# Evaluation of Value Proposition Projects

# Dudley Clinical Commissioning Group

2 November 2017

Submitted by ICF Consulting Limited and The Strategy Unit

2nd November 2017

Dr Nahid Ahmad

ICF Consulting Limited
30 St Paul's Square
Birmingham
B3 1QZ

T +44 (0) 121 233 8900

Nahid.ahmad@icf.com

# Document Control

| | |
|---|---|
| **Document Title** | Evaluation of Value Proposition Projects |
| **Prepared by** | Dr Nahid Ahmad, Dr Aisha Ahmad, Patrick Hall, Jane Greenstock, and Kelly Singh |
| **Checked by** | Dr Nahid Ahmad and Fraser Battye |
| **Date** | 2nd November 2017 |

# Contents

# 1 Introduction

This document contains the evaluation of Dudley Clinical Commissioning Group's (CCG) 'Value Proposition'[1] (VP) projects. The work was undertaken by ICF and the Strategy Unit as part of a broader programme of evaluation[2].

VP funding was provided by NHS England (NHSE) to Dudley CCG to accelerate the formation of Dudley's new model of care - the Multi-speciality Community Provider (MCP). This funding was used for multiple purposes (including funding this evaluation), but its primary aim was to support service innovations to create a foundation for the MCP.

The total investment in MCP development for 2017/18 is £5.386m. Of this, £4.386m is VP funding and £1m is CCG investment. This evaluation focuses on a selection of service innovations funded using these resources. Projects funded were designed to test approaches, before being considered for longer term roll-out within the MCP.

The context to this evaluation is therefore that:

- VP funding was used to support schemes to help bring about the MCP;
- Some of these schemes were one-off / time limited, designed to provide a temporary input to support change;
- But others were established on the premise that they might continue as part of the MCP, becoming a 'permanent' feature of care in Dudley. Moreover, within this class of scheme, some were more experimental than others with higher levels of attendant uncertainty;
- A decision is therefore required as to whether or not these schemes become part of Dudley's care model on-going. Presently (while the MCP is still being brought about as a legal entity) this decision rests with the CCG;
- All schemes were established in the knowledge that this would be the case. They were also therefore established with a requirement for self-evaluation / to supply evidence to inform decision making; and,
- This evaluation is being undertaken as part of a larger programme of evaluative activity in Dudley, funded by NHSE as part of the New Care Models programme. This provides a framework of questions and associated requirements. This year, guidance from NHSE has specific emphasis on service economics, specifically on setting out the relative costs and benefits of specific schemes.

Informing such 'stop-go' decisions is not always comfortable territory for evaluation. Nonetheless, providing an evidence base for such decision making is an important evaluative function. That is the purpose of what follows.

The following schemes were included in the evaluation:

1. **Integrated Plus.** This scheme provides a link with community and voluntary services, addressing non-clinical needs through 'social prescribing'. It works

[1] The 'Value Proposition' was, in effect, a bid to NHS England to gain resources to support the development of a new model of care. For Dudley's full Value Proposition, see http://www.dudleyccg.nhs.uk/wp-content/uploads/2016/07/Value-Proposition-Dudley-CCG-FINAL.pdf

[2] For other outputs from the evaluation, see: https://midlandsandlancashirecsu.nhs.uk/products-services/services/the-strategy-unit/dudley-vanguard-evaluation

closely with Dudley's Multi-Disciplinary Teams (MDTs) in primary care to support better coordinated person-centred care for high risk patients.

2. **Care Coordinator Service.** This scheme operates to provide a link within, and between MDTs, and between primary care and hospital services. It focuses on those who are most at risk of unplanned care – both preventative and supporting discharge from hospital.
3. **Sense.ly Kiosk.** This self-service 'kiosk', piloted in two practices, enables patients to take their own weight and blood pressure measurements prior to a primary care appointment. Guidance is provided by a virtual nurse avatar to input information and take measurements. The data is entered into the EMIS record.
4. **Sense.ly Patient Services App.** This smartphone app, piloted in two practices, combines an electronic triage service (symptom checking, signposting and information provision), with an appointment booking service.
5. **Falls and Fracture Prevention Service.** This service (joint commissioned with the Local Authority) aims to address the high rate of falls in Dudley by coordinating falls and fracture services in the community, general practice, hospitals and voluntary sector. The service uses greater clinical input and single point of access.
6. **Care Home Telemedicine Service.** This service supports care (and nursing) home staff to help prevent admissions to hospital (particularly out of hours) by providing clinical support to through telephone or video triage.
7. **Care Home End of Life Education Programme**. The Mary Stevens Hospice has been commissioned to train and support care home staff in caring for older people with end-of-life and palliative care needs, including in the use of advanced care plans and competency assessments for care staff.
8. **Practice Based Pharmacists.** This scheme is an extension of an established service to address medicines-related waste and avoidable harm. Pharmacists placed in primary care take referrals from MDTs, provide leadership for repeat prescribing management, and drug monitoring and review.
9. **Prescription Ordering Direct Contact Centre.** This scheme, currently involving five practices, aims to reduce prescribing waste through a centralised telephony system that standardises, coordinates and creates a single point of access for repeat prescribing processes.

## Method

The following tasks were undertaken as part of the evaluation method:

- We produced a standard template to guide evidence gathering and – by using consistent criteria – help those making decisions on schemes' futures by providing comparable information. This template is provided in Annex 1.
- Nine schemes were selected for evaluation. We interviewed project leads for each of them. We then conducted additional interviews with five of the projects: Integrated Plus, the Care Coordinator Service, the Care Home Telemedicine service, and the Sense.ly kiosk and app schemes. In total we spoke to 24 interviewees; these included three link workers, four care coordinators, two practice managers, two nurses, and a care home manager.

- We reviewed documentation for each of the schemes. Sources reviewed included the following:
  - Project Initiation Documents (PIDs) and other background and implementation documents;
  - Progress reports, self-evaluation reports, and in one case an external evaluation report; and,
  - Data dashboards, cost data and Excel spreadsheets containing outputs/outcomes data, and evaluation frameworks.
- We synthesised findings from interviews and the document review in order to complete an evaluation template, (see Annex 1). This report contains each of the individual templates for the nine schemes, (see Sections 2-9). Templates show an assessment of each scheme against five criteria: the project rationale, aims, design, implementation, and results. We also provide an assessment against the fit of the project with the implementation matrix for MCP capabilities, produced by NHS England. A summary of our assessments, and an explanation of the scale used to make these is provided below.
- We have drawn out cross-cutting themes from across the nine schemes, in order to draw out learning for the commissioning of this type of service innovation. These themes are presented in the form of conclusions and recommendations at Section 11. Recommendations are made at both a 'programme' level, and by individual scheme.
- We provided a copy of this report in draft to the CCG to take feedback and comments; we also presented provisional findings to the CCG Members' Event, which provided a further check on our conclusions.

Important strengths and limitations follow:

- The evaluation methodology has been rapid and 'light touch'. We have gathered and synthesised multiple sources of evidence over a short (two month) period. These sources are of varying degrees of quality, and given resource constraints, we have not been able to triangulate or validate data submitted to us. This includes reported cost savings, we have not tested calculations for validity, nor reviewed in detail claims behind any of the impacts reported here. We have prioritised those sources which show evidence of greater rigour, but nonetheless uncertainty remains.
- Limitations of time and resource have also limited the number of healthcare professionals interviewed, and so some of our findings here have been reported 'second hand' by other interviewees. We have made clear where indirect perceptions are being reported in this way. Similarly, we have not spoken to any patients or service users in this evaluation, and so are unable to draw confident conclusions on their experience of the services they've received under these schemes – other than that reflected in schemes' own evidence.
- We have applied assessment criteria to the schemes. These assessments are based on the material available for review, but are ultimately evaluators' own judgements. We have explained throughout how we have arrived at each judgement by providing supporting text for each assessment we make.

Notwithstanding these limitations, the approach taken for this study is likely to have wider applicability. The method used has provided a rapid cycle, highly applied

means of getting evidence into the decision-making process when considering multiple service innovations. There is likely to be merit in replicating this.

The main body of the report provides a scheme-by-scheme evaluation, guided by the template. The report then concludes with a short set of conclusions that are both cross-cutting and specific to each scheme.

Before providing this detail, the table below presents an ‘at a glance’ summary of results. Taking each of the nine schemes in turn, it provides a summary assessment against each element of the template.

## Summary of assessments

The table below presents a summary assessment of the nine schemes against the five evaluation criteria. Each criterion received a rating on either a three-point or a five-point scale as follows:

| Scheme | Rationale<br>*1 = Clear need*<br>*2 = Partially clear need*<br>*3 = Unclear need* | Aims<br>*1 = Clear*<br>*2 = Partially clear*<br>*3 = Unclear* | Design<br>*1 = Clear*<br>*2 = Partially clear*<br>*3 = Unclear* | Implementation<br>*1 = Extremely well*<br>*2 = Very well*<br>*3 = Moderately well*<br>*4 = Slightly well*<br>*5 = Not at all well* | Results<br>*1 = Extremely effective*<br>*2 = Very effective*<br>*3 = Moderately effective*<br>*4 = Slightly effective*<br>*5 = Ineffective* |
|---|---|---|---|---|---|
| **Integrated Plus** | ***Clear need*** **1** | ***Clear*** **1** | ***Clear*** **1** | ***Very well*** **2** | ***Very effective*** **2** |
| **Care Coordinator (CC) Service** | ***Clear need*** **1** | ***Clear*** **1** | ***Partially clear*** **2** | ***Moderately well*** **3** | ***Moderately effective (too early for tangible outcomes)*** **3** |
| **Sense.ly kiosk** | ***Unclear*** **3** | ***Partially clear*** **2** | ***Partially clear*** **2** | ***Not at all well*** **5** | ***Ineffective*** **5** |
| **Sense.ly app** | ***Clear need*** **1** | ***Clear*** **1** | ***Partially clear*** **2** | ***Slightly well*** **4** | ***Difficult to assess – no bench-marking*** |
| **Falls & fractures prevention** | ***Clear need*** **1** | ***Clear*** **1** | ***Clear*** **1** | ***Very well*** **2** | ***Very effective*** **2** |
| **Care Home telemedicine** | ***Clear need*** **1** | ***Clear*** **1** | ***Clear*** **1** | ***Moderately well*** **3** | ***Slightly effective*** **4** |

| | | | | | |
|---|---|---|---|---|---|
| **Care Home End of Life Education** | ***Clear need*** **1** | ***Clear*** **1** | ***Clear*** **1** | ***Moderately well*** **3** | ***Moderately effective*** **3** |
| **Practice based pharmacists** | ***Clear need*** **1** | ***Clear*** **1** | ***Clear*** **1** | ***Very well*** **2** | ***Very effective*** **2** |
| **Prescription ordering direct contact centre** | ***Clear need*** **1** | ***Clear*** **1** | ***Clear*** **1** | ***Very well*** **2** | ***Very effective*** **2** |

# 2 Integrated Plus

**Rationale for the scheme**

This scheme was set up to offer social prescribing support to patients in the top 2% of those at high risk of hospital admissions and frequent visits to GPs. Non-clinical needs may often explain frequent GP visits and risk of hospitalisation. Meeting non-clinical needs requires more coordinated, holistic care.

This is being addressed by the new care model through the MDTs, which bring professionals across the system together to look at the holistic needs of patients. Integrated Plus (IP) is integral to the MDTs; it was created to provide a link between health and social care, and wider community and voluntary services.

By working closely with the MDTs, IP supports integrated working across all parts of the system. A key purpose of the scheme is therefore to bring about coordinated person-centred (preventative) care for high risk patients, within the context of reducing budgets and resources.

Within Dudley, there were also low levels of referrals into the voluntary sector coming from GPs, indicating low knowledge in primary care of wider services. Without preventative intervention with this high-risk group, the CCG would face rising costs, outcomes for patients would worsen over time through repeated intervention at crisis points, and the new care model would be implemented using a clinical approach, without addressing social and economic needs.

**Summary assessment:** The rationale highlights a **clear need** for the project – better accounting for social needs has the potential to reduce inappropriate use of services across the sector. The scheme strongly supports the coordination theme of the new care model. Furthermore, this scheme has the potential for providing added value in catalysing a culture change around holistic care provision.

**Aims of the scheme**

The specific aims of the scheme were to:

- **Primary and secondary care services –** support patients with non-medical needs in order to reduce the demand on medical services. A particular focus is on reducing isolation and loneliness. This included ensuring that the holistic needs of patients are discussed and considered at MDT meetings.
- **Improve quality of life –** by reducing isolation and helping to resolve other issues (e.g. housing, finances, and benefit entitlements) it was hoped that patients would have an improved quality of life.
- **Voluntary and Community Sector (VCS) –** ensure that the VCS is represented in the new care model and to increase awareness of the VCS with GPs and other Health Care Professionals (HCPs) at the MDT meetings.
- **Community engagement –** encourage people to be active and involved in their communities and in doing so increase patient awareness of community services.

