative Solutions in Improving Outcomes in Asthma, Breathlessness and Chronic Obstructive Pulmonary Disease (COPD), is a respiratory carousel clinic at which patients can be reviewed by a respiratory Specialist Doctor and receive personalised advice on how to manage their condition. It should be noted that the local evaluation team was unable to evaluate the Mission ABC intervention due to sensitivity regarding the release of data from the delivery team to the RSM evaluation team. This section therefore focusses solely the Integrated Pharmacy evaluation.

7.4.1 Integrated Pharmacy

The South West New Forest and Avon Valley locality, as part of the West Hampshire CCG, has one of the highest patient percentages with long standing health conditions in Hampshire. Fifty-eight percent of the patient population within SWNF and Avon Valley suffer from long-term conditions, which is over 4 per cent higher than the England average of 53.2 per cent.³¹

Activity to date

As of March 2017 over 4,000 patient queries had been dealt with by members of the integrated pharmacy team. Of those:

- 2,111 patients (50.5 per cent) had a Practice Based Medication Review carried out;
- 688 patients (16.5 per cent) were supported by the integrated pharmacy team to integrate their care with the hospital;
- 277 patients (6.6 per cent) had a telephone consultation with the integrated pharmacy team;
- 243 patients (5.8 per cent) were supported by the integrated pharmacy team to integrate their care with the community pharmacy team;
- 118 patients (2.8 per cent) had a care home visit undertaken by the integrated pharmacy team;
- 44 patients (1.1 per cent) had a domiciliary care visit undertaken by the integrated pharmacy team.

Patient Outcomes

A total of 10 patients provided feedback directly to pharmacists involved in delivering the service³². Findings cannot be considered to be in any way representative of the patient population, but in the interests of using the data that is available, findings include:

- All 10 participants believed that the medical review they received was useful;
- 80 per cent (n=8) either agree or strongly agree that the service has provided relevant information to self-manage health and that staff were understanding and knowledgeable of their condition;

³¹ PHE FingerTips data

³² Note: the sample size is extremely small and subject to both selection and participation bias.

- 80 per cent (n=8) of respondents also believe that they receive appropriate treatment in good time within the Integrated Pharmacy service.

Staff Outcomes

A total of 12 staff responded to an anonymous paper based survey, administered internally by the Better Local Care Integrated Pharmacy team. Noting caution due to the small sample size, key findings include:

- Eighty-three percent of respondents (n=5, base=6) believe that the project has improved the management of patients requiring polypharmacy care. The same proportion of staff also believe that the project will free up GP time in the longer term;
- Sixty-seven percent of respondents (n=4, base=6) believe that the project allows for more efficient use of resources;
- Sixty-seven percent of respondents (n=4, base=6) believe that the project was good value for money.

As is the case regarding patient survey findings, given the significant likelihood of bias in these results, the fact that fewer than 100 per cent believe the project delivered more efficient use of resources, or that it represented good value for money, warrants further exploration.

System Outcomes

- Having interacted with 4,179 patients in total since September 2016, the Better Local Care cost per patient is currently calculated at £58.65.
- The 7 SWNF practices spent approximately £88,000 less in the period October 2016 to January 2017 compared to the same period in the previous year. This is an average saving of £12,500 per practice on high frequency medication.
- The other 43 non-vanguard practices spent approximately £215,000 less in the same period, averaging £5,000 less per practice.

While this analysis suggests that system costs are coming down because of the service, more data will be required before any concrete conclusions regarding cost effectiveness can be derived. In particular, the original cost saving target set out in the bid document was more than £190k (of which the current cost savings represent just 17 per cent), and the savings set out above do not factor in the original cost of the Integrated Pharmacy project.

Conclusions

While there is notable evidence within wider research literature to suggest that medicines optimisation delivers positive outcomes for patients, and the health care system more generally, the relative dearth of evidence available to the evaluation at the time of writing precludes any concrete conclusions regarding the project's effectiveness in either area. Early stage cost data does suggest that the intervention is reducing the cost of medicines within participating practices in comparison to non-vanguard practices.

