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| Evaluation of the Connected Care Partnership Vanguard |
| Scoping and early findings report |

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| Dr Jo Ellins, Dr Laura Griffith, Dr Rebecca Rosen, Dr Robin Miler, Hilary Brown, Professor Judith Smith  May 2017 |

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# **Key points**

* The Connected Care Partnership Vanguard is a bold and ambitious programme of transformational change that was, at the time of our research, moving from its design phase to implementation and into the final year of funding from the national New Care Models programme. The programme had embraced the NHS England vision of creating a new model of primary and community services based around general practice, building on extensive prior work – by Modality – to develop at scale general practice in the local area.
* There was a great deal of enthusiasm and support for the new care model, but also a lack of clarity about the programme’s longer term vision and how this linked to wider priorities and developments, for both the programme’s partner organisations and the wider system of care; this is a common finding in large-scale transformation and integrated care programmes.
* One of the major challenges that Connected Care was facing was how to reconcile different aspirations for redesign and views of success held by partner organisations – in particular there was a tension between focusing on transforming general practice and delivering wider system goals. It is imperative that partners reach agreement about what the programme is aiming to achieve and the balance between these different goals, to guide effective implementation and assessment of outcomes achieved.
* The challenges of partnership working in health and social care are well known, and the experience of partners within Connected Care echo findings reported from other change programmes. There was a widespread perception that the programme was Modality and primary care dominated, but also recognition of the steps that had been recently taken to create a stronger and more equal partnership. The programme was grappling with the complexity of governance and decision-making in a multi-stakeholder partnership and this was – at least for some workstreams – an obstacle to progress.
* The local financial context is critical to understanding how Connected Care has progressed so far. A key question for Connected Care is whether increasing and joining up delivery of community-based services can be done in a way that helps to address financial pressures in the acute sector, rather than increase them. This issue needs to be tackled more openly and explicitly by the partnership board, but partners should be mindful of evidence that integration and community-based care often do not deliver net savings. Connected Care partners and NHS England must be realistic about what can be achieved in terms of financial outcomes.
* Design has been largely driven by the programme team so far, without substantive input from frontline staff or patients. The lack of co-design risks the programme making changes that do not deliver real and meaningful improvements for patients, and Connected Care should take steps to address this. Given that implementation is underway in some workstreams, it may be more realistic to focus on capturing patient feedback on service changes and using this to make ongoing improvements.
* There is a lack of clarity about what will happen to the service changes being made after funding from the national programme has ended. Connected Care was confronting many of the widely reported barriers to commissioning integrated care. There were some frustrations that national action to address these barriers was progressing too slowly and, consequently, a risk that the programme would reach the end of its funding without arrangements in place to sustain positive changes and impacts.
* In light of these key findings, and the many others that we describe below, this report sets out a framework for evaluating Connected Care, including an assessment of the programme’s economic outcomes. Evaluating integration and community-based care is fraught with difficulty, but nonetheless it is important that this evaluation supports Connected Care to learn, improve and – wherever possible – document its early impacts. Our approach will bring together a range of outcome measures, data sources, perspectives and methods to achieve this.
* Alongside a focus on partnership working and developments at the overall programme level, we propose that the evaluation includes in-depth case studies of two programme workstreams: community outpatient services and multi-disciplinary teams. These have been chosen because they will enable the evaluation to explore the whole system impacts of the programme and provide insights into the extent to which Connected Care is transforming the local system of care. Future reports from the evaluation team will share the learning from this work as it progresses.

# **Introduction**

In December 2016, the University of Birmingham and the Nuffield Trust were commissioned to undertake an independent evaluation of the Connected Care Partnership vanguard – one of 14 multi-speciality community provider vanguards in NHS England’s national New Models of Care programme.

The first phase of evaluation runs from January to June 2017, and is guided by four key questions:

1. What key process changes has the vanguard made and what changes is it struggling to make? How have these changes been implemented and who is being affected by them?
2. What impact is the vanguard having on staff experience? How can it improve/measure team working and foster a sense of collective clinical ownership and accountability across our partners?
3. What impact is the vanguard having on patient experience? How can it collect and use both patient experience and patient-reported outcomes to inform programme development, on an individual level, service level and system level?
4. What are the relative cost/benefits of individual programmes/resources and how can the vanguard use this to refine the economics of the Connected Care programme? What programmes should be scaled/expanded and or changed/stopped based on an economics appraisal?

The evaluation is intended to be strongly formative and learning-oriented, generating insights that can be shared on an ongoing basis to support the partnership and delivery of the programme as it progresses. In the second phase of the work (June 2017-March 2018) this focus will be expanded to include an assessment of the programme’s early and interim effects, as well as giving consideration to issues of sustainability and legacy.

This is the first major output from the evaluation, and reports on work that was carried out between January and March 2017. It has three main functions:

* Describe the programme and its component workstreams, and situate these within its broader local and national context;
* Summarise the finding from the initial phase of mixed-methods fieldwork examining the development, design and early implementation of the programme;
* Outline proposals for undertaking an economic evaluation of the Connected Care vanguard and for measuring its impact.

This report will be followed in June 2017 by a summary of early findings from quantitative and qualitative research exploring patient and staff perspectives of the changes being made, which will focus on two of the programmes key workstreams: enhanced primary care and specialist outpatient services.

## **Methodology**

### The scoping phase

This report is based on mixed-methods research carried out between January and March 2017, which included:

* Interviews with 18 individuals involved in the development of the Connected Care vanguard and/or in the new care models programme at a national level. Our local sample included at least one representative from each of organisations that have formed the Connected Care Partnership, many of whom sat on one of the programme’s two main governance bodies: the Partnership board and Programme Steering Group, as well as members of the programme team, commissioners and wider system stakeholders. Interviews were semi-structured, typically lasted about 45 minutes, and were carried out either face-to-face and by telephone;
* Analysis of programme documentation – including the business case, logic models, minutes of partnership board and programme steering group meetings, detailed service specifications and quarterly reports of performance against local and national metrics – and reviews of published literature on key topics (eg. on evidence about integrated care);
* Attendance of key meetings and workshops at a local and national level, to keep up-to-date with developments in Connected Care and the New Care Models Programme nationally. This included participating in monthly teleconferences of vanguard evaluation leads to share emerging learning and evidence across the national programme;
* Regular meetings of the evaluation team and a team approach to the analysis and synthesis of findings and identification of lessons learned;
* Securing ethical approval for the project through the University of Birmingham’s research ethics committee, and liaison with research and development (R&D) leads in the programme’s partner organisations to secure any local approvals needed.

Over the same time period, the evaluation team were also designing and setting up research with patients and staff members to explore views about and experiences of the changes being implemented and identify evidence of early impacts. The next phase of the research includes in-depth interviews, focus groups and an online survey of staff across Connected Care’s partner organisations, and initial findings from it will be reported in June 2017.

In terms of the insights from this research, we would emphasise that:

* The research presents an assessment of the Connected Care vanguard at a particular point in time, as the programme was moving from the design phase to implementation. Large-scale change programmes of this kind constantly evolve, and so it is possible that some of the challenges and issues that are highlighted in our report have subsequently been addressed;
* The roles that our interviewees held, within their own organisations and in relation to Connected Care, were largely senior and strategic. Interviewees varied in terms of the nature and degree of their involvement in the programme’s design and implementation, and this variation is reflected in the wide range of views that were shared with us;
* A fuller picture of progress in the implementation of the new care model will emerge from the research we are undertaking with patients and frontline staff, and it is recommended that this report is read alongside future outputs from the evaluation.

### Designing an impact and economic evaluation

Alongside these scoping interviews, the evaluation team undertook work to design a framework for evaluating the outcomes and economic impact of Connected Care. Our brief was: to provide expert advice to the vanguard leadership team on options for undertaking an in-depth economic evaluation and impact analysis on patient health and wellbeing and service utilisation of Connected Care for each of the three service models targeted at different population segments.

Our approach included meetings with programme leaders and individuals involved in workstream delivery, as well as detailed review of documents describing proposed measures for assessing programme. In addition, the evaluation team held a workshop in March 2017 with participants from all Connected Care partner organisations (except the mental health trust which sent apologies due to a CQC inspection on the day of the meeting), which aimed to:

* Review progress to date with analysing the costs of services delivered under the auspices of the vanguard programme;
* Take stock of the main outcomes of interest for each service development;
* Consider different methods for undertaking economic evaluations and consider the strengths and weakness of each in relation to the vanguard service initiatives;
* Build consensus about the specific evaluation questions to be addressed and the most appropriate evaluation method for addressing the selected questions.

Data from these activities informed recommendations to the Connected Care Partnership Board on how to evaluate the economic and wider impact of the programme’s workstreams.