**Summary assessment:** The aims of the scheme were **clear** – the service provided independent, impartial and flexible support that links to the themes of the new care model.

## Design of the scheme

The IP service has five locality link officers (supported by five support workers), who attend all 45 MDT meetings across Dudley. Link officers focus on the non-clinical needs of patients discussed at MDT meetings. Most referrals to IP come via this route, and some are also through NHS.net and by fax. The IP team also supports navigation of the health and social care system for professionals, clearing blockages for example through their direct link into the MDT meetings.[3]

Interviewees reported that on average IP support people for three months. The IP link workers carry out home visits for all patients that accept IP input. Non-clinical needs supported by the service commonly include loneliness/isolation, housing and finance needs. The service also offers a signposting service across the system; 70% of outward referrals are into the voluntary sector, adult social care, and public health.

**Summary assessment:** The design of the scheme was **clear** – it responded to the rationale and aims by focussing on providing holistic care and supporting coordination in the new care model.

## Costs

- The scheme was originally commissioned in 2014 as a two year pilot. It received further funding for 2017/18: the total amount funded was £587,291, £220,041 of which was from VP funding, with the remainder coming from other CCG sources.

- Additional funding of £25,000 came from The Health Foundation for peer network support specifically for patients with Chronic Obstructive Pulmonary Disease (COPD) – this has allowed the group to meet once a week.

- In-kind contributions came in the form of room hire for a weekly men's peer support group in Lye. The team is looking to replicate this type of support in Wychbury for a women's support group.

## Implementation

Interviewees reported several key strengths and challenges to the implementation of IP:

**Strengths –** recruitment for the Link Worker roles has been successful. IP have recruited skilled staff with diverse experiences, including staff with previous experience of working with: people affected by substance misuse, drug teams, young people, training and employment, housing and voluntary sector councils.

Another key strength was in relation to link workers being embedded in primary care. Interviewees reported that whilst initially staff at MDT meetings were sceptical of the role, the

[3] The social and economic impact of the Integrated Plus service, main evaluation report, 1st September 2014 – 18th July 2017.

team is now well respected. Relationships have evolved and IP workers have carried out joint patient visits with other professionals (GPs, mental health workers and social workers) enabling them to offer better holistic services to patients.

Finally, a key strength is in the independence to statutory sector services, which has proved to be extremely helpful in engaging patients. Patients value the link worker role because they are not perceived to have a vested interest and are described as willing to 'go the extra mile'.

**Challenges –** interviewees reported challenges related to data administration as a key challenge, namely in terms of the time consumed by data entry. Interviewees described how the emphasis on cost savings has led to assessing a vast array of outcomes – some of which may not be relevant to the IP service.

Another challenge has also been that MDTs do not have shared information systems, resulting in duplication of efforts. Further inconsistencies are in the way in which MDT meetings are held; MDT meetings vary considerably in terms of their structure, agenda and the types of patient lists they discuss.

A contextual challenge reported by interviewees was that some local authority and VCS services that they would recommend to patients 'have closed down' due to funding cuts. Thus IP does not always have the services available in order to signpost patients.

**Summary assessment**: Implementation **went very well** and the service has had a steady number of referrals.

## Results: outputs and outcomes

IP routinely collect data and their most recent evaluation report details the following outputs recorded from September 2014 - July 2017[4]:

- 2,619 referrals were received[5] (broken down by locality and GP practices), 2,021 of these patients accepted the service, and 328 declined IP support.
- Data on the route of referrals show that there were 1,731 GP referrals to IP, 656 referrals from other MDT staff, and 232 referrals from other routes (e.g. Age UK social prescribing service).
- 5,766[6] outward referral destinations were recorded to 363 organisations, for services supporting basic needs; care and support; disability; faith; housing support; health and wellbeing; and mental health services.

IP's evaluation report also shows a range of qualitative outcomes reported through 35 patient interviews carried out during 2015-2016, and a HCP survey carried out in 2015 (16 respondents). Patient interviews showed that as a result of receiving the IP service the following outcomes were reported:

- 94% of patients reported the service to be excellent/good, with the main reported benefits of the service being that: patients felt listened to; they valued someone spending time

[4] The social and economic impact of the Integrated Plus service, main evaluation report, 1st September 2014 – 18th July 2017.

[5] Patient demographic data is also collected.

[6] There were multiple referrals recorded for individual patients.

with them; appreciated the independent and flexible nature of the support; felt IP workers had no hidden agenda; and that IP helped them find solutions to their problems.

- 25% of patients were now accessing financial support and 22% were better able to manage their own finances.
- 28% felt safer in their community and comfortable in their peer groups.
- 47% felt more able to get out and about and 43% felt they had an improved healthy lifestyle.
- 69% reported reduced stress and anxiety, and 66% felt better able to cope with life.
- 38% reported having secure and safer accommodation and 28% felt that their accommodation now met their needs.
- 63% had increased friendships and 50% of patients reported a better quality of life.

The HCP survey showed that the IP Link Officers added value to the MDT meetings, with 69% reported that IP workers added 'a great deal' of added value and 31% reported that they added 'a lot' of added value. Interviewees spoken to as part of this ICF evaluation reported that IP have "plugged a gap" and GPs describe them as "the gold of the model". They also reported that IP workers have enabled MDT meetings to gain structure and grow.

Cost saving outcomes are also presented in IP's evaluation report. These are derived from data generated using the PSIAMS Social Triage Assessment (STA). The STA is a tool used by the IP team to record client feedback on a range of outcomes (e.g. housing, financial, employment and training), which is then linked to PSIAMS software. This software has a cost saving methodology embedded into it. Savings are derived from data for the period September 2016 to July 2017 for primary care savings, and for the period September 2014 – December 2016 for secondary care savings.

The following cost savings have been reported using this methodology:

- **Primary care**: A reduction in demand was reported based on 438 (22%) patient referrals to IP (as extracted from EMIS). Cost savings are calculated using a scenario of estimated costs to the state if no interventions are provided compared to 12 month projected estimated cost to the state after IP support. Savings of around £18,000 were reported as resulting from:
  - A 24% reduction in visits to the GP.
  - A 15% reduction in GP home visits.
  - A 15% increase in GP telephone consultations.
- **Secondary care:** A reduction in demand based on the number of A&E attendances (estimated at around £120 per patient) and emergency admissions (estimated at around £1,580 per patient) by patients 12 months before and after IP support, was reported as follows:
  - A 4% reduction in A&E attendances, saving around £5,000 (522 patient referrals).
  - A 7% reduction in emergency admissions, saving around £80,000 (441 patient referrals).

**Summary assessment:** The scheme has been **very effective.** It has addressed social needs by providing holistic support, and has impacted positively on patient experiences. It has also contributed to reducing the demand on primary and secondary care services. Some outcomes reported are based on small sample sizes however.

## Relevance to the MCP implementation matrix

The IP service relates very strongly to sub element 1.1 (component 1.1.i) and 1.2 (component 1.2.i) through its understanding of holistic health needs of the population (component 1.1ii). In doing so IP connects people to community activities/resources. IP also partly relates to sub element 1.3 (component 1.3.i) through addressing the social elements impacting on people's lives and encouraging people to take more responsibility for their own health care. The service also addresses the care element of 'on-going needs – enhanced primary and community care'. This specifically relates to sub element 3.2 where IP connects the voluntary sector to the clinical model through the MDT meetings.

| Care element | Sub element | Sub element description | Scheme addresses: In principle | Scheme addresses: In practice |
|---|---|---|---|---|
| Whole population - prevention and population health management | 1.1 | Planning and tailoring services based on population health needs | Very strongly | Very strongly |
| | 1.2 | Better population health through community engagement | Very strongly | Strongly |
| | 1.3 | Supporting self-care and patient activation | Partly | Partly |
| Ongoing needs – enhanced primary and community care | 3.2 | Multi-disciplinary teams for those with long term conditions | Very Strongly | Very Strongly |

## Key learning

- **An alternative workforce –** IP has provided an alternative – a more cost effective and 'available' workforce than clinical staff and one that supports patients.

- **Culture change –** IP has contributed to the culture change hoped for by the new care model in supporting patients holistically, though this has not yet been fully achieved.

- **Data collection –** Interviewees reported that data recording methods were overly burdensome. There were suggestions that the cost saving element of the data collection tool has changed the nature of the interaction with patients from a person centred approach to an assessment based approach. This led some interviewees to suggest that the tool could be streamlined to better fit the service: ultimately a robust and easy to use tool is needed, which adequately captures outcomes to show the benefits of the scheme.

# 3 Care Coordinator Service

**Please note: This project is still at an early stage in terms of implementation and so the degree to which measurable outcomes can currently be explored is limited.**

## Rationale for the scheme

During 2015/2016, there were 17,560 emergency admissions for people aged 65 and over in Dudley CCG.[7] This equated to an increase of over 1000 emergency admissions compared with the previous year, reflecting a rising trend of secondary care utilisation within the CCG.[8] Additionally, the rate of delayed discharges attributable to social care in Dudley is higher than the national rate and forecasts indicate an estimated increase of 25,100 people in the over 65 population over the next twenty years.[9] This implies a rise of those in the over 65 population requiring an additional layer of support - both prior to, and following, discharge from hospital as well as an absence in the availability of services to bridge the gap between hospital and community support.

There was also a need for greater consistency across the MDTs. MDTs are a feature of the new model of care in Dudley, founded upon enhanced primary care services in the MCP. The MDT have been rolled out across Dudley CCG's 45 GP practices with each adapted as a model to best fit within the operations of each practice. As a result, the format, make-up and content of each MDT varies across the CCG, as does the extent to which each links with community and social care services. A solution was thus required for providing a consistent element in each, maintaining momentum between meetings and facilitating links among stakeholders within each MDT.

**Summary assessment:** The rationale highlights a **clear need** for the scheme. The Care Coordinator role supports the coordination theme of the new care model.

## Aims of the scheme

In light of the issues summarised above, the Care Coordinator service sets out to:

- **Prevent and reduce readmissions to hospital.** This is a primary objective for healthcare services in Dudley, and this scheme aimed to address this through providing a link between primary and secondary care and community services, assisting with emergency attendances, and supporting post-discharge care coordination.

- **Improve patient experience** through developing a more seamless, joined up, coordinated pathway of care and support following discharge from hospital.

[7] Dudley Clinical Commissioning Group Service Scope for Multi-Specialty Community Provider, NHS Dudley CCG, 2016.

[8] Ibid.

[9] Developing and Commissioning a Sustainable Model of Care – Operational Plan 2016/2017, NHS Dudley CCG, 2016.

- **Continue to improve the effectiveness and consistency of the MDTs** across the 45 practices within Dudley through communication and regular attendance at meetings, as well as providing extra capacity to support the MDT workload.
- **Improve communication and coordination** between members of the MDT as well as between hospital and community services, facilitating both 'vertical and horizontal' integration.

**Summary assessment:** The aims of the scheme were **clear** and align with one of the three themes of the Dudley MCP - to improve coordination for patients.

## Design of the scheme

Ten Care Coordinators (CCs) were recruited with two assigned to each of Dudley's five localities, based around the 45 GP practices. The CCs are employed by Dudley Group NHS Foundation Trust, providing them with direct access to patient information from the hospital, such as discharge and admission data. There are two main elements to the CC role:

- **Providing connections at a practice level** - attending the MDT meetings at each GP practice in their assigned locality, facilitating communication between members of the MDT, the hospital and community services. The CCs share information on A&E attendances, unplanned admissions and patients at risk of admission. Each CC also has responsibility for collating updates from those unable to attend to ensure the timely sharing of patient updates.

- **Providing connections at a patient level** - a key part of the CC role is to make contact with patients over 65 and registered with a Dudley GP who have been discharged from Russell's Hall hospital to provide a non-clinical welfare check by phone. This helps to identify if a patient needs support or signposting to other services following discharge - e.g. social care, district nurses and home aids - which the CCs can then arrange or refer patients onto. The CCs work alongside the hospital, with the aim of enabling patients to remain at home.

**Summary assessment: Partially clear** design - interviewees suggested that the CC role could be better defined and thus designed in order to achieve its aims (summarised below).

## Costs

The total investment from the Value Proposition in the CC scheme for 2017/2018 is £249,000. This was supported by in-kind resources from Dudley CCG and Dudley Group NHS Foundation Trust in the form of senior staff time to develop and implement the scheme.

## Implementation

The CCs were first introduced at the end of 2016 but initially went through an induction period to enable the team to build relationships and gain the local knowledge needed to best undertake the role, e.g. local services available and demographics of each locality. During this period, they shadowed different teams - including the IP team - and sat in on MDT meetings to understand their format. In early 2017, the CCs began to make contact with patients and joined the MDTs as official members.