Recommendations

In order to appropriately evidence the success or otherwise of the Integrated Pharmacy intervention, collection of feedback data from patients should be given higher priority in future so that sample

sizes are sufficient. If possible, a sample of those patients that provided feedback should be contacted independently to validate future findings.

7.5 Highest care interventions

Better Local Care supported two main interventions that sought to improve care for patients with the highest needs, these include;

Eastleigh Frailty Clinic: established in September 2016 for patients who require a comprehensive health assessment and a level of co-ordination of health and social care which cannot be provided within a standard 10 minute GP appointment.

Integrated Care Home Team: the MCP locality (Havant, Hayling Island and Emsworth) piloted this project as part of the South East Hampshire Frailty strategic approach. The project was designed with input from the Care Home team of community nurses, pharmacists and practice staff (both managers and clinicians), and was introduced in July 2016.

7.5.1 Eastleigh Frailty Clinic

The Eastleigh Frailty Clinic was established in September 2016 for patients who require a comprehensive health assessment and a level of co-ordination of health and social care which cannot be provided within a standard 10 minute GP appointment. The Frailty Clinic is available to patients registered with the St Francis and Park surgeries, with planned expansion to Brownhill surgery and Fryern surgery. The clinic is conducted at the Park surgery and is currently at a proof of concept stage running at low cost and is supported by goodwill from staff in the GP Practice, the local hospital and the council social care staff. The overall aims of the Eastleigh Frailty clinic are to:

- Increase integration of health and social care in the local community and improve the co-ordination of earlier integrated care to support patients who are frail; and
- Translate evidence into workable solutions that produce good clinical outcomes for the patient and minimise unscheduled primary and secondary care episodes.

The clinic uses Rockwood scale definitions of frailty for targeting patients for the clinic as the easiest to use visual scale for frailty. In practice, frailty patients referred to the clinic were those with the triad of mobility problems, carer needs and often cognitive problems (for example memory loss). All patients seen would have been expected to deteriorate and were at high risk of admission or dying in the following 12 months.

Service use data

The clinic is held approximately once every three weeks and lasts for four hours. Between 2 and 7 patients usually attend, depending on clinician availability. By March 2017 eight clinics had been provided, attended by 32 patients and 30 carers. The clinics are delivered by a consultant geriatrician and two specialist nurses (one a mental health nurse and one an advanced nurse practitioner). They are supported by the clinic's lead GP who provides clinical leadership, a clinical administrator and a medicines optimisation pharmacist who undertakes a medicines review for each referred patient.

Patient outcomes

There were generally high levels of satisfaction with the clinic, for example 13 out of 15 patients agreed or strongly agreed that they were satisfied with the way in which their health condition was handled. Ten of the 15 patients interviewed agreed or strongly agreed that the clinic enabled them to access additional care and support services. However, it should be noted that only three of respondents reported that they are now using less unscheduled care because of the clinic (one of the clinic's main aims).

Conclusions

- There is a strong rationale underpinning development of the Eastleigh Frailty Clinic, and the service is aligned with national and local policy regarding support to frail older people.
- Levels of patient satisfaction with the service are high, and the clinics act as a useful method of signposting patients to additional services.
- At the time of writing, it is unclear whether the service has resulted in any reduction in the use of either primary or acute care, and the cost-effectiveness of the service at current scale is unclear.

Recommendations

Key recommendations include:

- A dedicated project management information process to collate activity and outcome data specifically relating to frailty clinic patient outcomes would be a useful tool to monitor the impacts achieved by the clinic in the future, including individual-level acute care data on all clinic patients against a control practice to help estimate the incremental value of the frailty clinic.
- Enhanced use of shared care records and set out method plan for continued evaluation of patient experience using collaboRATE tools.
- Create clearer definitions of referral criteria that make patients eligible for clinic referral. Refine criteria into a clear guide so that, in the case of expansion, there is a formal, quantifiable process and subsequent steps for referral.
- Create care plans so carers and patients can monitor recommendations and progress can be measured at a later date upon further referral or clinic attendance. Formalising the creation of care plans as part of the formal operation of the clinic would be beneficial to ensure all patients and carers leave with the same level of guidance.