# **The Connected Care Programme**

## **The national new care models programme**

In 2014, NHS England published the *Five Year Forward View* (NHS England 2014). It acknowledged that the NHS had “dramatically” improved in the past 15 years, but set out a case for radical transformation of services to tackle widening gaps relating to health and wellbeing, care and quality, and funding and efficiency. It proposed re-shaping service delivery to be more integrated, proactive, personalised and efficient, with a stronger emphasis on empowering patients and communities. The central theme of investment in and development of primary care was taken up in the subsequent *General Practice Forward View (*NHS England 2016), which set out a series of commitments to build capacity and capability in general practice across three key areas of workforce, infrastructure and care design.

A series of initiatives followed, the most high profile of which is the New Care Models Programme. NHS England is funding 50 ‘vanguard’ sites to develop and test the new care models described in the Five Year Forward View, which will *“act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system”* (www.england.nhs.uk). Vanguards are receiving funding for three years (until end of March 2018) to develop and implement their local model; this includes specific funding to support monitoring and evaluation. The role of national bodies is to provide funding for the management of the projects, advise on technical issues and help overcome regulatory barriers (Collins 2016).

One of these models, the multispecialty community provider (MCP) model, will see groups, federations or ‘super-partnerships’ of general practices working with other local providers to deliver integrated primary and community-based services to their entire local population. MCPs are intended by NHS England to operate at four levels (Figure 1).

**Figure 1: The four levels of the MCP care model**



**Source**: *The multispecialty community provider (MCP) emerging care model and contract framework* (NHS England 2016b)

Recent commentaries have focused on the critical question of how local areas will contract for new care models such as MCPs, to ensure that they are embedded and sustained locally once the national funding has come to an end (eg. Collins 2016). NHS England is clear that it will not specify a single organisational form or contracting route that must be used. Instead they have pointed to three broad approaches that are currently emerging (Box 1).

**Box 1. Possible contracting routes for MCPs**

* **A virtual approach**: where providers continue to hold separate contracts and budgets for services, but they are bound together by an ‘alliance’ agreement;
* **A partially integrated model**: where some services (excluding core general practice) are brought together and commissioned through a single contract;
* **A fully integrated model**: where all primary and community-based services in an area are procured in a single contract. This is likely to be a much longer term contract than is typical in the NHS, in the region of 10-15 years.

**Source**: NHS England 2016b

Irrespective of the contracting vehicle selected, the long-term success of the new models of care being developed by the vanguards will be a social, as much as a technical, accomplishment, with the strength of relationships between the organisations and leaders involved likely to be a critical factor.

## **The Connected Care Partnership vanguard**

### Background to the vanguard

The [Connected Care Partnership](http://corporate.modalitypartnership.nhs.uk/our-new-care-model) is one of 14 MCP vanguards in NHS England’s New Care Models Programme. It is being delivered by a multi-agency partnership, led by the Modality Partnership (a super-partnership of 19 practices – see Box 2) and including Birmingham Community Healthcare, Birmingham and Solihull Mental Health Trust, the Intelligent Commissioning Federation (ICOF) of GP practices, and Sandwell and West Birmingham Hospitals NHS Trust.

**Box 2. The Modality GP Super-Partnership and at scale primary care**

In 2009, the partners from two GP practices in West Birmingham merged to create the Modality Partnership. Since then, the partnership has expanded to become one of England’s largest super-practices (Rosen et al 2016). It offers primary care services at 15 practices in Sandwell and Birmingham for a population of 70,000, and recently extended beyond the West Midlands to incorporate four practices in Hull. Its founding aims were to create a large partnership to provide sustainable and high quality integrated services; improve patient experience and be the preferred provider of primary care services in the region; and improve consistency of quality. There are 59 partners, who own shares in the organisation and employ over 400 staff. Day-to-day operations are run by an executive board with support from a senior management team on behalf of the GP partners.

Although not formally part of the partnership, other agencies including Sandwell and West Birmingham Clinical Commissioning Group (CCG) and local voluntary sector organisation Health Exchange are involved in the development and governance of the programme. The US health services company Optum has been contracted to support the programme with health analytics, actuarial services and decision-support tools. The main governance body is a Partnership Board, with operational matters managed by a programme steering group. It is one of only four MCP vanguards that is led by a provider organisation, rather than by a CCG.

The vanguard covers a population of just over 160,000 across the Sandwell and West Birmingham area, with all but four of the 26 general practices involved falling within the Sandwell and West Birmingham CCG patch (of the remaining four, three are within Cross City CCG and one with Birmingham South and Central CCG). The area covered by the vanguard is a predominantly inner city area, characterised by significant ethnic diversity and includes several areas with high levels of economic deprivation and poor health outcomes.

### The Connected Care model

The business case developed by Connected Care partners describes four key local drivers for the intended transformation of services:

* demographic pressures and increasing demand;
* poor access to GP services around Birmingham;
* unsustainable system strains;
* variations in quality and performance.

Against this context, the vanguard’s aim is to develop and implement a full population health model that is, *“underpinned by a 24/7 Single Point of Access, a broader range of home-based and community alternatives to the hospital, and engaging and empowering our population to manage their care with confidence.”* At the centre of the redesign is the use of risk stratification to target resources and tailor service delivery according to acuity and need. The population is segmented into three broad categories (Figure 2).

**Figure 2: Risk stratified pathways of care for the Connected Care population**



The Connected Care MCP model is comprised of several component projects and workstreams, with a focus that spans from initiatives targeting population wellbeing and community resilience, through to those which address the interface between community-based and acute services (Figure 3). Three ‘enabler’ workstreams address workforce development, communications and engagement, and IT and business intelligence respectively.

**Figure 3: The Connected Care Partnership MCP Model**



Redesign of primary care is at the heart of the Connected Care model, with workstreams focusing on increasing capacity and capability within primary care teams, and the establishment of formal arrangements for multi-disciplinary teamworking to join up primary care with other professionals and services to manage the care of patients with the most complex needs (Figure 4).

**Figure 4: Enhanced primary care and care management teams**



Key features of the approach will include:

* GP-led teams responsible for a defined population of around 3,500 patients, with teams meeting for a daily ‘huddle’ to plan and agree work and support learning;
* Introduction of new clinical roles in the primary care team, including practice-based pharmacists, extended scope physiotherapists, physician associates and mental health advanced nurse practitioners;
* Creation of new non-clinical roles through re-training of practice staff and collaboration with the voluntary sector. These include wellbeing coordinators to support with non-clinical issues and concerns for people with complex health needs, using a social prescribing model; and reception staff acting as care navigators, guiding people to the most appropriated source of help or advice;
* Multi-disciplinary teams (MDTs) working across an identified population of around 10,500, focusing on the 2% of patients with the most complex needs and supported by a dedicated care coordinator;
* Tailored programmes of condition management (moderately complex patients) and care management (most complex patients). Early identification of, and personalised care planning for, patients at risk of an adverse event, with a care manager assigned from the enhanced primary care or care management team according to patient need and complexity.

Connected Care incorporates, and builds on, key elements of Modality’s model of ‘at scale’ primary care, which has been developing since the super-partnership was formed in 2009 to improve general practice and extend the scope of general practice services provided locally. In particular it builds on:

* **Single point of access**: In 2014, Modality received funding from the national GP Access Fund to create a centralised clinical contact centre, offering new modes of access to primary care services and long-term conditions management. Patients are triaged to a either face-to-face appointment, or a range of alternatives including telephone and Skype consultations, digital resources and self-help materials. Under the vanguard, the contract centre will offer additional routes into primary care, increase the use of digital channels and introduce processes to improve care navigation, and use the capacity that is released to deliver proactive outreach services.
* **Specialist outpatient services**: Prior to the vanguard, Modality was already delivering outpatient services for dermatology, rheumatology and x-ray in primary or community settings. Under the vanguard, the range of primary care-sited outpatient services will be substantially increased (to include cardiology, gastroenterology, pain management, gynaecology, ENT, urology, orthopaedics, respiratory and ophthalmology), with some making use of telemedicine to offer virtual consultations as an alternative to face-to-face appointments. They will also be aligned with a new referral facilitation service being introduced across all Connected Care practices.

### The local context

As with all change programmes, the implementation and outcomes achieved by Connected Care will be shaped contextual factors, both national and local. It is not our intention here to provide an exhaustive summary of the wider environment into which the programme is being introduced; many of the most salient aspects of this environment are discussed in the following chapter where we present the findings of our scoping interviews.