**Worked well** – providing the CCs with a considerable induction period helped them to become familiar with local services and teams. Over time the role has been embedded e.g. with CCs attending discharge meetings in the community where if they feel the patients were not fit for discharge, they can raise a concern and get a response in 48 hours. There is an aim to further extend the patient contact calls made by CCs to include those under 65 years identified on the top 2% hospital avoidance list.

**Challenges** – there is an ongoing lack of clarity of the role of the CCs and their relationship with GP practices. This has led to some staff turnover. Each of the 45 MDTs in Dudley are considerably different and as a result the ways in which the CCs are used by each has varied, promoting some inconsistency across the team. The CCs have received a mixed welcome from practices as a result and so their added value in each MDT has yet to be effectively determined in some.

**Summary assessment:** The service is largely delivering as intended in relation to patient contact following discharge. It is more difficult to determine the maturity of the service in relation to working with MDTs as the service is still at an early stage - it is not wholly clear what the defined responsibilities for each CC are within an MDT and this is still being determined in some. As such, the service is being implemented **moderately well**.

## Results: outputs and outcomes

Contact data submitted by the scheme showed that:

- Between April and mid-August 2017, 4,492 patient contacts have been made by CCs with an average of 898 per month.

- Of the 4,492 patient contacts made:
  - 439 patients were given advice, including discussing carer's allowances, providing a number for patient transport services and giving information about local food deliveries.
  - 264 referrals were completed. This included 63 to services to provide equipment to support patients such as stair rails and wheelchairs, 44 to the local falls service and 27 to GPs.

- Every MDT meeting that has taken place within the CCG area has been attended by a CC.

At present, it is difficult to report on more measurable outcomes from the project due to the limited time it has been in place. However, interviewees described the following:

- **Better communication between staff** on MDTs as the CCs provide a consistent point of contact as well as facilitating the sharing of information on patients at risk of (re) admission and A&E attendance. This has supported better identification of patients to be discussed during MDT meetings allowing resources to be more effectively focussed.
- **Decreased use of primary care services** – some feedback from interviewees suggested that the service has had an impact on the pressure on primary care. Anecdotal feedback from CCs suggested that the number of telephone calls practices receive from patients following discharge from hospital has reduced as CCs now pick these up.
- **Increased patient awareness of services** – interviewees described that patients are often not aware of the services that are available to them locally following discharge from the hospital. As a result, interviewees noted that patients often think that the first point of

contact is A&E or an ambulance rather than other services and sources of support, which CCs can now signpost patients to or put into place.

- **Improved patient experience** – a number of interviewees described that the service provides a port of call for the patient should it be needed as patients often would not have contacted services again unless readmitted to hospital. Feedback collected by the team provides examples of how the service has enhanced patient experience. For example, one referral to a GP resulted in the patient being referred on to a respiratory specialist for COPD. The patient was reported to be "very happy" with the outcome. Another contact uncovered that a patient was not coping well at home and the CC contacted the person's GP and the patient was eventually placed in a care home. In addition, sometimes CCs have found that patients can be discharged without adequate assessment or appropriate packages of care in place. CCs are able to make an urgent referral for a package of care, which provides access to this support sooner for patients – potentially decreasing the risk of readmission.

**Summary assessment:** To date, based on output and qualitative data the project has been **moderately effective** and shows signs of promising potential, although it is too early to measure more tangible outcomes.

## Relevance to the MCP implementation matrix

The table below shows the care elements of the MCP implementation matrix that the service relates most closely to and the strength of these relationships. The scheme provides a point of access to wider services assisting patients to remain in the community and support themselves. The CC role strongly relates to the embedding of MDTs and in particular, proactively identifying patients at risk of (re)admission, better case management of patients in appropriate settings and supporting timely discharge. Linked to this, they help link patients in with appropriate support services in the community. The CCs also work with hospital discharge teams and provide a layer of support to patients upon discharge to understand their needs and ensure they are met, enabling patients to remain at home with appropriate services are in place.

| Care element | Sub element | Sub element description | Scheme addresses: In principle | Scheme addresses: In practice |
|---|---|---|---|---|
| Whole population - prevention and population health management | 1.2 | Better population health through community engagement | Partly | Partly |
| | 1.3 | Supporting self-care and activation | Partly | Moderately |
| Ongoing needs – enhanced primary and community care | 3.2 | Multi-disciplinary teams for those with long term conditions | Very strongly | Very strongly |
| | 3.4 | Services traditionally delivered in hospital are shifted to community settings | Partly | Partly |
| Highest needs – coordinated community based and inpatient care | 4.3 | Coordinated discharge planning and integration into community care | Very strongly | Strongly |

**Key learning**

- This scheme is at an early stage in terms of implementation but has shown signs of potential to date. Interviewees expected that the service would show greater impact and more tangible outcomes once it had longer to embed and mature. It was commonly compared to IP, which also took time to embed.

- Ensuring that a clear narrative about the CC role (and its support from senior stakeholders) is effectively communicated across the locality is vital to securing buy in and longer term sustainability, making sure that the roles are used as intended and to greatest effect.

- Embedding a process for capturing tangible outcomes is key to demonstrating the value of the role. The team should continue to develop the ideas they have and embed a system to capture information on admissions and outcomes from patient contacts. Linking current systems up with live hospital admission data to monitor whether a person has been readmitted is one idea being developed. Conversely providing hospital discharge teams with access to the system CCs use may also support more seamless transitions of care.

# 4 Sense.ly Kiosk

**Rationale for the scheme**

Using IT solutions to improve efficiency and reduce workloads across primary care practices, is highlighted as a priority in NHS Dudley CCG's plans for implementing the General Practice Forward View.[10] One possibly useful solution identified by NHS Dudley CCG was a self-service 'kiosk', designed by Sense.ly (a leading provider of digital healthcare solutions in the US) to enable patients to take their own weight and blood pressure measurements prior to their appointment.

This solution was thought to have the potential to save time and improve information available to GPs during consultations. Interviewees also agreed that there was a need to improve the consistency of the routine collection of patient weight and blood pressure measurements across Dudley GP practices, although did not indicate the scale of this problem. The project was designed as a pilot to explore the usefulness of this technology before potentially rolling it out more widely.

**Summary assessment**: While improving efficiency is a clear priority for primary care, it is **unclear** why self-service weight and blood pressure measurement technology was selected as an important solution to test. The scheme would have benefitted from a clearer articulation of the problem this solution was being used to address.

**Aims of the scheme**

The main aim of the pilot was to test user acceptance and utilisation of the kiosk in order to inform a decision on wider rollout.

As per the Operational Requirements[11] document, the agreed overall success criteria for the pilot and their measures included:

- 10% increase in the rate of blood pressure readings recorded in EMIS for the practice (data comparison to previous quarter average).
- 10% increase in the rate of weight readings recorded in EMIS for the practice (data comparison to previous quarter average).
- Patient satisfaction with the application (in-app patient feedback survey).
- Clinician satisfaction with the data received into EMIS (clinician interviews).
- Time spent by the clinician in verifying the readings must not reduce the time available for the patient's consultation (as above).

[10] NHS Dudley CCG (2017) *Implementing the General Practice Forward View in Dudley: Primary Care at the Heart of Healthcare in Dudley* Available online at: http://www.dudleyccg.nhs.uk/wp-content/uploads/2017/04/GPFV-Dudley-CCG.pdf pp3,6.

[11] Bedford, A. (2016) Dudley CCG Sensely Kiosk Pilot Operational Requirements. Internal document prepared for Dudley CCG by Alscient.

**Summary assessment:** This project had **partially clear** aims – the patient and clinician satisfaction criteria align with a user testing project, but the reason for selecting a 10% increase in blood pressure and weight measurement as an aim is less clear.

## Design of the scheme

The technology provided to practices as part of the Sense.ly kiosk 'kit' consisted of a blood pressure cuff, weighing scales and a tablet with a 'virtual nurse' app installed. The cuff and the scales connected to the app via Bluetooth, and apart from Wi-Fi, no other physical infrastructure (e.g. a self-contained booth) was provided. The kiosk technology was intended to be used in the following way:

- Patient checks in for their appointment in person or via automatic check in screens and is invited to use the kiosk technology, either by receptionists or via display screens in the waiting area, prior to their appointment.
- The patient follows guidance provided by a virtual nurse avatar ("Olivia", designed to look and sound like a British health professional) to input their information and take blood pressure and weight measurements, who reads them aloud.
- The patient is asked to take part in an optional short in-app survey to provide feedback on their experience of using the app.
- The app saves measurements into EMIS records,[12] which GPs review during the consultation and either saves them or deletes them if they suspect there is an error in the measurement.

The design (the app and the EMIS integration) of the scheme was developed by Sense.ly. Alscient, a technology company that supports Dudley CCG with IT infrastructure improvement, lead the production of a formal Operations Requirement document for the project. They also oversaw and supported the implementation of the pilots.

The kiosk was introduced into one surgery (St Margaret's Wells) before being extended to another (Lion Health). The two surgeries provided a contrast in practice size (small versus large) and patient demographics (Lion Health is based in a more affluent area).

**Summary assessment:** The design was **partially clear**. There was a clearly intended user journey for the kiosk technology, a built-in monitoring mechanism for measuring patient satisfaction, and there was a clear reasoning for EMIS integration in terms of saving clinician time. Given it was envisioned as a 'kiosk' however, a self-contained space for using the technology could have been provided; this had implications for implementation.

## Costs

Investment in both Sense.ly schemes (the kiosk and app) was made from the VP budget in 2016/2017, with a total figure of £80,000 for both schemes. A breakdown of the investment between the two projects was not available. As described below, Sense.ly and Alscient staff attended the surgeries to support patients; this support was provided weekly for a three month period from March 2017.

[12] The electronic patient record system used in Dudley surgeries.

## Implementation

Positive reflections from interviews included that during the design process there was good patient and public engagement - including consultation with individual practice patients and public groups and a communication strategy for promoting the kiosk. Some patients were able to use the kiosk app and appear to have found it straightforward to use – from the patient feedback that was available, this was very positive (more specific details are provided in the next section).

However, there was slow initial uptake and two interviewees reported that some patients (mostly older) were unwilling to use the kiosk technology without some guidance. Following feedback from practices Sense.ly and Alscient staff attended the surgeries (in alternate weeks) to provide assistance and talk patients through the process, but they still relied on practice staff to approach patients and encourage use on their behalf. One surgery, after initially promoting the facility to general list patients also altered this to target long term conditions (LTC) clinic patients instead, for whom they felt these measurements were more important and interesting. These steps lead to an increase in use.

As the kiosk app initially spoke aloud measurements, practices were not prepared to display the kiosk equipment in public spaces (e.g. the waiting area). Kiosk technology was instead stored in empty rooms (in one practice this was behind the reception area). Patients therefore needed directions from administrative staff to find the equipment and (some) older patients also asked these practice staff to demonstrate and support them to use the app. The app was later altered to show the measurements on screen rather than read them aloud but remained out of the public areas due to space pressures within the surgeries.

One interviewee indicated that clinicians found some erroneous or confusing blood pressure measurements (in particular) being recorded on EMIS that therefore required repeating during a consultation. Interviewees also reported that there was little buy-in or support from clinicians or practice management beyond those filling project governance roles in both surgeries.

**Summary assessment:** Implementation **did not go at all well** as the kiosk was not 'fit for purpose' as it was not in a visible location such as the waiting area. Some patients also required assistance to use technology that was intended to be self-service.

## Results: outputs and outcomes

Due to the implementation issues the success criteria of increases in blood pressure and weight measurements recorded in each practice were not measured. Instead the focus was on numbers of patients using the kiosk equipment, patient satisfaction received via the feedback survey and qualitative feedback from the practices.

In total up to June 2017 there were (estimated) 250 patients who used the kiosk equipment, the majority of whom did so between March and June 2017, and were patients of Lion Health. The numbers are not exact because they include ad hoc tests that Sense.ly were unable to differentiate from real patients.

From evaluation dashboard data[13] at St Margaret Wells, by May 2017 only 25 patients had used the kiosk equipment successfully. Of the patients who provided feedback (eight) there was a 100% satisfaction rate. They all 'agreed' that they found it easy to measure their blood

[13] Provided by Sense.ly to Alscient and Dudley up to May 2017

pressure and/or weight and would use the kiosk again. They also all agreed, some strongly (50%) that they enjoyed speaking with the virtual nurse, Olivia. Equivalent figures were not available for Lion Health patients, but there was feedback from the practice that a patient panel which discussed the kiosk early in implementation gave mixed reviews. While some felt it was a good idea, particularly for patients with LTCs, others take readings at home using their own equipment and therefore did not see an obvious/distinctive purpose.

Due to the slow uptake and difficulties that patients had with using the kiosk app, practices did not report that the kiosk scheme saved them time – the need to provide additional support staff and to repeat some queried measurements meant that the kiosk was not able to meet this aim.

**Summary assessment:** relative to expectations and the agreed success criteria the scheme was **ineffective** – it was not able to meet a number of its agreed aims, despite there being some patient uptake and positive patient feedback (based on a very small sample size).