7.5.2 Integrated Care Home Team

The MCP locality (Havant, Hayling Island and Emsworth) piloted this project as part of the South East Hampshire Frailty strategic approach. The project was designed with input from the Care Home team of community nurses, pharmacists and practice staff (both managers and clinicians), and was introduced in July 2016. The service involves two main elements, a reactive service that sees community nurses responding to GP call outs to Care Homes, and a pro-active service through which community nurses deliver holistic assessments, and training to Care Home staff. At the time of writing, the service had been implemented across 10 Care Homes, with a population of approximately 300 people managed by 9 GPs.

The Care Home team began initially with a senior nurse (Band 6 staff) and the team now includes

Band 5 staff with the senior nurse as team lead. The Band 6 nurse and Care Home team cover an area of 11.6 square miles. The CCG provide funding support for a pharmacist who carries out medication reviews and advises on medicines optimisations for patients within the scope of the project. The GP clinical lead is co-located with the nurse project lead at the Elms practice, and supports follow-up and patient reviews following home visits by the Care Home team.

Activity to date

Proactive educational training sessions had been delivered at all participating Care Homes, and a total of 206 Care Homes staff had been involved in training. Training sessions involving the largest numbers of participants include Pressure Ulcer Prevention (39 participants), Falls and Sbar (32 participants), Challenging Behaviour (28 participants) and 999 Calls (20 participants).

A total of 47 'reactive' visits had been completed by the nursing team on behalf of Elms Practice between July 2016 and March 2017, and 118 visits had been completed on behalf of Waterside Practice between July 2016 and December 2016 (latest available data).

Patient and Staff Outcomes

The Care Homes team gathered feedback from 13 patients in March 2017, and a pre and post staff survey was conducted in September 2016, with follow up in March 2017. It is not possible to draw any robust conclusions regarding patient or staff outcomes using the data due to the very small patient sample, and the inability to determine a consistent cohort of staff between baseline and follow-up stages of the staff research.

A separate, single time-point experience survey was completed by Care Home Managers in 8 of the 10 participating Care Homes. Again, noting caution due to the small sample, results of the Care Home Managers survey suggest high levels of satisfaction with the service. The training provided was deemed to be appropriate to the needs of their home, with the majority reporting that it is 'always' appropriate. All Care Homes reported they are likely to recommend the service and associated comments often included requests for additional training.

Service Outcomes

Plans to assess ED admissions and A&E attendances were altered due to changes in the regulatory environment regarding re-use and publication of SUS data by third parties. Data on the number of 999 calls and conveyances from Care Homes was, however, provided by SCAS. The number of 999 calls in a three-month period post intervention (Q1 2017) decreased for two of the nine Care Homes for which data was available (Cheybassa Lodge and The Wedge). The other seven Care Homes for which data was available made a higher number of calls in the first quarter of 2017 compared to the same quarter in 2016. Similarly, almost all Care Homes (except for Cheybassa Lodge, Oak View Residential, and The Wedge) experienced an increase in the number of calls conveyed in the first quarter of 2017 compared to 2016.

Conclusions

As noted above, it is not possible to draw concrete conclusions without additional contextual data e.g. rate of conveyances per Care Home population. Based on the evidence available to the evaluation, the Care Homes intervention does not appear to have had any notable effect on either the number of 999 calls made or the number of conveyances from Care Homes.

7.6 Professional & technological enablers

In addition to interventions that target population care needs, Better Local Care supported both physical and technological 'enablers'. These enabling interventions sought to better prepare and / or equip health and care teams across the Better Local Care geography to deliver New Models of Care. Two such interventions were the subject of evaluation Deep Dive reports;

One Team: designed to enable new, larger scale multi-disciplinary teams (MDTs) to build trust, and find new ways of working to improve both staff and patient experiences.