Key factors to understanding the local context of Connected Care are:

* *Sustainability and Transformation Plans (STPs):* Connected Care cuts across two STP areas (known as ‘footprints’): [Birmingham and Solihull](https://www.birmingham.gov.uk/downloads/download/1008/birmingham_and_solihull_sustainability_and_transformation_plan), and the [Black Country](http://www.dudleyccg.nhs.uk/wp-content/uploads/2016/11/Black-Country-STP-Full-Plan.pdf), with most of the practices involved in the vanguard falling into the latter. There is strong alignment between the Connected Care model and these local plans, with the Black Country STP describing the MCP and primary and acute care systems (PACS) vanguards being developed locally as ‘key enablers’ for the implementation of place-based models of care. Both STPs identify investment in and development of primary care services, delivering more care in primary and community settings, and achieving integrated working across services as key priorities. The importance of enhanced general practice to new models of care delivery is emphasised and in both cases is linked explicitly to the goals of reducing unnecessary use of acute services and securing long-term financial sustainability for local systems of care.
* *The Midland Metropolitan Hospital*: in October 2018, Sandwell and West Birmingham Hospital Trust – one of the Connected Care partners – will open a new acute hospital in Smethwick, funded through a private finance initiative (PFI). The financial business case for the hospital is predicated on certain levels of activity, which Connected Care could impact on in different ways. Efforts to move services out of the acute system and into community settings would reduce the acute trust’s income, while not necessarily enabling them to take out fixed costs – in effect, creating a financial deficit. On the other hand, if the enhancement of community-based services supports admissions avoidance and reduces length of stay, Connected Care could contribute to the trust’s longer-term financial sustainability.
* *Integrated care systems across the Black Country*: in April 2017, the four Black Country CCGs (Sandwell and West Birmingham, Dudley, Walsall and Wolverhampton) moved to a joint management structure. They have already announced plans to create a single accountable care provider (ACP)[[1]](#footnote-1) for acute care and another for mental health across the patch, signalling a clear commitment to integrating the funding and delivery of care services in the area. The creation of an ACP would build on recent moves to join up strategic planning about clinical services across three hospital trusts – Dudley, Walsall and Sandwell and West Birmingham – in the form of a [Black Country Alliance](http://blackcountryalliance.org/). If extended to primary and community services, these developments would help to pave the way for the creation of fully integrated MCPs.

# **Key findings**

## **The case for change, scope and goals of the programme**

Connected Care set out with a clear case for local service transformation. There was consensus among those interviewed for this evaluation that service redesign was needed. Interviewees highlighted a common set of drivers for change, including addressing fragmentation of service delivery; supporting a sustainable and high quality general practice service locally; shifting from a reactive to a more anticipatory model of care; having a stronger emphasis on population health and wellbeing, and meeting people’s wider social (not just clinical) needs; and providing services that are more accessible, convenient and which result in a positive patient experience.

There was also widespread support for the notion that services and pathways – particularly those for people with complex health needs – needed redesigning, and vanguard funding was welcomed as an opportunity to do this. Interviewees agreed that services were not being used efficiently, that too often patients were seen in settings or by professionals that were not best suited to their needs. Having access to a multi-disciplinary team, encompassing clinical and non-clinical skills, was strongly supported.

While there was a shared view about the drivers for change, there was a lack of consensus about what Connected Care should be doing in response to these drivers, and tensions between aspirations for the programme held by different partners. Modality had been encouraged by NHS England to bid for funding from the New Care Models Programme to develop a vanguard to deliver primary care and GP-led transformation. This would build on the work that the super-partnership had been progressing since 2009 to strengthen and extend primary care services in Sandwell and West Birmingham. The business case had subsequently been re-worked when the funding offered by NHS England was less than the partnership bid for, which strengthened the focus on primary care:

*“Now because the original business plan that went in was for about 15 million or something, it was then revised because NHS England didn't want to give that much money and the value went down to 4.6 or something like that, and the revised business plan cut out an awful lot of what would be delivered by the community services, so it actually became very primary care focused.”*

Connected Care had also been set up to deliver wider system goals – including moving services from acute to community settings, enhancing intermediate care, integrating service delivery across organisational boundaries and generating cost savings for the local health economy – and it was these goals that were critical in other local providers agreeing to join the partnership.

These goals – of primary care and wider system transformation – are by no means incompatible, but our evaluation found that there was a tension between them that Connected Care was struggling to balance, and which was affecting partnership working and the pace of progress. Moreover, there is a question about whether the programme can deliver both goals within the timescale and the funding that is remaining for the New Care Models national programme.

As Connected Care moves into its final year, there is a need for programme leaders to revisit its objectives and the work planned within individual workstreams to ensure that these are realistic and achievable. There may be a case for prioritising specific workstreams and projects, and targeting resources and action towards these. Above all, it is vital that partners reach agreement about how its delivery plans will balance the goal of redesigning primary care services and that of wider system transformation. This is imperative so that Connected Care has a clear sense of what it is aiming to achieve: to underpin effective implementation and assessment of outcomes achieved.

## **The partnership, governance and strategic context**

### Early development of the partnership

Like all complex change programmes, Connected Care is being developed and implemented by a multi-stakeholder partnership and the strength of relationships between partner organisations will be critical to its success (Best et al 2012). What emerged from our interviews was a sense that the partnership was still developing and, particularly in recent months, had undergone some important changes which many interviewees were positive about.

Not uncommon for a programme of this complexity and scale, there were some tensions within the partnership. Several interviewees commented on the dominance of Modality within the vanguard application and process, and the partnership itself. As a consequence the programme of change was felt to reflect Modality’s agenda and interests, to the extent that – for some – it was difficult to distinguish between Modality and the work of the vanguard. The decision to locate the programme management team within Modality, and the fact that service changes had, by the time of our research, largely focused on the implementation of enhanced primary care (EPC), had contributed to this perception. Although, on the latter of these points, our evaluation found that EPC had been able to progress far more quickly because it was changing the part of the system that was within Modality’s control: namely its own practices. It is important for programmes of this kind to deliver quicks wins, and EPC offered the opportunity to do this.

The imbalance within the partnership was recognised by senior figures in Modality, and was increasingly seen to be a barrier to delivering the programme’s goals around whole system change:

*“Despite NHS England kind of wanting us to continue that way, we weren’t able to. I felt we weren’t able to influence or negotiate a system wide approach just purely from an insular primary care angle.”*

Programme leaders had taken steps in the latter part of 2016 and early 2017 to create a stronger and more equal partnership, including a change of name from the Modality Vanguard to the Connected Care Partnership Vanguard; the secondment of a new programme director from the community healthcare trust; and the allocation of responsibility for specific workstreams to partner organisations other than Modality.

Interviewees were generally positive about the direction of travel for the partnership, acknowledging the changes that had been made to foster a more inclusive and system-wide approach. That said, several also commented on Modality’s continued dominance in the partnership and it was clear that the tension between competing visions for the programme was not yet revolved. For example, one interviewee commented that, *“It feels very much Modality and not a Connected Care partnership…It feels like it’s Modality’s money and the other partners have to fight to get access to it.”*

**The extent and experiences of partnership working**

Our evaluation found that relationships between four key partners – Modality, ICOF, the community trust and mental health trust – were generally strong, notwithstanding the challenges to collaborative working that we describe elsewhere. The inclusion of mental health in the partnership was considered to be a particular strength, providing the opportunity to focus on the integration of physical and mental health and, in particular, address longstanding issues about the role of general practice in managing mental health problems in community settings.

In terms of broader involvement:

* *The acute trust*: while the acute trust is a key partner, their attendance at board meetings had been sporadic and some interviewees questioned whether their attendance constituted true engagement. There was also a view that the trust’s contribution to discussions, where it had attended, had been largely focused on defending its financial position. But interviewees were also understanding of the “almost impossible” position that the acute trust was in – trying to square the financing of the new Midland Metropolitan Hospital with local strategic plans and programmes aiming to move more care into community settings.

The acute trust’s engagement in the programme will, our findings suggest, depend on Connected Care being able to offer solutions to help the trust deliver financial balance. If the strengthening of community-based services results in lower hospital spend, then it must also enable the trust to compensate for this (eg. by taking out fixed costs) so that it avoids going into deficit. The questions of whether and how extending service delivery in community-based services can be aligned with system-wide sustainability are critical. Our findings suggest that these questions need to be tackled more openly and explicitly by the partnership board and in the programme’s ongoing design work.

All schemes to shift care closer to home are likely to confront the same challenge, and recent evidence shows that initiatives have a more consistent positive impact on patient outcomes and experience than they do on cost savings (Imison et al 2017). The most successful schemes have targeted specific patient groups (such as those in nursing homes or at the end of life), improved access to specialist expertise in the community, and addressed gaps in services, rather than duplicating existing work. It is worth noting that a recent report on this issue concluded that, *“NHS bodies frequently overstate the economic benefits of initiatives intended to shift the balance of care”* (Imison et al 2017).