**Relevance to the MCP implementation matrix**

The table below shows the elements of the MCP implementation matrix where the kiosk potentially related to at least one sub element. These sub-elements relate to prevention at the level of the whole population, as well as at the level of people with LTCs.

In terms of prevention at the whole population level, the scheme is relevant to sub-element 1.1 (component 1.1.iii): it contributes to an overall focus on population level preventative services, at least in principle. The limited impact of the scheme shows however that in practice, the scheme has not made any in-roads into this effort. The scheme also addresses sub element 1.3 (component 1.3.i), as this project was designed to test whether the technology enabled patients (including those with a LTC) to take their own health measurements in real-time. The results of the pilot indicate that it may address this issue more in principle than in practice. Similarly, the scheme responds to sub-element 3.3 (component 3.3.iii): the potential for the kiosk to have impacted on self-care shows that in principle patients could have been empowered to manage their own LTCs, however in practice this outcome was not observed.

The scheme also potentially relates to two components of sub element 7.3 (components 7.3.iii and 7.3.vi). The integration into EMIS was a positive element of the scheme which did improve information sharing and the app was designed to improve patients' knowledge of their health and increase their independence in a particular aspect of their care. However, implementation issues again affected efficacy here.

| Care element | Sub element | Sub element description | Scheme addresses: In principle | Scheme addresses: In practice |
|---|---|---|---|---|
| Whole population - prevention and population health management | 1.1 | Planning and tailoring services based on population health needs | Strong | Partly |
| Whole population - prevention and population health management | 1.3 | Supporting self-care and patient activation | Strongly | Partly |
| Ongoing needs – enhanced primary and community care | 3.3 | Rapid clinical advice and guidance is available | Strongly | Partly |

| | | | | |
|---|---|---|---|---|
| Information, analysis and technology | 7.3 | Technology facilitates flexible working, improved communication and channel shift | Strongly | Strongly |

**Key learning**

From interviews key learnings emerged around implementation:

- A clear need for the scheme has not been demonstrated. However, should this or similar schemes be considered in the future, the technological literacy of some segments of the population will require attention. Those who do not have the skills to use the app, will require initial support, and this should be factored into the investment needed for the scheme(s).

- All interviewees suggested that if the technology was provided in a kiosk format and/or structure (similar to photo booths) this might have been familiar to more patients, more private, less intimidating and therefore have encouraged usage. One practice manager felt that instead of the avatar reading out the measurements this should have been printed on a ticket enabling the envisioned booths to be placed in more public and accessible areas of surgeries. However, space considerations would affect whether this different kind of scheme would be suitable for all GP practices. The limits of this evaluation have meant that we were unable to test these suggestions with patients themselves. The scheme would have been more effective had it been embedded within a wider approach aiming to change the culture of what patients should or can expect from health professionals and to encourage self-care. One suggestion was that a kiosk could collect wider health and lifestyle information (e.g. smoking and alcohol units) that patients are more uncomfortable discussing. The kiosk should not be the only self-care project implemented by a GP practice.

# 5 Sense.ly Patient Services App.

**Rationale for the scheme**

In Dudley (in common with national experience), primary care is facing a number of pressures, including an increase in public demand for appointments. Strategic NHS Dudley CCG documents indicate that pressure on primary care appointments increases by 4% each year (equivalent to around 6% cost pressure including inflation).[14] Patients can face difficulties booking appointments using telephone booking due to this increased demand and limited reception staff resources. There is therefore a need to find ways to reduce this pressure. This could be done by directing patients to health professionals or services that are more appropriate to respond to their symptoms than a GP e.g. pharmacies or Urgent Care Centres.

While the national urgent care telephone information service, NHS 111, aims to provide this kind of advice, according to latest figures it is also under increasing pressure – nationally, it has not met its target for answering 95% calls within 60 seconds for two and a half years.[15] The Sense.ly smartphone app aims to meet these multiple needs by combining an electronic triage service (symptom checking, signposting and information provision), with an electronic appointment booking service for two pilot GP practices in Dudley.

**Summary assessment**: There was a **clear need** for this scheme and it particularly supports the access theme of the new care model.

**Aims of the scheme**

The development of the app aimed to relieve pressure from both GP surgeries and potentially also from 111 while providing accessible, accurate and efficient self-care options to patients. The pilot also aimed to gather learnings on patient appetite for and utilisation of 'healthcare by app'.

Evaluation metrics were developed by Sense.ly, and include a comprehensive list of output metrics related to operations (e.g. assessment start date/end-date; number of patients alerted to the service by GPs etc.) that were intended to measure the correct implementation of the app. The patient-related metrics, which formed part of a regular weekly dashboard report created by Sense.ly, included usage figures for individual app features, and options within these features, including symptom checker outcomes and demographics of users (gender and age group) broken down by weekly and cumulative totals. However the framework did not stipulate explicit aims and objectives or specific success criteria.

**Summary assessment:** the scheme had **clear** aims but would have benefitted from specific success criteria by which to judge performance.

**Design of the scheme**

The Sense.ly Mobile Triage App, now called 'Ask NHS', was designed for both iPhone and Android operating systems. Using a virtual nurse avatar, named 'Olivia', the user is asked a series of questions, modelling a clinician-patient interaction. Following the input of this

[14] NHS Dudley CCG (2017) *Implementing the General Practice Forward View in Dudley : Primary Care at the Heart of Healthcare in Dudley* Available online at: http://www.dudleyccg.nhs.uk/wp-content/uploads/2017/04/GPFV-Dudley-CCG.pdf

[15] Nuffield Trust (2017) *Winter Insights: NHS 111 Briefing* Available online at: https://www.nuffieldtrust.org.uk/resource/winter-insight-nhs-111#a-brief-history-of-nhs-111

information the user is directed to the most appropriate service for their needs. At the time of development this included the following options: clinician advice (including advice to call 999 or 111 with varying levels of urgency); booking GP appointments at their registered surgery; provision of healthcare information (from NHS Choices, including a self-care A-Z) and localised patient services information.[16]

In order to provide correctly tailored information, patients from the two Dudley surgeries piloting the app - Lion Health and St Margaret's Well - were invited to download the app from either iTunes or Google Play using a code unique to their surgery. This code corresponded with a version of the app that had the correct information response pathways. A demo version was also produced to be shared with people interested in the app who were not registered with either of the participating two surgeries. Initially these invites were sent out by SMS to patients with registered mobile phone numbers.

**Summary assessment:** the design of the app was **partially clear.** The electronic booking feature clearly addressed the pressure surgeries face in patient demand for access. Tailoring the app to people from different surgeries was a positive personalisation element of the design. It was less clear why patients might use an app for other self-care options such as symptom checking, as this information was available in multiple other places (e.g. NHS Direct), not just 111.

## Costs

Investment in both Sense.ly projects (the app and a virtual nurse kiosk service described in a separate case study) came from sources other than the main VP budget. The total figure for 2017/2018 for both schemes was £80,000. A breakdown of the investment between the two projects was not available.

## Implementation

The electronic booking feature was considered by one practice to be the app's best feature. While some practices have their own in-house online booking systems, the app provides an additional means of accessing this kind of service. For one pilot practice their in-house service is only promoted to their new patients; this app feature was therefore considered particularly useful for expanding this service to existing patients. However, a lack of EMIS integration was considered an oversight by several interviewees – appointments had to be blocked out on EMIS by practices before being shared with the app data management team.

As the scheme is a pilot, take-up was initially controlled, in this case by promotion via text to only those registered patients with a mobile phone number in their records. For one practice this limited potential take-up to 5,000 from a surgery with a patient list of 26,000, so promotion was subsequently expanded to include other channels, such as patient newsletters.

There was general feedback from interviewees that beyond the weekly dashboards there was little detail circulated by Sense.ly about achievements or challenges, particularly to practices, and that it should have been more closely monitored with better feedback.

[16] A further iteration of the app, now more widely available as Ask NHS has recently been produced by Sense.ly collaboration with NHS Sandwell and West Birmingham CCG (the lead commissioner for the 111 service in the West Midlands) which involves more integration with 111 including automatic connection to a live advisor after certain information input or symptom checker outcomes. This version did not have this feature.

**Summary assessment:** Relative to expectations, implementation only went **slightly well**. The dashboard data (described further below) circulated by Sense.ly did not record all the output metrics stated in the evaluation framework; had this been the case a more comprehensive assessment of implementation could have been made.

## Results: outputs and outcomes

The most recent dashboard report for both practices was provided to Alscient,[17] in May 2017. This recorded that to date, 1,385 patients in total had registered for the app. Some key highlights are provided below but as stated, without targets it is hard to judge whether or not these numbers constitute success.

The electronic booking service was the most popular among patients – it had been accessed 1,943 times in total across the two practices. However only 53 patients were able to book appointments – 443 received the message 'No Appointments available'. Other users accessed the feature to query appointment times or cancel appointments. The popularity of the other features was in order: symptom checker (accessed 905 times in total) self-care A-Z (421 times) and Find Your Service (203 times).

Among those who downloaded the app, more patients were in the 36-46 age range than other ranges (383 in total across the two practices). Only 113 patients who registered for the app were over 66. This data would need to be cross-referenced against the ages of patients invited to download it, to understand its relative popularity with different ages.

Information from a full evaluation framework (involving quantitative, qualitative and comparative analyses with the 111 service) that was initially designed by Sense.ly was not available at the time of the evaluation. The reason for this was not clear but one suggestion from interviewee feedback was that Sense.ly attentions may have been redirected to the launch of the newer 'Ask NHS' app, that is being developed with NHS Sandwell CCG.

**Summary assessment:** It is **difficult to assess** the results of the app's performance without benchmark guidance or specific numerated success criteria, something that was missing from the evaluation framework. The rate of people able to book appointments using the electronic booking feature (53/496) appears low.

## Relevance to the MCP implementation matrix

The table below shows only the sub elements of the MCP implementation matrix which the app potentially relates to. While it can be understood to also support the self-care and patient activation sub element (1.3) of the Whole Population care element, the current component descriptions do not match well with the aims of the app.

The sub elements it does address include components of sub element 2.1 'Proactive community based approach to urgent care' – a loose relation to 'appropriate risk stratification of patients' (as per different symptom checker outcomes) (component 2.1.i) and educating the community about appropriate use of urgent care services (through its individualised signposting). The app does not meet the component descriptions exactly but does moderately support these elements.

It strongly relates to a component of sub element 7.3 'technology facilitates flexible working, improved communication and channel shift,' that describes that 'patients are offered a choice of electronic appointments and prescriptions' (7.3.iv). The related descriptions of what good

[17] The technology company overseeing IT infrastructure improvement for Dudley CCG, and the other Sense.ly kiosk project in particular.

looks like, that ‘patients and citizens have digital access to up to date information about all the services on offer within their area’ and ‘patients are able to book appointments, order repeat prescriptions and view their care record’ match very closely to the purpose of the app. However in practice, the number of people who were able to use the app to successfully book an appointment appeared low.

| Care element | Sub element | Sub element description | Scheme addresses: In principle | Scheme addresses: In practice |
|---|---|---|---|---|
| Urgent care needs-integrated access and rapid response | 2.1 | Proactive community based approach to urgent care | Moderately | Moderately |
| Information, analysis and technology | 7.3 | Technology facilitates flexible working, improved communication and channel shift | Strongly | Partly |

**Key learning**

- The app should be integrated with EMIS or patient records to gain most benefit from electronic booking features – it is more labour intensive for practice staff if it is not integrated.

- Benchmark metrics are needed to enable an assessment of efficacy of any similar projects - the evaluation framework for this project would have benefitted from including these and target success criteria. It is important to address these issues in the design phase of innovation projects; this then enables later decisions to be made on whether the project has worked and is suitable for further roll-out.

- More tailored and consistent promotion is needed to encourage uptake, and more consideration is required around what support different types of patients (e.g. older people) may need in making use of an app.

# 6 Falls and Fracture Prevention Service

**Please note: This project is still at an early stage in terms of implementation and so the degree to which measurable outcomes can currently be explored is limited.**

## Rationale for the scheme

In Dudley, between 2001 and 2014 there was a 23% increase in the number of people aged 65 and over[18]. One of the main areas of concern in the care of this growing older population is managing the risk of falls and associated admissions to hospital.

There are a number of indicators within the Health Improvement section of the Public Health Outcomes Framework (PHOF) relating to hospital admission due to falls. For each of these indicators, Dudley has a statistically significant higher falls rate compared to the England average. Dudley CCG also spends significantly more on falls related admissions than 10 comparative CCGs according to Commissioning for Value Packs produced by NHS England in December 2014[19].

The commissioning and delivery of falls and fracture services across the health and social care economy in Dudley was assessed in 2015 by Dudley's Office of Public Health in collaboration with Dudley CCG and the Dudley Group NHS Foundation Trust. This assessment concluded that falls and fracture services in Dudley in the community, in general practice, in hospitals and in the voluntary sector, lacked cohesion, a single point of access and sufficient clinical input. The report recommended a number of changes, including the development of the community falls service and an acute falls liaison and a falls register.