MiG (Medical interoperability Gateway): a secure middleware technology which enables the two-way exchange of patient information between local healthcare settings, based upon a live feed of patient data.

7.6.1 One Team

Better Local Care originally commissioned 'One Team', a team development programme, in September 2015, the scope and associated plans of which were updated in December 2015 and again in February 2016. The overarching objectives for the One Team programme were to:

- Accelerate the formation, capacity and capability of extended primary care teams;
- Build new and sustainable structures, processes and cultures across teams;
- Embed a model of care and way of working that can be scaled up at pace;
- Empower teams and service users to shape services around the needs of their local population;
- Share the latest ideas and thinking both locally and nationally; and
- Create a safe environment that enables teams to leave behind old models of care.

Activity to date

To date a total of 14 One Team 'programmes' (6 facilitated sessions in a programme) have been delivered to approximately 670 health and care staff in 14 localities. Participant ratings are positive, with the majority of respondents suggesting that there has been either "some" or "lots of" progress towards each of the team outcomes. Respondents held particularly strong positive views of the extent to which the One Team programme provided a forum for sharing ideas (n=24), accelerated the formation, capacity and capability of EPCTs (n=18) and created a safe environment to develop new models of care (n=16).

Patient and Staff Outcomes

The One Team programme is a team development programme, which means that it is unrealistic to expect that any programme activity could conceivably lead to attributable changes in patient outcomes (unless team development objectives were highly practical and very tightly defined, which was not the case). Aggregated participant monitoring data shows no significant difference in participant ratings of either confidence or motivation before and after the One Team programme.

In contrast, the data shows a significant increase in the percentage of participants rating the skills and knowledge of participating teams as very high in the final session (95 per cent rating skills and knowledge of the team as either quite or very high, n=91). Note that there is a risk of participation

bias in the final session data given that participants attending final sessions are more likely to have a positive view of the programme than those who did not attend. Data wasn't collected from participants that didn't attend final sessions and their views therefore aren't included in the analysis.

Conclusions and recommendations

- On the balance of the evidence available to this report, good value for money in terms of either patient benefits or system savings cannot be demonstrated. Better Local Care should therefore review the efficacy of the existing One Team model, and consider whether a distinct 'call-off' contract is required. Based on participant data and in-depth interviews, the critical components of the One Team programme are a) the investment in compensating clinical staff to give their time and b) providing dedicated time and space to bring MDTs together.
- If a distinct call-off contract is deemed appropriate, then it should as a minimum be much more tightly defined, including quantifiable participation targets, and a stipulation that each participating team tackle a known local problem which, if addressed, will result in tangible benefits to either patients, or the local health system.
- Progress reports should be developed consistently and regularly so that all involved are aware of the progress of the implementation and delivery of the project in each locality. Share both quantitative and qualitative findings more regularly to maximise the benefit of learning from across the wide One Team geography.
- There is a need to be explicit about programme goals with all organisations / leaders that the over-arching multi-organisation, multi-professional goal of Better Local Care will need to take precedence over individual aims.
- Agree at an early stage what is expected of General Managers, Lead GPs, Senior Community Nurses, CCG partners, central programme support and Local Project Managers;
- Assign higher priority to capturing participant data at first and final One Team modules, ensuring that final module participants can provide feedback anonymously. Capture data from at least 20 per cent of participants who did not complete the One Team course.

7.6.2 MiG (Medical interoperability Gateway)

The MiG is a secure middleware technology which enables the two-way exchange of patient information between local healthcare settings, based upon a live feed of patient data. MiG can share patient data between any of the health and social care systems (signed up with agreement) and currently connects almost 200 organisations across England, and shares 30 million real time patient records (over 50 per cent of the population) across GPs, trusts, hospitals, social care, mental health, children services, pharmacies, out-of-hours services, and the justice system.