* *Social care*:the absence of social care from the partnership was felt to be a limiting factor in terms of potential to transform ways of working and the local system of care, but was nonetheless considered understandable in the current financial climate. There is an aspiration for Birmingham City Council to join the partnership; current plans make no mention of Sandwell Council, which is where the majority of the vanguard practices are located. While the inclusion of social care opens up the potential for the programme to join up services across health and social care, it risks increasing the complexity of governance and decision-making and further expanding the scope of a programme that is already ambitious.
* *The voluntary sector*: views about the extent of voluntary sector involvement in the partnership were mixed. The involvement of Health Exchange in delivering the new care model and their representation on the programme steering group was taken by some as evidence that the voluntary sector are “a big part of what we’re doing”. While others felt that the programme was dominated by the NHS, and that the voluntary sector should be a fuller partner in the design and delivery of the new care model. The programme could consider whether there are particular workstreams or projects which might benefit from the resources and expertise that the wider voluntary sector can offer.

Several of our interviewees sat on the vanguard’s partnership board. The general view from this group was that the board needed further development to support effective governance and decision-making. In addition to the issue about attendance mentioned above, the main problem mentioned was a lack of clarity about function. One interviewed told us:

*“It’s partly trying to be a programme board to manage the NHS England money…And it’s partly trying to be a place where we might talk about a longer term ACO relationship. And because it’s trying to do both it can struggle.”*

While there were no specific recommendations about how the board should be revised, some interviewees suggested that the primary focus of the vanguard, and therefore the partnership board, should be designing and piloting new care pathways and services. But this raises a question about how the future of the new model is secured, and what role the partnership should be playing in this. While contracting is formally the responsibility of the CCG, provider organisations have a vital role to play in commissioning and contracting new models of integrated care, and evidence suggests that provider engagement is critical to success (Addicott 2014). As the vanguard moves into the final year of funding from NHS England, there is a pressing need for the partnership board to reach clarity about these issues.

**Barriers to collaborative working**

The institutional barriers to inter-organisational working are well documented in the research literature (see Box 4), and the Connected Care vanguard is therefore by no means unique in the challenges it is facing to deliver more coordinated and community-based care. The organisational incentives for partners to participate in the vanguard were highly varied, not least because – under current NHS contracting arrangements – the plan to deliver more care in community settings, and in particular in primary care, would create winners and losers as activity (and therefore income) shifted between providers.

Work undertaken by the programme team and Optum, modelling the efficiencies that could be achieved by enhancing and extending primary care services, had added to a perceived ‘us’ and ‘them’ problem. Partners voiced concerns about being asked to provide commercially sensitive information and how this would be used. These concerns, for some, were confirmed when the results of the modelling work was shared with them:

*“It was a bit of an explosive moment when the submission of the seventeen, nineteen plans for the vanguard work went to a conference call in, I would say, mid to late December, prior to the twenty third of December submission [to NHS England] and the numbers basically decimated the financial position of every organisation apart from primary care*.”

Optum’s involvement in the programme had added to the complexity of partnership working. The nature of the Modality/Optum relationship, with a perceived strong commercial orientation towards growing opportunities in primary care, had fuelled – in the words of one interviewee – “negative perceptions” and fostered some wariness about information sharing. Questions were also raised about the extent of Optum’s commitment to transforming services in Sandwell and West Birmingham, and the possibility that this commitment was dependent on them seeing a financial return on investment in the short-medium term, which – given the scale and complexity of the changes being made – was unlikely to be achievable.

**Box 4. Barriers to inter-organisational working**

Despite most people agreeing that partnership working is ‘a good thing’ there are considerable difficulties to implementing this. One of the expectations is that there may be improvements in a shared culture, although this has not been well evidenced to date (eg. Petch, Cook and Miller 2013).

Glasby et al. (2010) identify five common barriers to successful partnership working:

1. Structural (the fragmentation of service responsibilities across and within agency boundaries);

2. Procedural (differences in planning and budget cycles);

3. Financial (differences in funding mechanisms and resource flows);

4. Professional (differences in ideologies, values and professional interests);

5. Perceived threats to status, autonomy and legitimacy.

Whilst many of the barriers are the same as any large scale organisation change, Ling and colleagues (2012) argue that activities which are particularly important for delivering integrated care are the *“personal relationships between leaders in different organisations, the scale of planned activities, governance and finance arrangements, support for staff in new roles, and organisational and staff stability”.*

### Being a provider-led vanguard

An important feature of Connected Care is that is it a provider-led vanguard, one of only four such MCP vanguards in NHS England’s New Care Model’s programme. While Connected Care was demonstrating the potential for GP organisations to lead service and pathway redesign, being a provider-led vanguard had also created additional challenges. Most strikingly, there was a lack of clarity and agreement about what role the commissioner (Sandwell and West Birmingham CCG) should be playing, but at the same time many held the view that the programme would have benefited from engaging commissioners at an earlier stage.

Tensions between the national New Care Models programme and local implementation were evident, with the negotiation and signing off of the vanguard’s value proposition by NHS England leaving the CCG feeling somewhat sidelined in the design process*.* The CCG reported that there had been pressure, locally and nationally, to create a contracting vehicle for the new model of care. There was, however, no funding available through the national programme to support the work needed to achieve this in the necessary timescale, and so progress was being hampered by a lack of capacity within the commissioning team. For one interviewee, this risked the programme being *“set up to fail.”*

Our interviews with individuals involved in the national programme confirmed the challenges of embedding provider-led transformation into new NHS contracting arrangements. We were told that all the provider-led MCPs were facing similar problems because of their lack the leverage over contracting processes, and one interviewee concluded that:

*“If you take all the MCPs it would be fair to say that where there are commissioner-led MCPs, because we still exist in the commissioner environment, they’ve got some advantages over primary care led MCPs.”*

Poor definition of the role of commissioners and the lack of funding to support contracting processes are, our evaluation suggests, significant threats to the sustainability of provider-led vanguards.

## **Designing and implementing the new model of care**

### Views about the new care model

Our evaluation found strong support for many of the key elements of the Connected Care model of care, including the focus on enhancing and extending primary care, the management of population health and wellbeing, delivering risk stratified pathways of care and tailored interventions, and system integration (including strengthening the relationship between physical and mental health services). Interviewees were also very supportive of the new roles being introduced through the programme, with wellbeing coordinators in particular welcomed as an opportunity to achieve better coordination of services across the NHS and voluntary sector and enhance the support available for patients’ non-clinical needs.

There was also broad agreement that general practice was a logical place to start when designing a new model of community-based care, given the breadth and extent of its contact with the local population and role as a gateway into wider services. There was a clear and accepted rationale for strengthening delivery within primary care, building on the Modality model of care, to provide a firm foundation for redesigning pathways and implementing more complex inter-organisational changes.

However, the emphasis on general practice within the programme was nonetheless a source of contention. While some endorsed a model of care built around an enhanced and extended primary care service, others felt that too much of the new care model was focused within general practice. Several interviewees raised concerns that the design of the model – and the primacy of general practice within it – was not principally being driven by a clinical rationale or understanding of local population need, but rather by financial considerations:

*“[I said] “it feels wrong that there’s so much volume in primary care”. And their response, Optum’s response was, “Well putting the numbers in primary care in growth terms, in volume growth terms, is the only way that you can get the return on investment.” So we’ve gone over the little bit about appropriate clinical intervention location and we’ve gone straight to return on investment. It doesn’t matter where you put the required volume if it’s actually not the right clinical intervention.”*

Interviewees also commented on the extent of innovation in the new care model. There was a great deal of enthusiasm for certain innovations being trialled, such as plans to second mental health advanced nurse practitioners to work within primary care teams. The importance of the vanguard keeping innovation at the forefront of its approach was also mentioned, most often in relation to the development of community outpatient services. Some interviewees commented that the basic model of outpatient services had remained unchanged for many years and was rapidly becoming unsustainable. There was a view that the programme mustn’t miss the opportunity to address this problem. This would mean not just changing the location of outpatient services, but fundamentally re-modelling the way in which these services are delivered, including offering different modes of consultation and a much stronger focus on supporting patient self-management.

Our evaluation also found that the redesign was strongly focused on putting services into place for people with complex health needs. Less attention had been given to changing attitudes and behaviours, on which some of the programme’s main goals depend – most notably those around population wellbeing and patient-self management.