The consequence of not redesigning the falls pathway and providing additional clinical input across Dudley could be continued escalation of costs to the CCG and continued and worsening access and coordination of falls services, leading to poor outcomes for patients.

**Summary assessment:** The rationale highlights a **clear need** for the project. The falls and fracture liaison service supports the coordination theme of the new care model.

## Aims of the scheme

The CCG investment, and the falls service redesign more broadly sought to:

- Reduce falls-related costs to the CCG; and
- Improve access to improve coordination of falls and fracture services across Dudley.

The expanded and redesigned service also aimed at reducing residential and nursing home admissions and reduce referrals to social care services.

[18] Health Care Needs Assessment: Falls in the 65 years and older population of Dudley (2015), Dudley Council Office of Public Health.

[19] Ibid.

**Summary assessment:** There were **clear** aims for the redesigned service, developed through a clear understanding of the issues being addressed.

## Design of the scheme

The Falls & Fracture Prevention Service is a jointly funded, integrated service commissioned through the Better Care Fund (BCF). There is an ongoing commitment to the service from the council through its BCF funding for 2017-19.

The redesign expanded the existing Public Health commissioned service to include clinical input: two additional nurses, a physiotherapist and a part-time falls specialist pharmacist. The investment also funded additional administrative support. This additional capacity has implemented clinical triage for the overall pathway, working closely with the existing council-funded community team. The additional specialist nurses have established a falls risk register, working closely with the secondary care based fracture service to identify people who have fallen and are working across health and social care community services to track and record these patients and ensure appropriate referral and treatment.

**Summary assessment:** There was a **clear** design which met the aims of the service, drawing on the expertise of clinical staff to coordinate services and reduce falls.

## Costs

The CCG's investment (funded via the VP) in the newly designed pathway for 2017/2018 was £209,115. The redesigned pathway will likely attract in-kind costs (given the necessary input from partner organisations across the health and care economy).

## Implementation

The commissioning of falls prevention became a local government responsibility as part of the Health and Social Care Act 2012. Since then Dudley CCG has sought to ensure clinical input into falls prevention, which had become a largely social intervention.

The CCG's investment in the clinical expansion and the redesign of the service consisted of three phases: recruitment, the implementation of process changes, and full staffing accompanied by increasing referrals. The newly expanded and redesigned falls liaison service has been operational since April 2017, which represents a delay in the scheme, which was intended to be fully staffed in September-October 2016.

Interviewees and additional information provided by the project team suggests that the establishment of the single point of access has been successful. The establishment of the falls risk register is also seen by interviewees as having been implemented well by the new nursing staff, particularly in relation to cross-organisational collaboration and intelligence sharing with social care and NHS community services.

A big challenge for implementation has been the delay caused by the difficulty in recruiting the additional nursing staff. This delay in recruitment will affect expected savings. Difficulty in recruiting community nurses is an ongoing national issue.

**Summary assessment:** Although the scheme has yet to reach full maturity since beginning in April 2017, according to interviewees it has been implemented **very well** so far. However, the challenges associated with recruiting community nurses could have been anticipated in the planning process.

## Results: outputs and outcomes

The quarter one Single Point of Access performance reports from the project team (Dudley Falls Prevention) shows the following outputs achieved in quarter one (April-June 2017):

- 459 referrals in total;
- A broad spread of referral methods: phone, post, fax, email etc.;
- The majority of referrals coming from GPs (an average of 34%);
- A steadily increasing number of referrals as the scheme has begun embedding (140 in April, 151 in May and 168 in June);
- 181 patients were signposted or provided with information and advice;
- 129 patients were referred onward; and
- 122 patients had equipment supplied.

Early outcome data shows the reduction in waiting times for acute, consultant led falls services falling from 18 weeks to 12 since April. Anecdotally this reduction was supported by interviewees who talked about consultant ability to see urgent cases.

**Summary assessment:** Although the scheme has only been operational since April 2017, output data, as well as impact on acute waiting times, supported by interviews suggests that the scheme has been **very effective** so far.

## Relevance to the MCP implementation matrix

The Falls and Fracture Liaison service is relevant across many of the Care Elements in the implementation matrix. It strongly supports the preventative/whole population approach in component 1.3i as it identifies and supports people at risk of falling and triages to ensure they receive a package of support right for them. It also supports patients who have urgent needs by proactively identifying patients in order to prevent further deterioration and falls. It supports ongoing patient need by delivering services in the community through integrated teams (components 3.1ii and iii), extending clinical input (component 3.3ii) and focusing on reducing demand into hospital (component 3.4i). Finally, it supports those with the highest level of need by coordinating care across the whole pathway, particularly in connecting with acute care (component 4.2i and ii).

| Care element | Sub element | Sub element description | Scheme addresses: In principle | Scheme addresses: In practice |
|---|---|---|---|---|
| Urgent needs | 2.1 | Proactive community based approach to urgent care | Strongly | Strongly |
| Ongoing Needs | 3.1 | Scaled up and enhanced primary and community care | Very Strongly | Very Strongly |
| Ongoing Needs | 3.3 | Rapid clinical advice and guidance | Strongly | Strongly |
| Ongoing Needs | 3.4 | Services traditionally delivered in hospital are shifted to community settings | Very Strongly | Very Strongly |
| Highest Needs | 4.2 | Coordinated inpatient care across the system | Very Strongly | Very Strongly |

**Key learning**

- Dudley has a history of poor performance on falls. With a growing older population, this will be a key area for system-wide intervention. There is a clear rationale for action.
- The VP investment in a Falls and Fracture service is part of a system-wide redesign and should continue to be assessed on a system-wide basis.
- The scheme faced the challenge of recruiting community nurses which caused delay in implementation. If the recruitment of nursing staff is likely to form part of future plans, labour market issues should be considered at the project initiation stage and factored into savings assumptions.
- Despite the scheme being in its early stages, it is already showing signs of impact. It is also relevant across the Dudley MCP model.

# 7 Care Home Telemedicine Service

**Rationale for the scheme**

In 2015/16 there were 2,213 non-elective hospital admissions for care home residents in Dudley, costing the CCG a total of £4,997,180. Following a CCG analysis of 952 sample admissions between April and September 2015, it was found that 57% could have been prevented and managed in care homes and that 61% of these admissions occurred out of hours[20].

Care homes in Dudley (reflecting national trends) face financial challenges and difficulties with staff recruitment and turnover, and report increasing regulatory burden. Not intervening to support care home improvement in this context risked further escalation of non-elective admission and associated costs. In order to address this, the CCG proposed looking at alternative ways of supporting care home staff to help prevent inappropriate admissions to hospital.

One way to support care home staff to prevent inappropriate admissions (particularly out of hours) is to remotely provide medical support to non-medical staff through telephone or video triage. Airedale and Immedicare's telemedicine scheme was proposed as an appropriate way to do this. There is some evidence of telemedicine's impact on admissions although there are limitations and nationally, evidence is inconclusive.[21] The scheme is also proposed in the Enhanced Health in Care Homes framework[22] as an example of good practice.

**Summary assessment:** The rationale highlights a **clear need** for the scheme. The Telemedicine in care homes scheme supports the coordination theme of the new care model.

**Aims of the scheme**

The key aims of the scheme are to:

- Reduce conveyances and admissions to hospital from care homes;
- Reduce demand for primary care; and
- Increase adherence to patient's preferred place of care.

The scheme also aims to:

- Increase in patient satisfaction;
- Increase in GP satisfaction;
- Increase in proportion of older people who are still at home 91 days after discharge;
- Reduction in Delayed Transfers of Care; and
- Increase in dementia diagnosis rate.

**Summary assessment:** There were **clear** aims for the scheme. The scheme could have differentiated the potential impact on residential and nursing homes, and anticipated the potential for unintended consequences on primary care practice.

[20] Scheme PID document.

[21] TRiP-LaB (2012), Evidence briefing on teleconsultation.

[22] The framework for enhanced health in care homes (2017), NHS England.

## Design of the scheme

The service uses a nurse triage service which reviews care home residents who may be at risk of hospital admission and offers advice on continued treatment in the home setting through a secure 24-hour video conferencing and telephone line. The care home then decides on a course of action informed by the advice provided.

**Summary assessment:** The intervention had a **clear** design to meet its aims although the scheme could have tried to anticipate unintended consequences in design.

## Costs

The total sum invested from the VP budget for 2017/2018 was £336,000. The costs included one tablet per care home, installation, training plus the clinical triage at Airedale.

There are likely to have been in-kind costs imposed on care home providers, given the necessary commitment from care home staff and management to commit to changing practice and releasing staff to train in the use of the scheme.

## Implementation

The Telemedicine scheme became fully operational in 24 of the 52 participating care homes in January 2017. A further 23 became operational in February, with the remaining three care homes operational in March 2017. There have been a total of 2,937 calls to the scheme, with wide variation in use of the service (see Results section below).

Implementation included 1) Local 'on site' implementation of the technology and training into the participating homes, and 2) Remote implementation, which involved assimilation of Dudley homes and practices into the Airedale operation. Post-live support was coordinated locally by the CCG but was heavily reliant on remote issue resolution and production of management information.

### Worked Well

The majority of interviewees found the scheme useful in providing reassurance and additional clinical input. Most reported that, even when there were some initial reservations, staff had adopted the technology quickly and had shifted their working culture in response.

For residential care homes, the additional clinical input has been reported as very helpful in helping staff to manage residents with complex needs and prevent admissions. Interviewees from nursing homes described the service as providing reassurance for staff decisions (although not necessarily changing their approach). In most cases, the service did this in a timely manner. When operational problems have arisen, interviewees reported an ability to feedback to Airedale/Immedicare through home managers.

### Challenges

Some interviewees suggested nursing homes might be less keen to use the service because it either duplicates nursing decisions made in homes or creates a situation where the clinical decisions of nurses within homes are questioned creating further uncertainty. Nurses themselves, however, stated that they valued a second opinion when making difficult decisions.

A number of interviewees reported frustration with occasional long waits to be seen (reportedly up to two hours). These waits, interviewees claimed, undermined the purpose of the scheme and could lead to unnecessary admissions. One interviewee reported a discomfort when using the scheme to triage residents who had a "sensitive" issue using

video/internet technology, which may impact on their dignity, although others described measures taken to minimise this discomfort (use of private rooms, continuity of staff at Airedale, reducing background movement etc.).

It is difficult to determine if the scheme has reached full maturity as it has only been running since January, and in some places since the end of March. It is likely that further work is necessary to embed the scheme across care homes. This is reflected in variation of usage (see below). This variation, and the inevitable complexity of managing change in the fragmented care home sector, could have been mitigated by additional project support and further input from the Dudley Metropolitan Borough Council (MBC) and the West Midlands Care Association to increase engagement through contractual levers or provider-led initiatives.

**Summary assessment:** The scheme has been implemented **moderately well** relative to expectations.

**Results: outputs and outcomes**

It is important to note that the Telemedicine scheme has only been fully operational in most care homes since February 2017. Judgements about impact should be understood in this context.

Data collected from the project team shows that:

- 2,937 calls to the service were made in total.
- There has been variability in usage. Four care homes have not used the scheme at all, and the top five users called over 100 times.
- Residential care homes made 17 fewer admissions in April-June 2017 than in the same period the previous year.
- Nursing homes made 28 more admissions during the same time.

The April-June monitoring report[23] provides some evidence of the claim made by interviewees that there was a different attitude and approach to the scheme by nursing and residential care homes: residential homes have used the scheme to reduce admissions, whereas the scheme has not yet had the same impact in care homes. However, it is difficult to isolate the impact of the intervention from the wider context of increasing medical complexity of care home residents and the ongoing sector issues: funding, recruitment etc.

Managers and nurses within care homes described their changing relationship with primary care. Interviewees described a longer response time (than before the implementation of the scheme) when a visit from a GP was necessary, even when suggested by Airedale/Immedicare. Interviewees also described a shift in GP rounds in care homes.

The GP practice we spoke to described this as a "change of approach": GPs were saved time by the scheme and therefore focused on preventative and holistic work with patients with LTCs instead of "firefighting". However, one care home reported that GPs now only performed cursory "in-and-out" rounds.

[23] Immedicare monitoring data, 2017.

The majority of interviewees reported that they valued the scheme, and would like to see it continue. Most interviewees felt that the impact of discontinuing the scheme would be felt most acutely by residential care homes who value clinical input the most and would lead to increased admission from these homes, if not replaced by an equivalent intervention.

**Summary assessment:** Given the relatively short amount of time the scheme has been in operation, it is difficult to make a judgement about its effectiveness. On available evidence, we would consider the scheme as having been **slightly effective**, given the limited impact (so far) on hospital admission rates from care homes, and the potential for a negative impact on GP engagement with care homes.