The overarching objectives for the MiG project are to:

- Enable Primary Care clinicians access to community information. Primary care clinicians will be able to see records on RiO for a patient who is receiving Mental Health, Child Health, Adult Nursing and Therapies services from Southern Health;

- Provide community care clinicians with access to primary care information. Southern Health community services staff who use RiO will be able to see information recorded on primary care systems;
- Capture feedback on what information needs to be shared; and
- Evaluate the benefits of the interoperability solution.

Activity to date

At the time of writing, 103 out of 112 GP (90 per cent) practices invited across Fareham and Gosport, West Hampshire, South Eastern Hampshire and North Hampshire have signed up to the project. Overall, between September 2016 and March 2017, Southern Health staff accessed patient information recorded by GPs via the MiG a total of 7,952 times i.e. 345 times a week over a 23 week period. However, more recent months exhibit higher usage, increasing to an average of 728 times per week in latter months (February / March 2017). It is anticipated that a further 11 practices (bringing the total from 92 live currently to 103 practices) might be a reasonable conservative estimate regarding what 'full rollout' will look like. Therefore, it may be reasonable to assume a 10 per cent increase in weekly usage could be anticipated upon enhanced roll-out i.e. c. 800 accesses per week from SHFT into GP patient records.

Conclusions

The evaluation, at this stage, signals there are areas in which positive outcomes are being generated through the implementation of Phase 1, namely:


- The majority of staff surveyed using MiG feel that information sharing between GPs and SHFT has improved since the implementation (88 per cent, n=7, base =8);
- Internally, some staff have reported benefits with regard to avoiding duplication and improving patient care with regard to patient records (through being able to access data immediately, therefore saving up to 10 minutes per new referral). This has supported, for example, improved knowledge about patient interventions to date e.g. vaccinations, to prevent duplication of efforts.

The implementation of the MiG has experienced setbacks with regard to anticipated timing. However, sustained efforts have been made to achieve significant GP Practice buy-in (c. 90 per cent of practices involved in Phase 1). The implementation of Phase 2 will enable GPs to review/gain improved access to community data, and this should result in enhanced usage and therefore wider benefits from the implementation of MiG. Assuming usage maintains at c.800 accesses per week, the implementation of MiG will be expected to yield long-term cost savings through efficiencies across GP practices and SHFT (anticipated in the region of net £59,000 savings per annum system wide).

Recommendations

The emerging recommendations for the continued implementation of MiG, which have been attained through staff feedback, include:

- Deliver Phase 2 (i.e. potential for full sharing of information of relevant data between primary and community care);

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- Bring together primary and community care staff to discuss how information is being used to encourage both parties to better understand what is recorded, what this means for patient care, and how this information should be used by clinicians to change and improve patient care practice. Senior clinical leadership from primary and community settings will be required to support, explain and champion this work to best deliver usage and time savings;
 - Maintain sustained communication between the MiG delivery team (within SHFT) and practices, with clear channels for staff at primary and community level to report any issues, and to provide recommendations regarding data they want to see shared (subject to relevance within the ten tabs)³³, cost and information sharing protocols, and Caldicott principles;
 - Consider providing funding (estimated c. £12,000) to upgrade to MiG Detailed Care Record v2, and estimated £46,000 for datasets which would mean that all of the data items is available to SHFT staff, so that they do not have to request the patient summary from the GP practice. This would save time for both the GP practice and the community care team.

³³ i.e. Summary Record, Patient Details. Problems. Diagnosis, Medication, Risks and Warnings, Procedures, Investigations, Examinations and Events (Admissions/Referrals)

8 CONCLUSIONS & RECOMMENDATIONS

8.1 Aligning population care and efficiency drivers

The NHS has faced sustained financial pressures for almost a decade. These pressures are reflected in strategic policy documentation at all levels, from the national 5 Year Forward View and General Practice Forward View, to regional and local policies referred to in this section.

Ultimately, the drive for improved efficiency and effectiveness has had a significant influence on the focus of Better Local Care resources towards addressing system issues such as access to primary care and prevention of secondary care use. As discussed in Section 4, these drivers have taken a prominent role alongside improved patient care in the allocation of Better Local Care resources. Locally, severe pressure on primary care, particularly in more deprived localities, has also been a key feature of decision making.