At the heart of the programme is an aspiration for people to play a more active role in their own healthcare. This is dependent on shifting from the traditional needs-based model of care to one that is holistic, enabling and collaborative, that builds people’s confidence and skills to participate in their health and care. There is a tendency within the NHS – which is also evident in Connected Care – to concentrate on building self-management by educating and equipping patients; this is necessary but not sufficient. There is a growing body of evidence which points to the importance of training healthcare professionals for a different way of working with patients, and embedding self-management support into mainstream care processes (Ahmad, Ellins and Krelle 2014). Our findings suggest that the approach which Connected Care is taking to supporting self-management is too narrowly focused on changing patient behaviours, and as a consequence this may limit what can be achieved in terms of increasing patient empowerment and self-reliance.

**Patient and clinical involvement in designing the new care model**

Although there was broad support for many elements of the Connected Care model, there was nonetheless a view from many partners that the design process had not been sufficiently inclusive, with key groups of stakeholders lacking clear channels and opportunities to influence. Our findings suggest that the design process had been largely driven by the programme team. While some interviewees accepted that this was inevitable in a large-scale change programme, others were more critical about the impact this was having on the partnership and its ability to achieve a shared vision for the future of community-based services in the area*.* There were calls for partners to play a stronger role in leading the delivery of workstreams and for a more clinically-led approach to redesign, with representation from frontline staff across all collaborating organisations.

A major theme emerging from the evaluation was the lack of patient, carer and community voice in design of the new model of care and/or its implementation. There had been very little patient engagement in the programme, either in terms of representation on governance or operational groups or through direct consultation about changes to local services.Where consultation had taken place, it had been largely ad hoc and informal (for example, some general practices had shared the changes being made at a practice level with their patient participation groups) or about specific issues (such as patient information materials) rather than core elements of design.

While one interviewee suggested that pubic engagement “is the commissioner’s job”, the more common view was that the new care model should be co-designed with patients and that it was the programme’s responsibility to do this. Failure to do so would risk the programme focusing on redesigning structures and care processes, but without delivering real and meaningful improvements for patients. We were told that the single point of access established by Modality prior to the vanguard had received mixed feedback from patients, and the aim to enhance access through increased use of technology would not be appropriate to all. This is an aspect of the programme where input from patients could help to enhance further redesign. Consultation carried out by the mental health trust, as part of a wider transformation of services in the area, had uncovered some concerns about general practice playing a stronger role in managing mental health issues:

*“[Mental health service users] do worry because we’ve done consultations with them, you know we’ve spoken with them about the different ways of working They do worry about going back to the GP because their GP doesn’t understand.”*

Giving such groups the opportunity to share these concerns is important, but the opportunity to do this might be missed if Connected Care doesn’t move soon to build a more focused and structured programme of engagement into its work. Projects and workstreams for which plans have already been agreed and are underway should focus instead on gathering patient feedback about the service changes, and using this to make improvements where necessary.

### Progress with implementation

At the time of our initial research, Connected Care was moving from its design phase to implementation. Not untypical of a programme of this scale and ambition, implementation timescales had slipped and there was some frustration about the pace of change. But at the same time there was recognition that a great deal of preparatory and ‘back room’ work was needed before new services and pathways could be launched, and that this was where much of the change process had been focused so far; this included (re)designing job roles, staff engagement and training, and work on IT systems. Another key challenge for the programme was balancing the tension between working collaboratively and ‘getting things done’. Again this is a common theme in the literature on large-scale change in the NHS, with the difficulty of reconciling robust programme management and bottom-up innovation frequently reported (Best et al 2012; Holder et al 2015).

It was clear from our findings that the wider environment was acting as both a barrier and enabler to change. The programme had encountered problems with data access, sharing and governance which were affecting both the planning of services changes and their implementation. This is a common problem facing integrated care; it has been widely reported across the vanguard sites and by other national initiatives such as the Integrated Care Pioneers Programme, and is a common theme in both UK and international literature (Erens et al 2015; Ling et al 2012). NHS England, informed by the experiences of vanguards and other national change programmes, was working with other national bodies to address these data issues. But almost two years into the national New Care Models Programme it appeared that relatively little progress had so far been made.

Interviewees commented extensively on whether and how the vanguard fitted with existing local plans and priorities, and there were a wide range of views expressed. Some emphasised close alignment between the new model of care and key themes in local STPs, including investment in general practice services, service integration and an emphasis on wellbeing and prevention. On this more positive view, STPs were seen to be providing an added impetus to improve coordination and outcomes across local systems of care. Others, however, were frustrated at what they saw as a lack of coherence between local plans, and the difficulty of operating across multiple poorly aligned planning footprints.

Many interviewees were of the view that changes to primary care services could be achieved relatively straightforwardly, at least within the Modality practices, and that this was where the programme would make most progress in the coming months. Inter-organisational changes would be more complex and take more time, and were – crucially – dependent on agreements being reached about how services would be changed that were acceptable to all partners. Recent work to strengthen the partnership was felt to be an important development in this respect.

## **Contracting and sustainability**

The question of how to commission new models of care – especially those involving integrated delivery of services across organisational boundaries – has received substantial attention recently, with interest growing as the drive towards place-based systems of care takes foot (Collins 2016; Ham, Smith and Eastmure 2011). Commentaries have pointed to the uncertainties and challenges which beset the commissioning of integrated care, and many of these were apparent in our evaluation.

The original aspiration for Connected Care – central to the business case – was that it would become a “list-based accountable care organisation.”[[2]](#footnote-2) While the creation of accountable care organisations (ACOs) is supported by local STPs, Sandwell and West Birmingham CCG was planning to commission for a larger area than that covered by the vanguard, meaning either one or two ACOs covering the CCG’s overall population. There was broad, although not unanimous, support for this decision, with most interviewees agreeing that the case for a ‘Connected Care ACO’ was not well supported given it didn’t align with current patient flows, risked creating further fragmentation in the local system of care, and was unlikely to achieve the size of population needed for the full benefits of population health management to be realised.

At the time of our interviews, the CCG had recently started work to develop an ACO or ACOs locally and agree how this/these should be commissioned. It was expected that the new care model would be commissioned – whether this be through pooling budgets and services into a single contract or using a vehicle such as alliance contracting[[3]](#footnote-3) – by 2019. This raises significant questions about the sustainability of the services and pathways being introduced by the vanguard, given that the changes currently being implemented will be superseded by a CCG-wide ACO in two years’ time. Interviewees anticipated that there would be strong similarities in the designs of the vanguard and the new care model developed by the CCG, but also recognised that any differences between them would mean that changes currently being implemented would have to be changed again.

More pressing still is the issue of how the new care model will be funded in the gap year between the NHS England funding ending (31 March 2018) and the start of the new commissioning arrangement (April 2019). One interviewee suggested that the new model could be sustained through existing contracts if partners could reach agreement about re-allocation of income to reflect changes in patterns of activity; but it was unclear whether this option had been discussed at the partnership board, and whether other partners were willing to enter into an arrangement of this kind.

Above all, there was a great deal of uncertainty about this issue, and concern about the impact on organisations, relationships and patient care if the new model of care had to be scaled back or unpicked because the funding to sustain it could not be secured.

**Challenges and barriers to commissioning**

The inherent difficulty of commissioning a new model of care was a major theme emerging from the evaluation. There were differing levels of enthusiasm for the idea of having an integrated contract covering all community-based services. Some felt that this type of contract was a necessary lever for collaboration, that it would incentivise and hold providers to account ‘as a system’. Others were more cautious about entering into what were seen as an unproven set of arrangements with significant organisational and financial risks. A key point from the literature is that contractual vehicles such as ACOs can support the successful integration of care, but they are not sufficient in themselves to bring this about. Several other factors have been reported as having an important role in effective commissioning of integrated care (Box 5).

Once again, there was an evident tension between national and local. Many were frustrated about the lack of progress that had been made nationally to address the barriers that existing contractual and payment mechanisms present to commissioning integrated care. While acknowledging work that NHS England was leading on this issue, several people argued that far more needed to be done, and done quickly to avoid vanguards reaching the end of their funding without arrangements in place to sustain positive changes and impacts.

**Box 5. Factors that support effective commissioning of integrated care**

Research by Ham, Smith and Eastmure (2011) examined the learning from efforts to commission integrated care, bringing together a range of qualitative and quantitative data including a survey of primary care trusts (PCTs) and evidence from eight NHS case study sites. Their analysis found that more successful experiences of commissioning were associated with:

* **Strong managerial and clinical leadership**: including a willingness among primary care doctors to lead the development of integrated services, compete for contracts and hold new forms of budgets;
* **Robust performance management**: with parties agreeing performance and outcome indicators and then organising and funding the necessary data collection, synthesis and analysis to monitor progress against them;
* **Commissioning for a registered list of patients**: with providers assuming a capitated budget of deliver a range of health management services for a defined population;
* **Provider engagement**: with commissioners and providers working closely to develop new care pathways and service specification. The authors notes that in the most successful examples *“commissioners were seeking to exploit the strength of providers as developers of services, encouraging them to do this in a way that enabled better integrated care.”*
* **Time and persistence**: the research found that the integration of services in the case study sites had been a long term process, in most cases taking place over a number of years.