## Relevance to the MCP implementation matrix

The establishment of the telemedicine scheme supports the appropriate use of urgent care services through rapid response to quickly assess, treat and support patients at risk of hospital admission in their own homes (component 2.1 ii). It supports people with ongoing needs through the design of services to ensure default delivery of care is in the community unless there is a clinical need for hospital admission (component 3.4 i).

The scheme also supports those patients with the highest needs, in particular through the implementation of the Enhanced Health in Care Homes Framework[24] (component 4.1iii).

| Care element | Sub element | Sub element description | Scheme addresses in principle | Scheme addresses in practice |
|---|---|---|---|---|
| Urgent and Emergency | 2.1 | Proactive community-based approach to urgent care | Very Strongly | Moderately |
| Ongoing Needs | 3.4 | Services traditionally delivered in hospital are shifted to community settings | Very Strongly | Moderately |
| Highest Needs | 4.1 | Coordinated care across the whole pathway for those with the most complex needs | Strongly | Moderately |

## Key learning

- There is a clear rationale for intervention into care homes in Dudley to prevent unnecessary conveyances and admission to hospital when residents' needs could be managed in the home. The Airedale/Immedicare model is one such intervention. Some practices within the CCG chose to adopt a different approach. For instance, Lion Health employed a rapid, face-to-face response service from Advanced Nurse Practitioners. When thinking about the future of this intervention, it may be useful to compare the impact of different approaches with practice's participating in the Airedale/Immedicare scheme.

[24] The framework for enhanced health in care homes (2017), NHS England.

- There has been a variation of usage among participating care homes. Engagement and cooperation with both local authority contracting and care provider forums (Dudley MBC and West Midlands Care Association) could help address this variation and provide incentives for participating care homes. As the Enhanced Health in Care Homes framework recommends: "This is incentivised through both contracts and partnership working and delivered in collaboration between social care providers, NHS, local government and the voluntary and community sectors."[25]

- We heard that the scheme is of more help to residential care homes (who do not have immediate clinical input). For some of these homes, removing the service without replacement could lead to an upswing of admissions. It may make sense to consider future commissioning of the service in residential and nursing homes separately, contrasting implementation challenges and emerging impact on admissions.

- Key policy drivers (including the Five Year Forward View[26]) emphasise the need for *enhanced* access to primary care in care homes. The use of the telemedicine scheme by care homes, although intended to stem demand to primary care from these homes, should not act as a barrier to resident access to primary care. Indeed, access to primary care among participating homes should be monitored and contractual mechanisms used to ensure practice engagement.

[25] Ibid.

[26] Five Year Forward View (2014), NHS.

# 8 Care Home End of Life Education Programme

**Please note: This project is still at an early stage in terms of implementation and so the degree to which measurable outcomes can currently be explored is limited.**

## Rationale for the scheme

Between 2001 and 2014, there was a 23% increase in the number of people aged 65 and over in Dudley, with a 58% increase in the over 90s in the same period.[27] This implies a rise in the numbers of people requiring additional end-of-life support. Where patients identify their preferred place of palliative care as their usual place of residence, as opposed to hospital, this will require expanded community support, including in nursing and residential homes.

The Dudley VP document[28] identified a specific shortcoming in care experiences at the end-of-life in care homes and the scope for improvement:

*"Local analysis has shown that we do not consistently provide patients and their families with a good experience at the end of life. Moreover, we make sub-optimal use of resources – suggesting scope to improve care, outcomes and efficiency. We have identified a particular need to address skills and confidence in care homes and nursing homes. We will therefore: implement a structured training and monitoring programme across homes in the borough."*

Not intervening in this area could lead to continuing underperformance on providing good end-of-life care and a growing number, and proportion of people in Dudley dying in hospital when their preferred place of care is in their care home.

**Summary assessment:** The rationale highlights a **clear need** for the project. The End of Life Education Facilitator role supports the coordination theme of the new model of care.

## Aims of the scheme

The scheme aimed to improve resident management in care homes at the end-of-life. It set out to:

- Reduce admissions to hospital from care homes for people at end of life;
- Reduce the number of deaths in hospital where the preferred place of care is place of residence; and
- Facilitate the patient's preferred place of care and ensure the recording and implementation of this preference.

These aims were to be achieved through the improvement of skills, education and training of the care home workforce.

[27] Dudley Joint Strategic Needs Assessment 2014

[28] Dudley Multi-Speciality Community Provider Value Proposition, February 2016.

**Summary assessment:** There were **clear** aims for the scheme, which support the rationale. However, the aims could have more clearly articulated the potential challenges of working with care homes, given their diversity and labour market issues.

## Design of the scheme

Dudley Clinical Commissioning Group commissioned Mary Stevens Hospice to train and support care home staff in caring for older people with end-of-life and palliative care needs, including in the use of advanced care plans and competency assessments for care staff.

The process began with a preparatory audit of care home end-of-life procedure and practice in participating care homes. The training material was developed by Mary Stevens and Macmillan Cancer Support. Training was designed to respond to the needs of care homes, and was delivered in the care homes themselves as well as community settings accessible to care homes. Staff champions were to be identified in participating homes in order to 'cascade' learning to other staff.

**Summary assessment:** The scheme had a **clear** design which responded to its aims, but it could have tried to anticipate the impact of staff turnover on ability of homes to cascade learning.

## Costs

The total sum invested from the Value Proposition budget for 2017/2018 was £75,000. There are likely to be in-kind costs, given the necessary commitment from care home staff and management.

## Implementation

The training programme has been rolled out quickly beginning in March 2017 and has covered the majority of care homes within Dudley, a small proportion of out of borough placements, as well as a small number of extra care housing schemes within the borough. The scheme also produces a newsletter and enables participants to communicate through social media platforms.

The initial procedure and practice audits uncovered a wide variation in practice with regard to end-of-life care across Dudley and contracted providers out of the borough. Interviewees described that when the scheme has been completed, further audits and competency assessments with participants will enable the team to identify the impact on practice across the participating homes.

Interviewees reported that participating staff have been keen and engaged with the training enthusiastically. They reflected on the fact that staff are often low paid and not often equipped with specific training given the issues they face, including balancing priorities of safeguarding, personal choice and the need to prevent unnecessary admissions.

Interviewees reported that a small group of care homes were reluctant to engage with the scheme, possibly due to a lack of available staff to participate. It was suggested by interviewees that participation could be incentivised through contracts with the CCG. Closer cooperation with Dudley MBC could also facilitate participation. Although there has been

some contact, further engagement with the West Midlands Care Association may also help in engaging the remaining homes and continuing engagement with others.

Although the scheme has achieved good coverage of care homes, there remain challenges related to workforce issues in the care home sector, which reflect national pressures. Staff turnover in care homes was, in particular, identified by interviewees as a potential barrier to the embedding of good practice. High turnover prevents the embedding of practice for individual care workers and their subsequent 'cascading' of the End-of-Life training to co-workers.

It is difficult to make a judgement about the maturity of the scheme as it has only been actively delivering since March 2017. However, it is clear there is potential for fuller and more joined-up rollout, possibly in collaboration with Dudley MBC and the West Midlands Care Association.

**Summary assessment:** The scheme has been implemented **moderately well** relative to expectations. It faced two fundamental challenges: high turnover of staff and difficulty convincing a fragmented sector of care homes to attend and contribute to training sessions. Nevertheless the scheme has engaged a large proportion of homes, with a relatively small investment, and in a short time.

**Results: outputs and outcomes**

To date, data are only available on the outputs of the scheme. Outputs data show that the scheme has delivered training to over 200 members of staff, in seven sessions delivered on the Mary Stevens premises and 6 sessions delivered in care homes. 20 staff have been trained as champions in their respective organisations. The training has been delivered to diverse roles within care homes including care assistants, registered managers and nurses.

Interviewees have reported that participants have been keen to pass on learning and improve practice within their homes.

Participants and trainers are keen to see the continuation of the scheme in order to "maintain momentum" and embed the learning in homes. It was suggested in interviews that the scheme would be of benefit to domiciliary care agencies and further extra care housing schemes.

**Summary assessment:** It is difficult to determine the effectiveness of the scheme given the short amount of time it has been operational. So far based on the information available, the scheme has been **moderately effective** relative to expectations.

**Relevance to the MCP implementation matrix**

The table below shows only the sub elements of the MCP implementation matrix which the end-of life education facilitator relates to. The scheme clearly supports the implementation of the MCP care model in urgent care and supporting those with ongoing and high level needs. Specifically, the scheme addresses:

- The establishment of an education programme on the appropriate use of urgent care services (component 2.1 iii);

- Design of services to ensure default delivery of care is in the community unless there is a clinical need for hospital admission (component 3.4 i); and

- Implementation of guidance in the Enhanced Health in Care Homes framework[29], specifically the delivery of "high quality end-of-life care ensures that people die in the place of their choosing with dignity and in comfort" (component 4.1 iii).

| Care element | Sub element | Sub element description | Scheme addresses: In principle | Scheme addresses: In practice |
|---|---|---|---|---|
| Urgent and Emergency | 2.1 | Proactive community-based approach to urgent care | Very Strongly | Very Strongly |
| Ongoing Needs | 3.4 | Services traditionally delivered in hospital are shifted to community settings | Very Strongly | Very Strongly |
| Highest Needs | 4.1 | Coordinated care across the whole pathway for those with the most complex needs | Very Strongly | Very Strongly |

**Key learning**

- Practice in End-of-Life care is varied across Dudley's care homes and care home staff are often low skilled/low waged, while facing significant challenges in addressing the palliative care needs of care home residents.

- Care home staff are keen to engage with good practice in End-of-Life care, but there remain a number of homes which are challenging to engage with. Staff turnover in care homes and the large number of out-of-borough placements makes consistent engagement even more challenging.

- There is a clear need for a systematic (and multi-organisation) approach to care home staff development that meets the needs of residents. This will require the development of care home systems that reinforce and embed the learning from such opportunities, the input of local government in promoting a stable market, and the involvement of provider representative organisations to promote good practice.

- Further evaluation, comparing the initial audit of practice with a later assessment may help with identifying outcomes and challenges to further engagement. This will help commissioners make more informed decisions about the potential for expanding the initial investment.

[29] The framework for enhanced health in care homes (2017), NHS England.

# 9 Practice Based Pharmacists

**Please note: This is not a new project, the Practice Based Pharmacists (PBP) service has been running for nearly 15 years. The Value Proposition funding enabled additional hours for the extended PBP role.**

## Rationale for the scheme

Medicine management and prescribing waste are high on the national and local agenda. An estimated 30%-50% of prescribed medications for those with LTCs are not taken as recommended.[30] In Dudley, the Prescribing Budget is 15% of the overall CCG budget. More effective and efficient prescribing and medicine management would help reduce waste and generate cost savings.

A quarter of the population have a LTC which constitutes 50% of GP appointments.[31] Within the context of an ageing population this demand on the GP workforce is likely to increase further still. A substantial amount of GP time is spent on medication-related issues: managing prescribing, reviewing medicines, reconciliation of letters and discharge forms, addressing patient compliance and managing LTCs. The skills of pharmacists have clinically developed over recent years and they have become qualified to carry out medication related tasks. Two thirds of the PBP team are qualified Independent Pharmacist Prescribers (IPPs). The PBP helps address the pressures facing general practices, through providing support to the primary care workforce and carrying out medication reviews leading to better management of LTCs.[32]

**Summary assessment:** The rationale highlights a **clear need**; the scheme potentially responds to the workforce challenges facing primary care, as well as addressing waste management.

## Aims of the scheme

The PBP service aims to:

- Improve the review and reconciliation of medication changes from secondary care;
- Improve the number of medication reviews in patients with LTCs;
- Improve access to the GP and wider workforce;
- Improve better self-care/self-management;
- Reduce emergency admissions for people with LTCs; and to
- Reduce repeat prescribing and waste management.

[30] Barber et al (2004) as cited in the service specification document

[31] Service specification document

[32] Primary Care Medicines Management Service- Practice Based Pharmacist service, including Older Persons' Specialist Pharmacist Service, service specification document, 2015.

**Summary assessment:** The scheme had **clear** aims linked to specific outcome measures and success indicators. Extending the roles of PBPs supports the vision and new care model by potentially improving primary care access.

## Design of the scheme

There are 36 PBPs, who are practicing clinicians, that work across all 45 General Practices in Dudley. The PBP service has been running for almost 15 years and the VP funding has allowed for additional hours for the extended role of these pharmacists. The extended role includes additional clinical responsibilities such as Independent Prescribing, engaging in and taking referrals from MDT meetings, taking leadership for repeat prescribing management and the management elements of prescribing of high risk drugs within GP Practices, and drug monitoring and review of results.[33] The extent to which these roles are delivered by each PBP is dependent on their individual level and clinical expertise.

The PBP service takes referrals from patients, carers, specialist services, and clinicians. Referrals are reviewed by the team within three working days. The PBP will carry out either a face-to-face, telephone or notes review with the patient. This is followed by a medication review and where required intervention (medication changes), and prescribing.