At an aggregate level, the social and clinical context suggests a need to direct resources towards refocusing systems to provide effective care for an ageing population, and on interventions that promote prevention and self-management in relation to lifestyle risk factors and long-term conditions. Further information on these risks can be found in the Joint Strategic Needs Assessments for Hampshire and Southampton.

Learning from Year 1 of the Vanguard identifies a need to better align population health and care needs with system efficiency and effectiveness objectives. Specifically, internal stakeholders have highlighted the importance of risk stratification and pro-active case finding in Year 2, to ensure that areas of high need *that can be realistically affected* become the clear focus of Year 2 activity, to achieve the secondary efficiency objective.

8.1.1 Recommendation

To assist in refining Better Local Care's focus on these dual objective areas, the programme delivery team should put a more rigorous 'intervention case' process and bid template in place. The template should require that, as a minimum, granular details are available regarding target populations, project objectives, output targets and expected short-term outcomes.

8.2 Better Local Care's role in the new landscape

Internal and external strategic stakeholders believe that there is currently a greater alignment between CCGs, Better Local Care, and national policy than there had been at the outset of Better Local Care. Several strategic stakeholders also believe that there is better alignment between the objectives of commissioners and those of primary care providers because of Better Local Care.

Interviewees indicated that the changing strategic landscape (which is moving towards a more regionally focussed STP) is likely to have a positive impact on the infrastructure within the Better Local Care area, although the current reality is that Better Local Care is operating in a highly fluid organisational context.

This fluidity has exacerbated what is already a challenging resourcing landscape, and there has been recognition via strategic stakeholders and delivery teams that the MCP Vanguard has been

subject to staff capacity constraints. More certainty regarding the organisational context may have facilitated stronger relationships with, for example, CCGs, Acute Providers, and other key system providers such as SCAS.

8.2.1 Recommendations

To ensure that the Vanguard learning is not lost, Better Local Care should be positioned in Year 2 as an 'enabler' for bringing commissioners and primary care providers together under the new Sustainability and Transformation Plan Footprint.

Staff capacity constraints have been consistently highlighted during Year 1 of the evaluation. In Year 2 Better Local Care should take the opportunity presented to prioritise a smaller number of projects, so that capacity constraints are minimised to the extent possible within the current context. The Better Local Care team's position and role within the STP should also be widely and clearly communicated by system leaders.

8.3 Project level learning

Detailed findings from Deep Dive evaluation research is available in individual project evaluation reports. Thematic analysis of key findings from Vanguard funded projects across the population care needs triangle highlights the following:

8.3.1 Whole population interventions

Better Local Care has supported a range of interventions that target whole population needs, spanning brief intervention initiatives such as MECC in Gosport, electronic solutions for improving access to primary care via WebGP and signposting initiatives that seek to better address population needs via a combination of primary care and community based services.

By their nature, these initiatives take much longer to realise patient health and wellbeing outcomes, and require sustained and concerted evaluation effort over several years. Based on the evidence available to the evaluation,³⁴ key findings at this stage suggest varying degrees of success, including:

- **MECC:** The MECC initiative in Gosport could be expected to build and sustain effective working relationships between local authority, primary care, and community and voluntary sector organisations. Early evidence of MECC training participant outcomes suggests positive effects on confidence to support lifestyle changes (73 per cent of participants denoting a positive change, n=11). In-depth interviews identified an opportunity for MECC training to fill a gap in existing 'difficult patient' training that may emerge as a result of Southern Health's acquisition of a group of GP practices in Gosport. The MECC in Gosport initiative should consider contributing to the national evidence base by capturing evidence on service user behaviour change outcomes.

³⁴ Deep Dive evaluation reports detail methodological and data limitations to each study.