Further insights are offered by Addicott (2014), drawing on learning from five case study sites. She described four key factors that support effective commissioning of integrated care:

* Ongoing engagement with providers, patients and the wider community to define the problem and identify appropriate solutions;
* Nurturing trust and building relationship between providers;
* Aligning payment mechanisms and incentives across providers;
* Providers leading on the development of governance arrangements and organisational models.

## **Benefits and impacts**

A critical question for any change programme is whether it is delivering the improvements and positive outcomes that it set out to achieve. By the time of our initial research, Connected Care was just getting underway with major service changes and so it was too early to tell what impact the programme was having. We were told that the changes which had been made so far had been positively received on the whole, and some interviewees were confident that these would translate into positive outcomes over the coming months.

The general view was that demonstrating the impact of the vanguard was imperative and yet extremely challenging given the multiple workstreams and gradual programme of implementation. We address this further in chapter 4 below. The issues raised by interviewees echo the challenges of evaluating complex change programmes and integrated care which are well documented in the literature (Bardsley, Steventon, Smith et al 2014). Box 6 summarises these issues and proposes how each of these can be addressed in the design of the Connected Care evaluation.

**Box 6. Challenges to demonstrating the impact of Connected Care and how these will be addressed in the evaluation design**

**Timescales**

*The challenge:* many of the most important programme goals are long term but there is pressure – locally and nationally – for Connected Care to show results now.

*How this can be addressed in the evaluation design*: it is critical that the evaluation gathers evidence about whether and where progress is being made, while avoiding making summative assessments about programme impact at too early a stage. This will be achieved by using process measures and interim markers of success, to assess whether the work is going in the right direction.

**Measurable and intangible outcomes**

*The challenge*: some outcomes will be far easier to document than others. Programme outcomes relating to integration, culture change and patient empowerment will be particularly difficult to assess given the limited focus of routine NHS data, and lack of tools available to measure such outcomes.

*How this can be addressed in the evaluation design:* this calls for a mixed-methods design, which combines data from different sources and perspectives to create as complete a picture as possible of what is being achieved. Qualitative research has a particularly important role to play here in exploring complex processes (eg. culture change) that are not easily captured through standardised tools. A key function of the evaluation will be to synthesise quantitative and qualitative insights.

**Patient-reported outcomes**

*The challenge*: the goal to improve the quality and provision of care as it is experienced by patients is at the heart of Connected Care, but there is a risk – particularly in the current financial climate – that improvements for patients may be overlooked in the drive to show that service redesign has improved efficiency or made cost savings.

**Box 6. Challenges to demonstrating the impact of Connected Care and how these will be addressed in the evaluation design (continued)**

*How this can be addressed in the evaluation design:* the evaluation includes a dedicated workstream exploring patients’ experiences of new and changed services and what difference these services are making to the outcomes that people value most. The programme has also contracted iWantGreatCare to gather patient-reported outcomes; this work must capture outcomes that are important to the programme, using tools that are meaningful to patients. Recently developed tools such as IntegRATE (http://www.integratescore.org/) fulfil both these criteria.

**Taking a whole system view**

*The challenge*: given the complexity and extent of interdependencies within the local system of care, it is vital that any benefits seen in one part of the system are understood in relation to possible knock-on effects (positive or negative) elsewhere.

*How this can be addressed in the evaluation design*: we propose that the evaluation includes two in-depth case studies, focusing on the implementation of MDTs and the creation of new community outpatient services. These are proposed because they represent two of the most ‘whole system’ elements of the programme and so provide the opportunity to explore impact across multiple organisations and from different partner perspectives. See Chapter 4 for further information.

There were differences of opinion about the issue of financial impact brought about by the vanguard to date. Some felt that the vanguard must demonstrate cost savings, particularly in the acute sector: to justify NHS England’s initial investment, provide evidence to secure the future of the new model of care or simply because of the importance of redesign efforts contributing to long-term financial sustainability of local services. Others felt that this goal was unrealistic, and were more concerned that the vanguard demonstrated it was helping make best use of the workforce and resources to deliver better care.

Evidence for the financial impact of integrated and community-based services is weak (Nolte and Pitchforth 2014), and evaluations of such programmes have consistently reported that cost savings were not achievable in the short-medium term (even longer-term financial savings are uncertain). It is vital therefore that Connected Care partners and NHS England are realistic about what can be achieved and that a range of outcomes and measures are selected against which to judge success (Bardsley, Steventon, Smith et al 2014; Lamont et al 2016).

We now move on to discuss what a robust and realistic approach to measuring outcomes might look like in practice.

# **Options for undertaking an economic evaluation and measuring impact of the Connected Care Vanguard programme**

## **Options for an economic evaluation of vanguard activities**

With the health economy under significant financial pressure, it is essential for Connected Care to deliver cost effective changes in local services which achieve the same or better outcomes as current services but at lower cost. This section identifies two vanguard initiatives for which an early economic evaluation could provide insights into the economic impact of service re-design *across the whole Connected Care health system.* It also identifies possible costs and effects that could be evaluated, with the caveat that the precise questions to be addressed by an economic evaluation will need to be defined and agreed by the Partnership Board once the workstreams for evaluation have been approved. Proposals in this section are informed by a workshop with key stakeholders, held in March 2017, to explore options for economic evaluation. An account of the workshop is presented in the accompanying paper on economic evaluation and measuring the impact of the Connected Care programme.

#### Workstreams for economic evaluation

We recommend focusing the first phase of an economic evaluation on specialist outpatient services and multi-disciplinary team work. These reflect the phasing of the vanguard project plan and the need to evaluate the workstreams that are sufficiently far advanced that they will have started to have some impact. Other areas of the programme could be added once data collection tools and processes have been developed through the first two workstreams.

We have not recommended a stand-alone economic evaluation of the enhanced primary care (EPC) workstream because capturing the wide-ranging ‘effects’ of EPC in a single economic evaluation would be a huge methodological challenge. We therefore recommend evaluating individual workstreams in which EPC plays a central role, with the aim of capturing costs and effects across all participating partner organisations. We have also not recommended evaluating the healthy communities workstream because, although implementation of this workstream has started, the projects are relatively small scale and effects will accrue over many years so a short term evaluation with limited resources will be unlikely to demonstrate cost effectiveness.

***Specialist outpatient services***

This workstream aims to: i) improve access to specialist appointments; ii) reduce waiting times (for diagnostics and outpatients); and iii) reduce overall health care utilisation and per person per year costs.

*Justification for this option*

This option is included because all of the main provider organisations in Connected Care are involved in developing and delivering the service. Also the new service is likely to result in rapid and measurable changes in patient flows to different provider organisations.

*Advantages of this option*

* A vanguard workstream is dedicated to community outpatients and implementation has started;
* Some of the clinics are live so data will be available about a group of vanguard services involving more than one partner agency;
* This evaluation could be designed to focus only on activity in community clinics or its scope could be broadened to include examining wider effects on the hospital of transferring outpatient activity into the community.

Some community specialist clinics have been running for years so there is potential to compare the impact of newer clinics that have been developed as part of the vanguard with the impact of established clinics designed and implemented by Modality.

***Complex case management through multi-disciplinary teams***

This workstream aims to: i) improve care co-ordination for the 2% of patients with the most complex needs; ii) link the extended primary care team with district nurses from the community trust; iii) reduce A&E attendances and emergency admission; and iv) improve the health and wellbeing of patients and carers.

The MDT meetings are due to be implemented during the first quarter of 2017-18, so there would be time to undertake a 6-9 month evaluation starting in late summer 2017.

*Justification for this option*

This workstream includes all the main Connected Care providers and reflects the scale of ambition of the vanguard. If effective, it will help to take out cost at scale from the hospital and allow evaluation of a whole pathway of care.However, evidence that this kind of service can result in cost savings is mixed (Imison et al 2017) and research suggests that where savings are made, they take two and a half to three years to accrue (Ferris et al 2015). An early stage, rigorous economic evaluation of this workstream is particularly important, but may need to continue for up to three years if it is to capture the longer term economic impact of multi-disciplinary working.

*Advantages of this option*

* Data from the care management templates will be available through EMIS searches. This will reduce the risk of delay due to slow access to data stored in clinical records across multiple organisations;
* Data about use of hospital and community services could be obtained in an aggregated form from their clinical systems OR each encounter could be coded into GP records to support longitudinal tracking of service use in individuals patients;
* There are opportunities for improving data quality by training staff in general practice to code data on hospital and community services encounters accurately.