**Summary assessment:** The scheme had a **clear** and comprehensive design with well-defined roles and responsibilities for staff.

## Costs

- **Investment** – In 2017/18 there was a total VP investment of £556,000 to increase the PBPs extended role by an additional 375 hours per week. As of July 2017, the team had expanded to 300 hours per week.[34]

- **In kind contributions** – interviewees reported that the PBP leadership team make substantial in kind contributions, working beyond their contracted time.

## Implementation

The following **strengths** were reported:

- **Developing the pharmacist role** – the demands of pharmacy have changed because of the changing GP workforce and responsibilities. The new care model has seen more work shifting to general practice and as a result pharmacists are expected to do more. Interviewees reported that the service was about developing pharmacists' skills and the service has been successful in growing a new workforce by training pharmacists up to work in general practice. Pharmacists are now clinically skilled to deal with much more, for example, some pharmacists are practising clinicians who will see patients and will deal with drug queries.

[33] This is not an exhaustive description of the extended role of PBP, for a more detailed list of duties please refer to the service specification document.

[34] PBP presentation to the partnership board July 2017 (reporting on data from Jan - July 2017).

- **Contract for services** – the service has standardised the approach to contracts by more consistently offering pharmacists contracts for services rather than contracts of employment. Interviewees reported advantages of this approach in that the PBPs are commissioned to do specific tasks in the service specification, giving them the freedom to decide how they do these. Interviewees described that this has allowed them to recruit a good calibre of pharmacists and also offers management the flexibility to terminate contract for services should they need to.

The following **challenges** were experienced:

- **Recruitment and developing a workforce** – Interviewees described that recruiting the 'right' pharmacists is sometimes a challenge because of the specific clinical skill requirements; i.e. being able to make decisions in general practice. Interviewees described that sometimes hospital pharmacists are used to working in a very hierarchical organisation, and have excellent clinical skills but are not so skilled at decision making, whereas someone from a community pharmacy background is used to making lots of decisions on their own but might lack the clinical skills. Thus the management team are required to recruit those that have the potential to suitably adapt to the PBP role.

- **Managing expectations** – Interviewees described that the biggest challenge before acquiring the VP funding was getting GPs to accept the extension of pharmacists' role within the workforce. This is slowly changing. The challenge now is to manage GP expectations, for example interviewees reported that GPs find it challenging when the pharmacists are absent – either on holiday or if they have had to be withdrawn, and stressed the difficulty in offering practices a replacement pharmacist immediately because it is challenging to find the right people.

**Summary assessment:** The scheme has reached maturity, has been implemented **very well**, and has been successful in growing a new workforce. Notwithstanding there is an ongoing challenge of recruiting the 'right' pharmacists for the PBP role.

**Results: outputs and outcomes**

Data is routinely collected and quantified using the 'Pharmoutcomes' software on a monthly basis. Interviewees suggested that attribution for the extended PBP hours – the specific element funded by the VP – is difficult because they cannot separate outputs/outcomes of the extended role of pharmacists from their core role. Therefore outputs/outcomes reported below are for the PBP role generally and are not specific to the extended hours funded by the VP.

Outputs collected from Jan-June 2017[35], since the expansion to 300 hours per week include:

- 58,294 patients reviewed; 45,713 interventions documented and 4,447 drug discontinuations.

- 369 Hospital Admissions Related to Medicines (HARMS) interventions accepted.[36]

- 326 hours spent developing robust repeat prescribing practices, and 67 hours spent supporting practices in MDT meetings.

[35] Presentation to partnership board, July 2017

[36] Admissions that are related to medication related issues, such as adverse drug reactions which could be avoided.

- A number of outputs specific to general practice are also collected:
  - 2,536 outpatient letters reviewed and actioned.
  - 111 patients reviewed and triaged.
  - 589 patients prescribed high risk drugs that were reviewed on behalf of the practice.

The reported **outcomes** from Jan-June 2017[37] from the expansion to 300 hours per week are:

- Savings of at least £174, 000 on medication review related interventions.[38]
- Waste savings of £221,035 made associated with improved repeat prescribing and better waste management.
- 182 hospital admissions avoided.
- More specific outcomes for general practice included:
  - 1,896 GP appointments avoided; and
  - 2,031 hours of GP time saved;
  - Actual reported savings of £1,337,446[39] resulting from the preceding two outcomes.

**Summary assessment:** The initiative has clear outcomes and cost savings that the service have been measuring from the outset. Outcomes indicating improved patient outcomes and cost savings show that the service has been **very effective**.

**Relevance to the MCP implementation matrix**

The table below shows the care elements of the MCP implementation matrix that the PBP service relates most closely to and the strength of these relationships. The PBP service falls within the 'ongoing needs – enhanced primary and community care' element of the matrix, and relates to sub elements 3.1 and 3.2. The initiative is not directly relevant to sub elements 3.3 or 3.4.

Through its placing of PBP in each general practice in the Dudley CCG area and standardising contact time across practices, the scheme strongly contributes to scaling up and enhancing primary and community care. The extended role of the PBP included attendance at MDT meetings, and receiving referrals from the MDT. The initiative also has specific outcome measures associated with this. It therefore relates very strongly to sub element 3.2.

| Care element | Sub element | Sub element description | Scheme addresses: In principle | Scheme addresses: In practice |
|---|---|---|---|---|
| Ongoing Needs – enhanced | 3.1 | Scaled up and enhanced Primary and Community Care | very strongly | very strongly |

[37] Presentation to partnership board, July 2017

[38] Medications reviews completed in 5,050 patients with LTCs and 1147 patients newly discharged from hospital, 105 housebound patients, 375 patients in Care Homes, 3,364 patients on 5 or more medicines with 2 or more LTCs, 5,578 reauthorisations.

[39] The savings from relieving pressures on primary care were yet to be evaluated.

| | | | | |
|---|---|---|---|---|
| primary and community care | 3.2 | MDTs for those with long term conditions | very strongly | very strongly |

**Key learning**

The following key learning emerged from the interviews:

- Having a pharmacist as part of a MDT has enabled more effective distribution of work within general practice, so the most appropriate person is picking up different elements of the workload. The service has demonstrated that there is a new growing pharmacy workforce in general practice.
- Interviewees suggested that many of the PBPs have portfolio careers and are also working in other areas which adds to the expertise they can bring to their PBP role; for example, the service have a neurology specialist pharmacist who also works at a hospital, and another respiratory specialist pharmacist. So the team have not only been able to "skill people up" but have also learnt from their expertise on how best to work as efficiently as possible.
- Interviewees claimed that more resource is needed to improve management support for the initiative. They reported that the sustainability of the service is somewhat dependent on the types of contracts they are able to offer PBPs, and suggested that offering longer contracts would be helpful in order to retain the level of skill and to get a return on their investment (on the time taken to train people).

# 10 Prescription Ordering Direct Contact Centre

**Rationale for the scheme**

Prescribing waste at a national level is estimated at costing the NHS £300million per year. In a CCG the size of Dudley, estimates for prescribing waste are in the region of £4million per annum.[40] This waste comes from inefficiencies in the system, inefficient drug costs, where prescribed drugs are not used, and poor medicine adherence – which is not only a significant financial problem but also a clinical issue.[41] The Prescription Ordering Direct (POD) service seeks to eliminate waste by applying more stringent assessment of need at the point of prescribing.

Variation in the repeat prescribing ordering systems at GP practices also contributes to prescribing waste. In Dudley the length of time of repeat prescriptions varied from 28 days to around 84 days. The POD was put forward as a solution which could help reduce prescribing waste through a centralised telephony system that standardises, coordinates and creates a single point of access for repeat prescribing processes.

**Summary assessment**: the rationale highlights a **clear need** for the scheme. The POD scheme aimed to centralise prescribing and in doing so responds to all three themes of the new care model: access, continuity and coordination.

**Aims of the scheme**

The POD initiative set out to standardise and streamline the management of repeat prescribing across Dudley and reduce waste. The specific aims of the scheme were:

- **Centralise the system of telephony.** To develop a centralised system where patients call up to order their repeat prescriptions. The aim was to create a single point of access for patients. Patients are also signposted to other services, for example reminding patients to have their flu vaccine, or signposting them to lifestyle (e.g. Slimming World), mental health or mindfulness services.
- **Reduce prescribing waste.** The aim of the POD was to improve repeat prescribing processes and to reduce waste associated with prescribing, including unused drug and inefficient resource costs. This project was expected to have a positive impact on the prescribing budget, in terms of managing waste medicines.
- **Better self-care/management.** The POD aims to empower patients to take control of their own medication requirements which will reduce medicine waste and improve medical adherence.
- **Reduce the pressure on general practices.** It was anticipated that the POD replacing the repeat prescribing ordering systems at GP practices would in turn help reduce general practice and community pharmacy workload.

[40] POD business case document.

[41] Evaluation of the Scale, Causes and Costs of Waste Medicines (2010), York Health Economics Consortium and School of Pharmacy, University of London.

**Summary assessment**: The aims of the project were **clear** and align with the access, continuation and co-ordination themes of the new care model through aiming to standardise and streamline repeat prescribing.

## Design of the scheme

The POD is a call centre which is responsible for repeat prescriptions. The Dudley POD was developed using the Coventry and Rugby CCG POD model as a starting point. The Coventry and Rugby POD started in June 2015 and is operated by trained call handlers who ask a series of set questions when taking requests for repeat prescriptions. Prescription queries are passed to GP practices only if deemed necessary by the call handler. The model reported early positive outcomes and generated a significant saving – for example, with a 6% reduction in the number of prescriptions issued by GPs.

Similar to the Coventry and Rugby model, the Dudley POD provides a single point of access for patients to order their repeat prescriptions. The POD is manned by four trained POD operatives who establish need by asking patients a standard set of questions. The team also includes a duty POD pharmacist. The POD is open from 10am–2pm, five days a week.

The Dudley model set out to have a staged approach to the number of practices involved with the POD. They currently have five practices on board, and aim to offer it to all Dudley practices over the next two years. Of the three practices that data are available for, two serve patient populations which are highly deprived and have low levels of literacy, and in one practice population English is not the first language. The third practice serves a more affluent population.

One key difference between the Coventry model and the Dudley model are the calls that are referred back to the general practice. In the Dudley model calls not dealt with by the POD operative are first referred to the POD pharmacist on duty. The calls that are not dealt with at the POD (either by the operative or the pharmacist) will then go to the general practice to be dealt with by either the PBPs or the GPs.

**Summary assessment**: The POD scheme had a **clear** design, which meets its aims by adapting the Coventry and Rugby model. There is however potential to deliver the POD more efficiently – e.g. by extending opening hours and improving the telephony in order to reduce the volume of dropped calls (see below).

## Costs

The POD initiative had a three year business plan based on an investment of £200,000 per year; this was the amount funded by the CCG for 2017/18. The interviewees spoken to as part of this evaluation suggested that the whole team regularly put in extra time to the POD project. In-kind contributions were estimated to be in the region of an extra 20% of people's time every week.

## Implementation

**Strengths –** The interviewees felt that the POD initiative is relatively mature in terms of the population it is covering. The POD covers a population of 40,000, and they are hoping to increase this to a population of 65,000 by the end of year one (total Dudley population is

312,000). The POD has recently increased from working with three practices to five, and many interviewees said that many more have expressed interest to be involved.

**Challenges –** Whilst the scheme has shown positive results (as presented in the next section) the interviewees expressed that there have been challenges in the implementation of the POD project. These specifically included challenges around project support, in terms of improving financial information flows and the need for greater engagement with IT.

**Summary assessment:** The scheme has been implemented **very well** and is being delivered as intended despite the challenges highlighted above. The POD service has grown from working with three practices to five practices, serving a population of 40,000. The engagement of IT and leadership support is imperative if the POD is to continue.

**Results: outputs and outcomes**

The POD initiative reports on a wide range of outcomes on a monthly basis. As part of this, they collect data on call analytics – the kind of interventions the POD operatives and pharmacists are making, and the impact of the call volume. To date there are six months of data (from Oct 2016 – April 2017) available, from three practices (a large, medium and small practice).[42]

The main **outputs** include 20,205 POD calls handled; 1,954 POD pharmacist queries taken; 5,234 operative interventions made; and 2,410 clinical interventions made by the POD pharmacist.

The following **outcomes** were reported:

- **Reduced prescription volume and cost savings:** Data show that there is around 7% reduction in prescription volume as a result of putting this system in place (collectively for those GPs that are part of the POD), resulting in around 3% reduction in cost. In comparison, there is a 2% increase in prescription volume for the rest of the practices in the CCG that are not part of the POD, showing less than 1% increase in cost. Interviewees reported that the POD predominantly influences volume, but other things introduced might also influence this. Nonetheless interviewees reported that these early results show that the POD is making a difference.
- **Reduced pressures for practices:** The POD pharmacists deal with 80% of the queries not dealt with by the POD operative. Queries not dealt with by the operatives do not automatically get referred to the general practice, as is the case in the Coventry model. In 17% of these cases prescriptions will be written by the POD pharmacist, showing a reduction in the workload of general practices.
- **Dropped calls:** the POD is reported to be dropping large volumes of patient calls. Anecdotal feedback from patients when they get through to the POD indicate that patients are not entirely happy with the length of time they are waiting to get through. Data shows that 10am – 12pm is the busiest times of the week, and interviewees suggested that patients will not get through on Mondays or Tuesdays because of the lines being so busy.