- WebGP:** The WebGP evaluation³⁵ findings highlight that there is good uptake among GP practices in line with original targets, as 130 (87 per cent) of the 150 Practices in scope were recruited across Hampshire. The evidence base generated via Better Local Care is considerably more robust than the Hurley Group's own research, which was the basis upon which providers had to make procurement decisions prior to Better Local Care. The Better Local Care evaluation challenges some of the original assumptions, including uptake by 20 per cent of registered patient populations, and should be widely disseminated to inform future procurement by providers nationally. Almost 44,000 'unique' individuals have used the eConsult service, saving an estimated 11,200 GP appointments since July 2016, which clearly contributes to the Better Local Care objectives of alleviating pressure on General Practice and freeing up GP time. As with all Year 1 evaluation activity, wider system impacts could not be measured because SUS data was not available. This analysis, together with independent assessment of longer-term patient outcomes, should be a priority for any future evaluation.
- Surgery Signposters:** While there is a clear rationale within national and regional policy for the Surgery Signposters intervention and it demonstrates strong alignment with national objectives, uptake in Phase 2 of the service has been lower than anticipated, resulting in lower than anticipated usage (358 patients assisted against a target of 500). While early indications from patient surveys suggest increases in health confidence and self-management ability³⁶ the evidence base was limited at the time of writing (with follow-up data for just 15 of 99 patients). Further, a notable proportion of staff (33 per cent, n=9) suggested there is scope to improve levels of awareness about the service among staff in participating practices. There are important lessons to be taken from the attempt to spread the Surgery Signposters initiative beyond pilot practices, and at the time of writing this programme report, the Better Local Care delivery team have already acted to increase uptake.

8.3.2 Urgent care interventions

Better Local Care supported interventions that seek to address urgent care needs have been driven by the pressing need to sustain primary care, improve access and free up GP time to consequently prevent conveyances, ED attendance and emergency admissions. The clear driver for these interventions have been translated (via Better Local Care staff and lead GPs) into clear objectives, and there is commitment to monitoring and evaluation activity. As such the evidence base underpinning these interventions, while not perfect, is more complete compared to other Vanguard funded interventions, and has produced the following key findings:

- Same Day Access Service:** SDAS evaluation findings suggest that the service has performed well against numerous targets including call triage (averaging 3,700 per month), reduced call-back timeframes, and a reduction in the need for face to face appointments by GPs. There has been a considerable decrease in the value of locum allowances among SDAS practices. This is likely to be largely attributable to the merger of four GP practices which now make up the Willow Group under Southern Health. Nevertheless, it is in contrast to increases seen in other Gosport

³⁵ The WebGP evaluation had been extensively planned prior to the involvement of the external evaluation team, and was therefore conducted internally by Better Local Care staff. The evaluation approach and methodology were robust.

³⁶ R-Outcomes question: 'I can look after my health', percent who strongly agree.

practices who remain uninvolved in the service. Restrictions on access to SUS data has limited the extent of analysis regarding some system-wide logic model outcomes, however a basic analysis of costs and cost savings shows cost per patient falling by approximately 15 per cent because the proportion of GP cases has been shown to fall.

- **Paramedic Home Visiting Service:** The service has supported more than 1,000 patients over a 10-month period, addressing issues such as respiratory symptoms, swelling / joint pain, urinary symptoms, diarrhoea and vomiting. A majority of patients were seen within two hours of a slot being claimed. Thirty-nine percent of patients (n=389) were seen within an hour and 28 per cent (n=273) were seen between 1 and 2 hours, comparing favourably to benchmark data regarding regular GP home visiting schemes (citing 10 per cent of visits occurring within 1 hour). However, there is scope to improve service utilisation among some participating practices, based on a range of between 60 per cent and 93 per cent. Levels of patient satisfaction were high, with 100 per cent of PHVS patients (n=38) reporting that they were either 'satisfied' or 'very satisfied' that their issue had been resolved and 100 per cent believing that they were treated in a kind / caring manner. A majority of respondents to an online survey of GP practice staff (n=16, base =19) indicated that the PHVS had freed-up time and reduced their existing workload, equating to a net time saving of c.3 hours per week. Several GPs commented that they did still carry out home visits, but that these were fewer and typically involved more complex cases. A total of 17 out of 19 GP survey respondents (89 per cent) stated that the PHVS had been 'very beneficial' for non-complex patients. While 18 out of 19 respondents to the GP practice survey believe that the service should be continued, and that it should also be rolled out, uncertainty regarding availability of appropriate staff resource to scale up, and lack of clarity regarding a future commissioning model constitute two notable challenges to service sustainability. Overall costs and cost savings (estimated on a 'per appointment saved' basis) suggest a net value of in-practice appointments of £188,160 against non-overhead projects costs of £252,070 – a difference of -£63,910. When calculated on a 'unit cost' basis i.e. not reflecting initial overhead costs, the PHVS could be considered as having the potential to generate net savings of between £25,755 and £71,411.