There are also various validated measurement tools available to capture patient experience of complex case management and care coordination (for example the four-item IntegRATE questionnaire). These would allow comparison of the patient effects of multi-disciplinary working with traditional GP care for complex patients.

#### Recommended design of an economic evaluation

We recommend that an economic evaluation is undertaken to compare the costs and effects of the new services versus existing services that they are expected to have an impact on. This pragmatic suggestion takes account of the nature of information needed from an economic evaluation to reach a decision about the cost effectiveness and, importantly, the affordability of the new services; the constraints on resources available for the evaluation; and the complexity and likely evolving nature of the new services.

This will require further clarification of which existing services are likely to be affected and what effects (eg. cost reductions, reduced waiting times, higher patient satisfaction) are of key interest. Additional advice on measuring effects is included below.

The economic evaluation would need to capture the full costs of the new services as well as computing unit costs – such as the cost per patient, cost per attendance etc as appropriate – to compare with total and unit costs of the comparator/existing services. The counterfactual to the new services could be defined in a before and after way. That is, the costs of the new service could be compared with the costs of the ‘old’ service before the new services started. Or (or, possibly and), the counterfactual could be constructed by comparing the costs for patients using the new services with the use of services by those from non-vanguard practices (in the case of the community outpatient services).

***For community outpatient services***

Cost measurement might include:

* Full cost of service delivery in community and hospital;
* Unit costs – such as the cost per patient, cost per attendance etc as appropriate.

Effect measurement might include:

* Waiting times for hospital and community clinics;
* Number of encounters per completed episode of care.

***For MDT working***

Cost measurement might include:

* Full cost of delivering MDT meetings;
* Full cost of implementing care plans;
* Total cost of services used by patients on MDT case load and control patients without MDT review and care planning.

Effects to be measured could draw on data from primary, community and acute providers including any or all of:

* Emergency admissions and length of stay are potential measures for the MDT/care management work;
* Number of appointments with the GP over time;
* Number of contacts with community trust staff.

Patient measures for both workstreams could include any or all of:

* PREMS/PROMS measures developed with iWantGreatCare (IWGC);
* Bespoke data collection through a pathway or service specific data collection tool – which could include the IntegRATE measure to evaluating MDT working;
* Friends and family test scores.

Data analysis to develop full incremental cost effectiveness ratios would be beyond the scope of this evaluation.

The above could be augmented with qualitative data to explore possible causal mechanisms to explain observed effects and to create a formative element to the evaluation. This would help to address questions such as: are there ways to deliver a similar intervention more cost effectively? Could delivery be improved or streamlined?

|  |
| --- |
| **Recommendations to the Connected Care Partnership Board for an economic evaluation**   1. In the coming year, following clarification on some key issues of scope and effects of interest, undertake a cost effectiveness evaluation of the two proposed workstreams. 2. Set up an evaluation of specialist outpatient services first and then establish an evaluation of multi-disciplinary team working. This will give the latter workstream more time to become established. 3. Use the first two evaluations to develop a collection of standardised data collection tools and processes that can be used to evaluate other care pathways and workstreams. 4. Develop a phased role out of similar evaluations of other workstreams as they come on line, using the data collection processes and methods developed through the first two. |

## **Measuring the effects of vanguard activities**

The initial phase of the evaluation also included an aim to develop recommendations for measures to evaluate the impact of vanguard initiatives for each of the three target population segments in the vanguard logic model (described in Figure 2 on page 7 of this report).

The Connected Care logic model and programme ‘workbook’ set out a wide range of outcome measures to monitor progress at a granular level in each workstream and for each patient subgroup. The identified 118 measures across all the programme’s workstreams of which 27 relate to the target population subgroups and cover five domains:

1. Quality and safety (eg. improved quality of life)
2. Health and outcomes (eg. improved vaccination and screening rates)
3. Efficiency (eg. reduced waiting times, reduced unplanned admissions)
4. Patient experience (eg. improved access, improved patient and carer experience)
5. System improvements (eg. improved staff satisfaction, and recruitment and retention)

Baselines have been quantified for outcomes that will be monitored using routine health system data (eg. data on delayed transfers of care, ACS sensitive admissions, bed days, emergency admissions and A&E attendances per 1000 population). Public health data has been used to define baselines for prevention and screening interventions and a range of QOF data on clinical measures will be used to track health and outcomes at population level.

In addition, Connected Care have been working with iWantGreatCare to develop methods for routine collection of Patient Reported Outcome Measures (PROMS) and Patient Reported Experience measures (PREMS) and a data collection tool is in preparation.

### Selecting and using measures to evaluate impact

With such a wide range of measures already identified, we suggest criteria for selecting a sub-set for which it should be a high priority to establish systems to collect, synthesise and analyse data. These criteria take account of the measures already being submitted as part of the national vanguard evaluation programme and focus on monitoring those outcomes which are most important to service users and staff at a local level.

The rationale for identifying indicators and deciding how they will be used is that ‘the right things’ should be measured and appropriate analytic methods used such that when a change in outcomes is happening, it has a good chance being picked up; and when a change has not occurred, the likelihood of a false positive is low.

Given limited resources for evaluation, we suggest that, where possible, generic measures are used so that a single data set can be used to evaluate multiple initiatives and to avoid the need to train staff how to use/manage data from multiple data collection tools. That said, condition or patient group specific tools may also be useful in some situations and a description of the wide range of potential measures that could be used is presented in the accompanying economic analysis paper. Measures should be selected with the following in mind:

* Ensure that each workstream has clearly defined aims in relation to patient and staff experience, patient and population health outcomes and whole system utilisation *and* a ‘theory of change’ for how it will contribute to the formation of a sustainable, integrated, MCP provider;
* Identify at least one process or enabler measure and at least one outcome measure related to each aim of the service development ***and*** to track progress with forming the MCP itself (see template below);
* Ensure that staff and/or resources are allocated from the launch of each workstream to design and set up monitoring and evaluation;
* Select measures where changes in score will reflect anticipated changes in service delivery or outcome;
* Keep the measures as simple as possible, and minimise the burden of data collection;
* Measure things that are meaningful to people;
* Ensure that ongoing review of the data collected informs the ongoing refinement of services.

The template for identifying potential evaluation measures presented below builds on learning from a recent evaluation of primary care homes (Nuffield Trust, forthcoming).[[4]](#footnote-4) A primary care home is an emerging model of care linking general practice to wider primary and community services. There is no specific ‘organisational form’ for a primary care home, but over time, they will deliver integrated services targeted at all the different population subgroups (frail elderly, mainly healthy adults etc) registered with participating practices. Yet, to emerge as ‘organisations’ they need to develop infrastructure, governance, a shared culture and more.

This work highlighted the need to ensure that each initiative to develop a new, integrated service – delivered by partner organisations – needs to fulfil its own aims for patients and staff, but also contribute to an overarching aim of creating a sustainable PCH organisation. The template below – building on the approach used in the PCH evaluation – suggests a way of aligning local service development goals with those of developing a new organisational model for Connected Care. It also provides a framework for selecting a limited group of measures through which to track clinical impact and monitor progress towards establishing an MCP organisation.

##### **Figure 2: Mapping template for linking the aims of each workstream to the overarching aims of creating a sustainable MCP**

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| --- | --- | --- |
| Overarching aims to develop a multi-speciality community provider | Domains of measurement for each programme workstream (see above) | Examples of ways to measure this (see appendix tables 1-4 below) |
| Improve whole population health and wellbeing | Healthy Outcomes | *Exemplar measures that could be used (see appendix below):*  EQ5D  WEMWBS |
| Improve quality and experience of care for patients | Quality and safety  Patient experience | *Exemplar measures that could be used (see appendix below):*  Condition specific clinical measures  QOF data  Locally devised PROM/PREM scores  National patient survey data |
| Improve utilisation and sustainability of local health and social care resources | Efficiency | *Exemplar measures that could be used (see appendix below*):  Hospital admission rates  A&E attendance rates |
| Cost effectiveness | *Exemplar measures that could be used (see appendix below*):  Outcomes of economic evaluation |
| Improve staff experience | System improvements | *Exemplar measures that could be used:(see appendix below):*  Warr-Cook-Wall staff survey  Team Working Assessment Tool |
| Create infrastructure for the Connected Care MCP | System improvements | *Exemplar measures that could be used (see appendix below*):  Process measures of progress with integrated IT implantation |
| Develop culture and leadership for the Connected Care MCP | System improvements | *Exemplar measures that could be used (see appendix below)*:  SCORE survey to assess organisational culture |

