New care models

Evaluation strategy
for new care model vanguards

Our values:
clinical engagement, patient involvement,
local ownership, national support

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Prepared by: Operational Research and Evaluation Unit, NHS England

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Contents

1 Introduction

Vanguards have been established across England as part of the new care models programme (see appendix 1). Evaluation is at the heart of the programme in order to provide robust results and learning that can be rapidly disseminated across the NHS and elsewhere. The new care models programme is complex in its breadth and depth. This calls for an innovative, sophisticated and multi-faceted approach to measurement and evaluation. Furthermore, to be truly effective the results must be properly communicated across the NHS. This document outlines the overall evaluation strategy for the vanguards programme.

2 Background

Vanguards have been established across England as part of the new care models programme. The programme is central to implementing the Five Year Forward View, alongside programmes such as self-care and integrated personal commissioning. Furthermore, the programme links with other transformation work across the NHS such as the clinical commissioning group improvement and assessment framework (CCG IAF) and transformation and sustainability plans (STPs).

In January 2015, the NHS invited individual organisations and partnerships to apply to become vanguards.

In March 2015, the first group of 29 vanguards were chosen. There were three vanguard types - integrated primary and acute care systems (PACS); enhanced health in care homes (EHC); and, multispecialty community providers (MCP).

Integrated primary and acute care systems will join up GP, hospital, community and mental health services, whilst multispecialty community providers will move specialist care out of hospitals into the community. Enhanced health in care home vanguards will offer older people better joined up health, care and rehabilitation services.

In late July 2015, eight additional vanguards were announced. Urgent and emergency care (UEC) vanguards will develop new approaches to improve the coordination of services and reduce pressure on A&E departments. A further 13 vanguards were announced in September 2015 - known as acute care collaborations (ACC), they aim to link hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency.

All 50 vanguards were selected following a rigorous process, involving workshops and the engagement of key partners and patient representative groups.

Evaluation of these vanguards is at the heart of the programme: the widespread adoption of new models of care that improve the health and wellbeing of patients; the quality and equality of care that patients receive; and the efficiency of the overall system. The evaluation, therefore, needs to provide information about the improvements in outcomes that the new care models are making in each vanguard, and of the cost-effectiveness of changes made. Furthermore, information needs to be available quickly to facilitate learning and improvement. This information also needs to be comparable with findings from other programmes to avoid contradictions. The evaluation also needs to help us understand how and why these impacts are arising so that the learning about what works, and what does not work, can be shared rapidly among the vanguards and spread throughout the NHS. The new care models programme is complex in its breadth and depth. It also combines experimental discovery with standardisation. This calls for an innovative, sophisticated and multi-faceted approach to measurement and evaluation.

Evaluation of the vanguards will support the delivery of the new care model locally and help us develop nationally replicable and scalable models. It is critical to answering the following questions:

- What is the context (e.g. history, culture, relationships, health inequalities, local and national policies, national legislation) in each vanguard into which new care models have been implemented?
- What key changes have the vanguards made and who is being affected by them? How have these changes been implemented?
- What is the change in resource use and cost for the specific interventions that encompass the new care models programme locally?
- How are vanguards performing against their expectations and how can the care model be improved?
- What impact are the vanguards having on patient outcomes and experience, the health of the local population and the way in which resources are used in the local health system?
- Which components of the care model are really making a difference?
- What are the 'active ingredients' of a care model? Which aspects, if replicated elsewhere, can be expected to give similar results and what contextual factors are prerequisites for success?
- What are the unintended costs and consequences (positive or negative) associated with the new models of care on the local health economy and beyond?

Our approach to evaluation, set out in this paper, has been developed through discussions with national evaluation experts (who are now part of an ongoing new care models evaluation strategy group), vanguards and their evaluation partners. It has been shared and tested with stakeholders - including through direct discussion with vanguards, at NHS Expo 2015 and at a Nuffield Trust expert conference on evaluation of complex care programmes. It has also been discussed and approved by the new care models programme evaluation oversight group.

As set out in the new care models programme national support package (published in July 2015), the new care models team is providing vanguards with support for evaluation and metrics through:

- Supporting the vanguards to implement well-designed care models, based on sound logic and evidence;
- Supporting rapid learning through feedback and the sharing of learning and emerging evidence;
- Identifying the impacts on health and care outcomes, efficiency, and wider effects which are attributable to the care model in each vanguard;
- Understanding the key interventions that each vanguard has introduced, how these were designed and implemented, and how these contributed to outcomes and impacts;
- Identifying the key ingredients of success for each of the five care models. These will include the interventions themselves, the local context, and the process by which change occurred. This aspect of the evaluation is vital for national replication.

The draft evaluation strategy, discussed with vanguards in October 2015, covered multispecialty community provider, integrated primary and acute care system and enhanced health in care home vanguards. Since then, urgent and emergency care and acute care collaboration vanguards have been announced. The approach to evaluation we have outlined here will also apply to any work we undertake with these newer vanguards.

3 Approach to evaluation

Figure 1 illustrates how the evaluation supports the overall aims of the new care models programme in terms of understanding the costs and benefits of the care models, and the context and changes needed for replication of the models elsewhere.

The new care models being implemented by the vanguards are a mix of complex and interacting interventions and the models are being introduced in an environment in which other changes are taking place. This presents challenges for evaluation, on top of the practical and methodological difficulties that any successful evaluation must overcome. Therefore, the evaluation must take account of the influence of other policies, such as the CCG IAF and STPs. Furthermore, we will not be prescriptive about the methodology that should be used, which allows for proportional approaches to be applied and innovation in methodology where appropriate.