8.3.3 Ongoing care need interventions

Evidence on the impact of Better Local Care investment in supporting initiatives that address ongoing care needs is extremely limited. This is in part because the external evaluation team was unable to access information regarding the Mission ABC clinic, but also reflects capacity constraints among Integrated Pharmacy staff to engage in the evaluation.

Integrated Pharmacy: The Integrated Pharmacy pilot has delivered high volumes of activity, and findings from a staff survey do suggest that the project has improved the management of patients requiring polypharmacy care and can be expected to free up GP time in the longer term. However, the extent to which staff believe that the project allows for a more efficient use of resources, or that it represents good value for money is questionable and warrants further exploration. Analysis of medicines costs in SWNF practices vis a vis non-vanguard practices suggests that system costs are coming down as a result of the service (average savings of £12,500 in SWNF practices compared to average savings of £5,000 in non-Vanguard practices). Fuller data will be required before any concrete conclusions regarding cost effectiveness can be derived.

8.3.4 Highest care need interventions

As with findings regarding investment in whole population interventions, evidence on the efficacy of initiatives that target patients with high care needs, specifically a Frailty Clinic in Eastleigh and support by an integrated Care Homes team, is also mixed.

Eastleigh Frailty Clinic: While there is a strong rationale underpinning development of the Eastleigh Frailty Clinic, and levels of patient satisfaction with the service are high, it is unclear whether the service has resulted in any reduction in the use of either primary or acute care, and the cost-effectiveness of the service at current scale is therefore also unclear.

Integrated Care Team: While the Integrated Care Homes team has provided support to all ten Care Homes in scope, (pro-active educational support and reactive Care Home visits), to date it does not appear to have had any notable effect on either the number of 999 calls made, or conveyances from the involved Care Homes.

8.4 Reaffirming higher priority for monitoring and evaluation

NHS England's investment in evaluating the Vanguard, and the role of the NCM evaluation team is likely to have increased the focus of local teams on the value and importance of evaluation. However, there remains considerable scope to further prioritise the role of evaluation among local teams.

As can be seen in the summary findings presented above, this applies at the level of local teams, who should be supported to allocate time to monitoring and evaluation, but it also applies at the programme level. Anecdotally, the evaluation team observed considerable efforts to report monitoring and evaluation data to the central NCM team, and individual projects were invited to present on progress at Board level periodically. The scope for improvement exists in the Board's use of monitoring and evaluation activity to inform day to day decision-making. This has inevitably been hampered by Information Governance issues, but should be reaffirmed as high priority in Year 2. Information Governance restrictions have constrained the extent to which system outcomes can be reported, and ultimately therefore the spread potential of individual projects.

8.4.1 Recommendation

Discussions with Better Local Care staff have indicated that work is already underway to further integrate monitoring and evaluation into day to day decision making. Better Local Care staff are also working to resolve Information Governance issues, and the external evaluation team is involved in the design of the Year 2 metrics. However, in order to avoid similar data availability issues in Year 2, and to allow monitoring and evaluation data to have appropriate priority in day to day decision making, NHS England and the NCM team should assist as far as possible in resolving Information Governance issues, and reaffirm the importance of independent evaluation so that it is effectively cascaded to local teams.