Drawing on the information above, we recommend that Connected Care should focus on monitoring a limited range of outcome measures that allow the programme to combine monitoring the progress and impact of each workstream with an evaluation of progress towards establishing a sustainable MCP.

|  |
| --- |
| **Recommendations to the Connected Care Partnership Board on measurement of outcomes and effects**   1. Identify at least one process or enabler measure and at least one outcome measure related to each aim of individual workstream for patients, staff and use of health care resources **and** to track progress with forming the MCP. 2. Ensure that staff and/or resources are allocated from the launch of each workstream to design and set up monitoring and evaluation. 3. Select measures where changes in score will reflect anticipated changes in service delivery or outcome. 4. Keep the measures as simple as possible, and minimise the burden of data collection. 5. Measure things that are meaningful to people. 6. Ensure that ongoing review of data informs work to review and refine services. |

# **Conclusion**

The Connected Care Partnership Vanguard is a bold and innovative programme of transformational change, being implemented at a time when service redesign and securing long-term financial sustainability for the NHS are at the forefront of NHS policy. Like all vanguards in the NHS England programme, Connected Care is providing valuable learning about how to make change at scale and pace, and about the barriers and enablers to achieving this. As it moves into its final year it will add to this with evidence about the early outcomes of extending and integrating the provision of community-based services, and strengthening joint working across the interface between community-based and acute care. The findings from the initial phase of our evaluation offer important lessons, not just for Connected Care, but also for the other vanguards, and indeed integrated care and whole-system change programmes across the NHS.

Connected Care has embraced the NHS England vision of creating a new model of primary and community services built around general practice. It is one of only four provider-led MCP vanguards in the national New Care Models Programme and, of these four, is distinctive in that it builds on extensive prior work – by Modality – to develop at scale general practice in the local area. This prior work has provided a firm foundation for the programme to implement change, particularly in terms of further strengthening, enhancing and extending the services that can be offered in primary care settings.

These changes are ambitious and some are highly innovative; they include many features common to integration programmes, such as the establishment of multi-disciplinary teams, but also go well beyond these. Moreover, whereas many integration programmes target specific populations, Connected Care is a full population health model, with the goal to improve access, experiences and outcomes for all of the 160,000 people that it will serve. The approach is similar to the Primary Care Home (PCH) model currently being trialled in 15 sites across England, and comparisons with PCH sites (a member of our team is working across both evaluations) suggests that Connected Care is making solid progress with establishing this.

That said, the programme needs to consider how it will support the transition to a more collaborative and enabling model of care, which is critical to programme goals around population and patient empowerment. There is a tendency for change programmes in the NHS to focus on redesigning services and processes, with less attention given to changing the relationship between patients and care providers; this is also true of Connected Care.

A key finding from the evaluation is that there was a great deal of enthusiasm and support for the new care model, but also a lack of clarity about the programme’s longer term vision and how this linked to wider priorities and developments, for both the programme’s partner organisations and the wider system of care. This is a common finding in large-scale transformation and integrated care programmes in particular, and the evidence from our research is congruent with what is found in studies of comparable programmes, nationally and internationally.

One of the major challenges that Connected Care was facing was how to reconcile a tension between different the aspirations for redesign and views of success held by the partner organisations. Above all, partners are yet to reach agreement about the right balance within the programme between a focus on transforming general practice, and delivering wider system goals including integrating service delivery and generating cost savings for the local health economy. There was a widespread perception that the programme was Modality and primary care dominated, and this was an obstacle to effective partnership working and – at least in some parts of the programme – to progress.

As Connected Care moves into the third of its externally funded set up years, it is vital that partners reach agreement about how its delivery plans will balance work progressing the redesign of primary care services and work progressing wider system transformation. This is imperative so that Connected Care has a clear sense of what it is aiming to achieve: to underpin effective implementation and assessment of outcomes achieved.

As change programmes grow in scale and ambition, the size of the organisational partnerships needed to deliver them increases, and so too does the complexity of governance and decision-making. Connected Care was also grappling with this issue: it was making good progress in the primary care-focused elements of the programme, but finding it much harder to reach agreements about workstreams involving complex inter-organisational changes and move these from design to implementation. This raises a question, about whether there is a ‘tipping point’ beyond which change programmes increase in complexity but not in their potential to deliver major outcomes, at least not in the timescales and resources that they are likely to be working with. The learning from across the vanguards should be brought together to explore whether this is the case.

Many of the challenges of partnership working within Connected Care echo experiences reported across the NHS and social care. These included organisational disincentives to integrate services, and share risks and rewards; lack of coherence between local plans; difficulties operating across multiple and poorly aligned planning footprints; and problems of data sharing and governance. Two further issues were the lack of engagement from social care, and the involvement of Optum. While programmes of this kind may have to buy in specialist services to support programme design and delivery, the learning from Connected Care is that having a commercial partner (especially one based outside the UK) has implications for building relationships and trust that must be carefully considered and managed.

A critical factor affecting partnership working in the Connected Care context is the financial environment. In effect, there are two competing financial ‘logics’ within the programme. The first is about moving care closer to home and ensuring the sustainability of general practice – this is the major driver for Modality as lead of the programme. The second is about finding solutions to support the acute trust to manage increasing demand for services and address its financial deficit, upon which the acute trust’s engagement may ultimately depend. The question which Connected Care is grappling with, and indeed which many schemes to move care closer to home are encountering, is whether increasing and joining up delivery of community-based services can be done in a way that helps to address financial pressures in the acute sector, rather than increase them.

Our findings suggest that this issue needs to be tackled more openly and explicitly by the partnership board and in the programme’s ongoing design work. But partners should also be mindful of the evidence base for integrated and community-based care, which shows that few schemes deliver net savings, and some can even increase overall costs. Connected Care partners and NHS England must be realistic about what can be achieved, particularly within the timescale and the funding that is remaining for the New Care Models national programme.

While Connected Care has a strong narrative about how it will benefit frontline staff and patients, the design process had been largely driven by the programme team and both these groups lacked clear channels to influence the process. Large-scale programmes need strong programme management, but this shouldn’t stifle local innovation and opportunities for co-design. This lack of involvement risks the programme making changes that do not deliver real and meaningful improvements for patients. For workstreams where implementation is already underway, the opportunity for co-design has passed and the focus instead should be on gathering patient feedback about the service changes, and using this to make improvements where necessary.

A fundamental question for Connected Care, and indeed all of the vanguards in the national New Care Models Programme, is whether and how the new model of care will be sustained after the funding from NHS England has come to an end. The barriers to commissioning integrated care are well known, and Connected Care was confronting many of them. These barriers need national action, and our findings suggest that much more needs to be done to address them, and for this to be done quickly to avoid vanguards reaching the end of their funding without arrangements in place to sustain positive changes and impacts. In terms of Connected Care, there was still a great deal of uncertainty about the future of the service changes being implemented, and a need for this to be urgently addressed by the Partnership Board and CCG.

These findings present challenges and opportunities for the evaluation team. Evaluating integration and community-based care is fraught with difficulty, but nonetheless it is important that this evaluation supports Connected Care to learn, improve and – wherever possible – document its early impacts. This calls for a combination of outcome measures, data sources, perspectives and methods, through which we can assess whether the programme is moving in the right direction, addressing the challenges we have described above, and staring to deliver some of the desired outcomes. No evaluation can fully capture the breadth of initiatives within a large-scale programme of this kind. With this in mind, we propose that the evaluation retains a focus on partnership working and developments at the overall programme level, but also includes in-depth case studies of two programme workstreams: community outpatient services and multi-disciplinary teams. As we explain in Chapter 4, these will enable the evaluation to explore the whole system impacts of the programme and provide insights into the extent to which Connected Care is transforming the local system of care. Future reports from the evaluation team will share the learning from this work as it progresses.

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1. Accountable care organisations (ACOs) or accountable care providers “bring together together a number of providers to take responsibility for the cost and quality of care for a defined population within an agreed budget.” They can take different forms, from fully integrated systems through to looser alliances and networks of providers. For more information, see <https://www.kingsfund.org.uk/topics/integrated-care/accountable-care-organisations-explained>. [↑](#footnote-ref-1)
2. An ACO holding a contract to provide services for a GP registered population. [↑](#footnote-ref-2)
3. An alliance contract is a contracting arrangement between a commissioner and an alliance of providers who agree to share the risk and responsibility for meeting agreed outcomes. For more information, see <https://www.kingsfund.org.uk/publications/commissioning-contracting-integrated-care/summary#alliance>. [↑](#footnote-ref-3)
4. See <http://www.napc.co.uk/pch-story> for more information about the Primary Care Home model and its evaluation. [↑](#footnote-ref-4)