[42] Presentation to the partnership board July 2017 (reporting on data from Jan - July 2017).

**Summary assessment:** To date, based on six months of outcomes data the project has been **very effective**. However, these findings are based on the POD operating in a limited number of practices.

## Relevance to the MCP implementation matrix

The table below shows the care element of the MCP implementation matrix that the POD service relates most closely to, indicating the strength of this relationship. The POD service relates most closely to the care element 'ongoing needs – enhanced primary and community care'. The initiative most strongly relates to sub-element 3.1 through it offering a scaled up response – it is currently serving a population of 40,000, and hoping to increase this to a population of 65,000 by the end of year one. The POD scheme partly relates to sub-element 3.3, through empowering patients to improve their self-management by taking control of their own medication requirements.

| Care element | Sub element | Sub element description | Scheme addresses: In principle | Scheme addresses: In practice |
|---|---|---|---|---|
| Ongoing Needs – enhanced primary and community care | 3.1 | Scaled up and enhanced Primary and Community Care | Very strongly | Moderately |
| | 3.3 | Rapid clinical advice and guidance | Partly | Partly |

## Key learning

Interviewees spoken to as part of this evaluation suggested several key points of learning, as follows:

- New and innovative projects like the POD require open channels of communication between the commissioner and service provider. Interviewees suggested that such projects should take a partnership approach.
- As described above there are a large number of calls that are being dropped from the POD, which potentially impact on time inputs made by the team. For optimal call handling a telephony system that supports a scaled up POD service is needed. The interviewees suggested that increasing the number of telephone lines, increasing the opening hours, and the number of call operatives will allow the POD to reach its full potential.
- Interviewees reported that the POD service (and its success) has been heavily reliant on in kind contributions in terms of people's time, and that this "good will" is not sustainable in the long run.

# 11 Conclusions and recommendations

Value Proposition funding was used in Dudley to support different types of scheme. Those considered in this evaluation could be described as service innovations. Here, the funding has been used to support service changes that exemplify and catalyse the model of care required by the MCP. Within this broad category, a diverse set of schemes have been evaluated. They differ in terms of the resource invested, as well as their intentions, and maturity.

While the intention for the evaluation was not to directly recommend which schemes to continue to support (since the evaluation does not have sight of either the total resource available for on-going investment, nor the full range of potential / competing uses) there are some general lessons arising which can inform future commissioning:

- **The type of service invested in.** The logic of Value Proposition funding was to test innovations such that, if successful, they could be scaled up and become a 'mainstream' way of working within the MCP. The great majority of schemes considered in this evaluation match this description. Yet one – the Practice Based Pharmacists – was perhaps too much of a 'safe bet' to have been funded in this way. Paradoxically, using Value Proposition funding for relatively safe schemes raises the opportunity cost by foregoing the generation of new knowledge and ways of working. Here it seems that the NHSE requirement to demonstrate a 'return on investment' on VP funding provided an incentive for the CCG to be more risk averse than it might have been with greater encouragement to innovate.

- **The design stage of such schemes.** The requirement for innovation brings uncertainty. This cannot be mitigated entirely (and nor should it), but it can be bounded by taking care at the design stage. In practice, this would mean:

    - *Getting design questions in the right order.* Almost by their nature, service innovations risk being supply-led (solutions in search of a problem). The source / sponsor of an innovation (new technology; an idea tried elsewhere; etc.) is often seeking a means of taking their idea to the next level. This risks missing a foundational question in the design process: 'what is the problem we're facing?' Starting with this question guards against supply-led innovation; following it with 'and how does the proposed innovation address this?' further sharpens the design process and helps reduce some of the uncertainty associated with a new way of working. Logic models are a useful tool to aid this process;

    - *Specifying decision rules 'up front'*. Implementing innovation is not a neat business. In practice: innovations become (personally) associated with innovators; as implementation progresses the original reasons for change become lost; changes in direction become post hoc changes in rationale. All of these factors tend against coherent decision making as to whether or not to continue / scale up an innovation. It is better therefore to specify both the nature of the decision required (stop / go; roll out / not; etc.) and associated tests that the innovation would have to meet (e.g. 'in order to justify roll-out, a / b and c would need to be seen'). This then sets the requirements for data collection; and,

    - *Expecting (even desiring and encouraging) 'failure'.* The logic of the new care models programme should demand that innovations within a Vanguard programme push the limits of what is practically possible. Vanguards are an investment in the NHS' R&D. Some degree of failure (of results not matching

ambitions) should therefore be expected. Then, in order to fulfil the R&D function, the results of these failures should be widely shared such that others in the system could avoid similar approaches. Lack of learning, not lack of results, is the outcome to avoid.

- **Programme management infrastructure.** The evaluation has highlighted that testing innovation in this way requires the support of a robust programme infrastructure and associated processes. A partnership approach between commissioners and providers, as well as system-wide engagement is likely to be most valuable. More specifically project support should include:
    - *Guidance with set-up* – as stated above adopting a logic model approach would ensure a more considered design phase. As well as facilitating theory of change development (perhaps through programme level workshops), this should ensure a key set of deliverables are produced by every scheme, such as a tight Project Initiation Document; a case for change; clear 'up front' decision rules; and the identification of clear success measures.
    - *Ongoing support with progress* – at the very least this should include open channels of communication between commissioner and providers, but could also include more innovative ways of sharing learning across the schemes – e.g. by facilitating a 'network' approach through providing opportunities to share implementation learning – both across the programme and within individual care elements of the implementation matrix.

In addition to these general lessons, there are specific recommendations for each of the schemes:

- **Integrated Plus Service –** The service responds well to a clearly identified rationale. It is well designed, making an important contribution to the new care model, by supporting non-clinical needs and coordinating support from across the health and social care system. Implementation has progressed well and proven the scheme to be valued by professionals across the system. The scheme is also 'data rich', supported by PSIAMS software providing information against a range of outcomes. Output and outcomes data (qualitative and quantitative) show that the scheme has been effective in addressing social needs, has been positively experienced by patients, and has reduced inappropriate demand on services. There is also a suggestion of cost savings resulting from a reduction in A&E usage – although validating this was beyond the scope of this evaluation. Future funding of this scheme would benefit from a more tightly specified understanding of impact. Data collection and reporting would also benefit from being simpler.

- **Care Coordinator Service –** This scheme has a clearly identified rationale and aims, although the CC role could have been more clearly defined at the design phase. Implementation has shown that the patient support at discharge element of the service is being delivered as intended. However, partly owing to a lack of detailed definition of the role, CCs are not yet fully embedded in the MDTs. Output and qualitative data suggest moderate effectiveness to date, but the scheme has not yet reported more tangible outcomes. It is crucial that this scheme is viewed within the context of the short length of time it has had to embed the CC role, and that the absence of outcome data is not taken to show its lack of effectiveness.

- **Sense.ly Kiosk –** This is the scheme which has suffered most from a weak design process. There was no evidence of the 'problem' having been clearly defined before the solution of the kiosk was selected, and the design did not fully reflect the aims of the

scheme. The rationale was therefore unclear, and the aims and design only partly clear. The results showed the scheme to be ineffective as it was unable to meet its aims. Positive patient feedback is based on a very small sample, limiting conclusions that can be made from this. Whilst technology-based solutions have a part to play in whole-population preventative approaches, they need to be embedded within a broader culture of change (in this case towards self-care) at both the CCG level and within individual practices adopting such schemes.

- **Sense.ly Patient Services App –** The key issue with this scheme has been the lack of early definition on what success should have looked like. In addition, some of the features of the app duplicate the functions of other services – such as NHS Choices and practices' own in-house online appointment booking systems. The rationale, aims, and design of the scheme were therefore only partly clear, and an assessment of the scheme's effectiveness cannot be made without success criteria. The electronic appointment booking feature also failed to save practice staff time as it was not integrated with EMIS. Introducing an appointment booking app across the CCG could potentially offer an attractive solution to alleviate demands placed on reception staff, however far more careful design work is needed to ensure integration into existing mechanisms and infrastructure.

- **Falls and Fracture Prevention Service –** Given the fact that the new team has only been operational since April, conclusions at this stage can only be preliminary. Nevertheless, the scheme has a clearly identified rationale, aims and design. Implementation has been successful thus far, with the newly established single-point-of-access quickly attracting referrals, and demonstrating an impact on demand for the acute based falls service in Dudley. Anecdotal feedback suggests this may also have increased consultant ability to attend to more complex cases. It is still too early at this stage to evaluate the impact on falls-related admissions.

- **Care Home Telemedicine Service –** Given the growing number of admissions (particularly out-of-hours) from care homes, there was a clear rationale to invest in supporting care home staff to care for residents who, although often in crisis, would be better managed in the home. Airedale/Immedicare's remote telemedicine scheme is one intervention which aims to do this. The scheme has provided reassurance and guidance for care home staff, particularly residential home staff who value access to clinical input. However, the scheme has yet to show the promised impact on admissions from care homes. It may also be having an unintended impact on GP engagement with care homes. The decision to continue to support the scheme should be taken within the context of seeing it as one – but not the only – option to provide clinical input to care/residential homes. Other options (e.g. the solution being implemented at Lion Health) may therefore warrant further investigation.

- **Care Home End of Life Education Programme –** the performance of care home provision at end of life provides a clear rationale for intervention to support staff training. The commissioned training programme has been rolled out quickly and effectively. Participants appear to have been highly engaged and valued the programme. In its short time, the programme has exceeded expectations. However, participants often move on quickly in the 'high-turnover, low pay' social care sector and this poses a problem for the retention of the expertise imparted by the programme. This challenge cannot be tackled by the CCG alone, but requires a systematic (and multi-organisation) approach to care home staff development. This will require the input of local government in promoting a

stable market and the involvement of provider representatives to develop systems for retaining good practice.

- **Practice Based Pharmacists –** As highlighted above, there are limits to the extent to which the decision to fund this scheme is in keeping with the original aims of the Value Proposition funding. This service has been running for nearly 15 years and has a clearly identified rationale, aims, and design. Implementation has shown that the scheme has reached maturity and has been successful in growing a new workforce within Primary Care. Data have shown the scheme to be very effective, demonstrating improved patient outcomes and cost savings. The service is clearly valuable and effective, with a highly compelling argument for inclusion in mainstream service provision.

- **Prescription Ordering Direct Contact Centre –** This service has a clearly identified rationale, aims, and design focused on creating a centralised prescribing service. Outcomes data have shown that the POD has been very effective in reducing prescription volume and generating cost savings as a result of this. Positive results however need to be understood within the context that this is a relatively new service, and is only operational in five practices, with data being based on outcomes from three practices. Though the service has been implemented well there have been challenges around project support that need to be addressed if the service is to continue. Further investment should also be accompanied with efforts to improve the efficiency of the telephony, and better integration of the service with existing in-house services. It is also recommended that there be further investigation on why calls are being dropped, and the links of this to negative patient feedback.

# Annex 1: Project Evaluation Template

**Rationale for the scheme**

What is the problem or opportunity to be addressed? How was this identified? What were the missed opportunities / negative impacts of not putting the scheme in place?

- Summary assessment: does the rationale highlight a clear need; partially clear need; or unclear need?

**Aims and design of the scheme**

Given the problem(s) identified, what did the scheme set out to achieve? What were the desired outcomes? In practical terms, how were these to be achieved?

- Summary assessment: clear aims; partially clear aims; aims unclear

**Costs**

What were the inputs to the scheme – in cash (from the VP and any other sources) and also in-kind (e.g. any partner / staff time used not covered by the cash inputs?)

**Implementation**

How did the scheme go in practice? What went well in terms of implementation (and why)? What went less well (and why)? To what extent did the scheme reach 'maturity' (i.e. delivering as intended)?

- Summary assessment: relative to expectations (plans), implementation went: Extremely well; Very well; Moderately well; Slightly well; Not at all well.

**Results: outputs and outcomes**

What was achieved? What outputs were produced (e.g. specific products; numbers of patients supported, etc.)? What outcomes were achieved (e.g. efficiency savings; improved patient experience; etc.)

- Summary assessment: relative to expectations (plans), the scheme was Extremely effective; Very effective; Moderately effective; Slightly effective; Ineffective

**Relevance to the MCP implementation matrix**

Which elements of the matrix does the scheme relate most closely to – and how strong does the relationship appear to be?

**Key learning**

What were the key lessons learnt from this scheme? What are the recommendations for improvement and future sustainability?