Early evaluation activity will be focused on laying the foundations for robust evaluation through the promotion of well-designed models. We are supporting vanguards with development of their logic models (theories of change), which will provide a basis for developing local process and outcome evaluation metrics which are linked together through causality. We are also working with partners to promote learning from the current evidence on the key interventions used, for example risk stratification (the process of classifying patient populations into high risk and low risk groups) and what methods or tools are appropriate to implement these interventions.

The impact of the vanguards on health and wellbeing, care and quality, and efficiency is being evaluated nationally using a set of around six high level outcome indicators for each care model type. We will also be looking at a small set of common national "enabler" metrics showing progress towards the core components (such as multidisciplinary teams, integrated care records, and whole population budget). We will report quarterly to the vanguards against the national metrics showing change against a counterfactual (what would have happened in the absence of the vanguard). Cost effectiveness will also be examined (e.g. by undertaking economic analysis of total cost across a patient pathway).

In addition, to allow replication of vanguards we need a detailed understanding of what accounts for their results. This means understanding the local context (relationships, culture and history), what each of them is doing, and how they are doing it. The new care models programme evaluation team needs to draw on the knowledge and intelligence of local vanguards and evaluators working within these vanguards, to build this understanding. As a result, our evaluation approach will involve close working with vanguards, and their local evaluation partners. We are providing vanguards with guidance on the approach to local evaluation.

Evaluation is needed across the lifecycle of the programme as shown in Figure 2.

Figure 1: Evaluation to support the aims of the programme

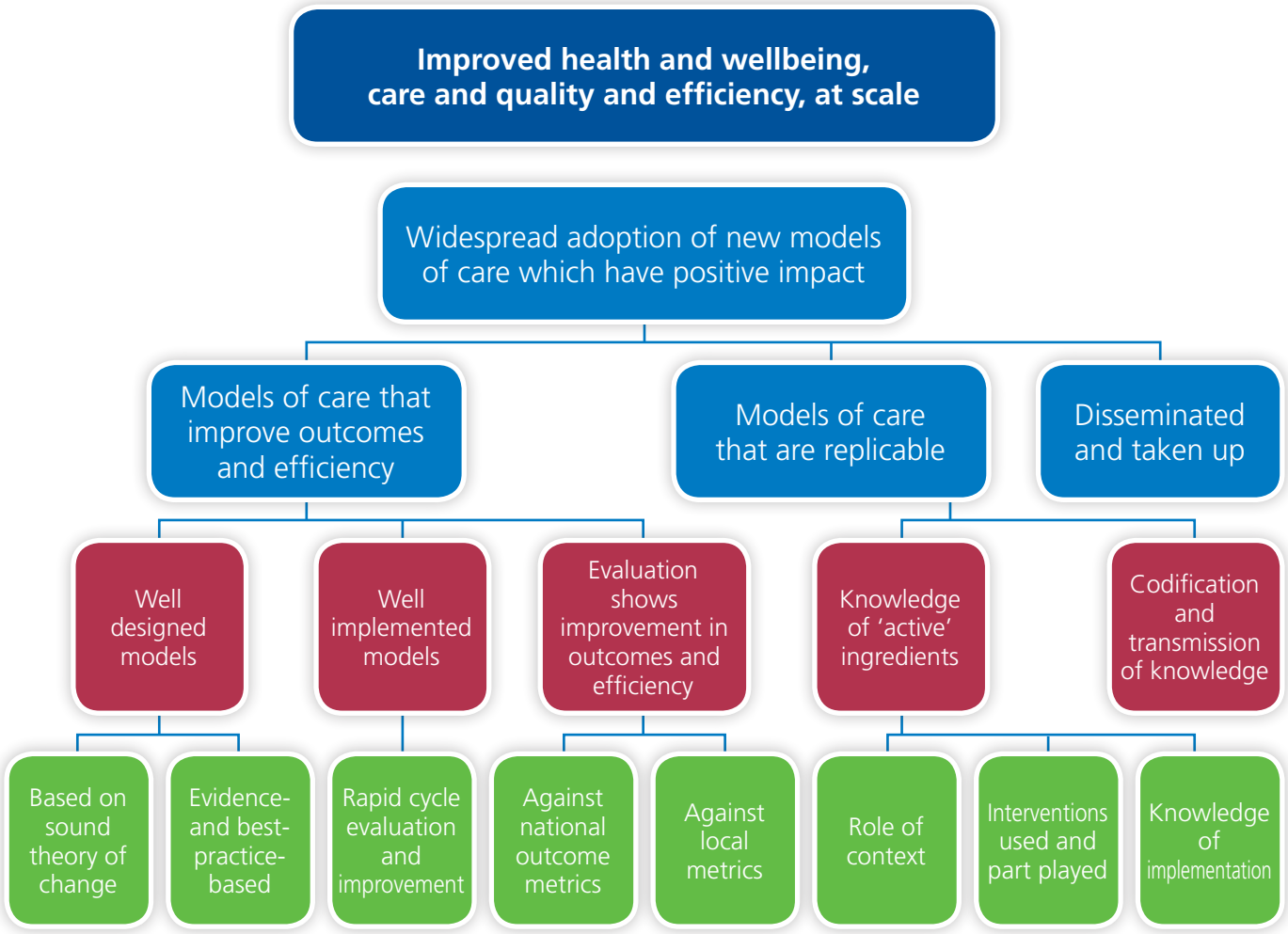
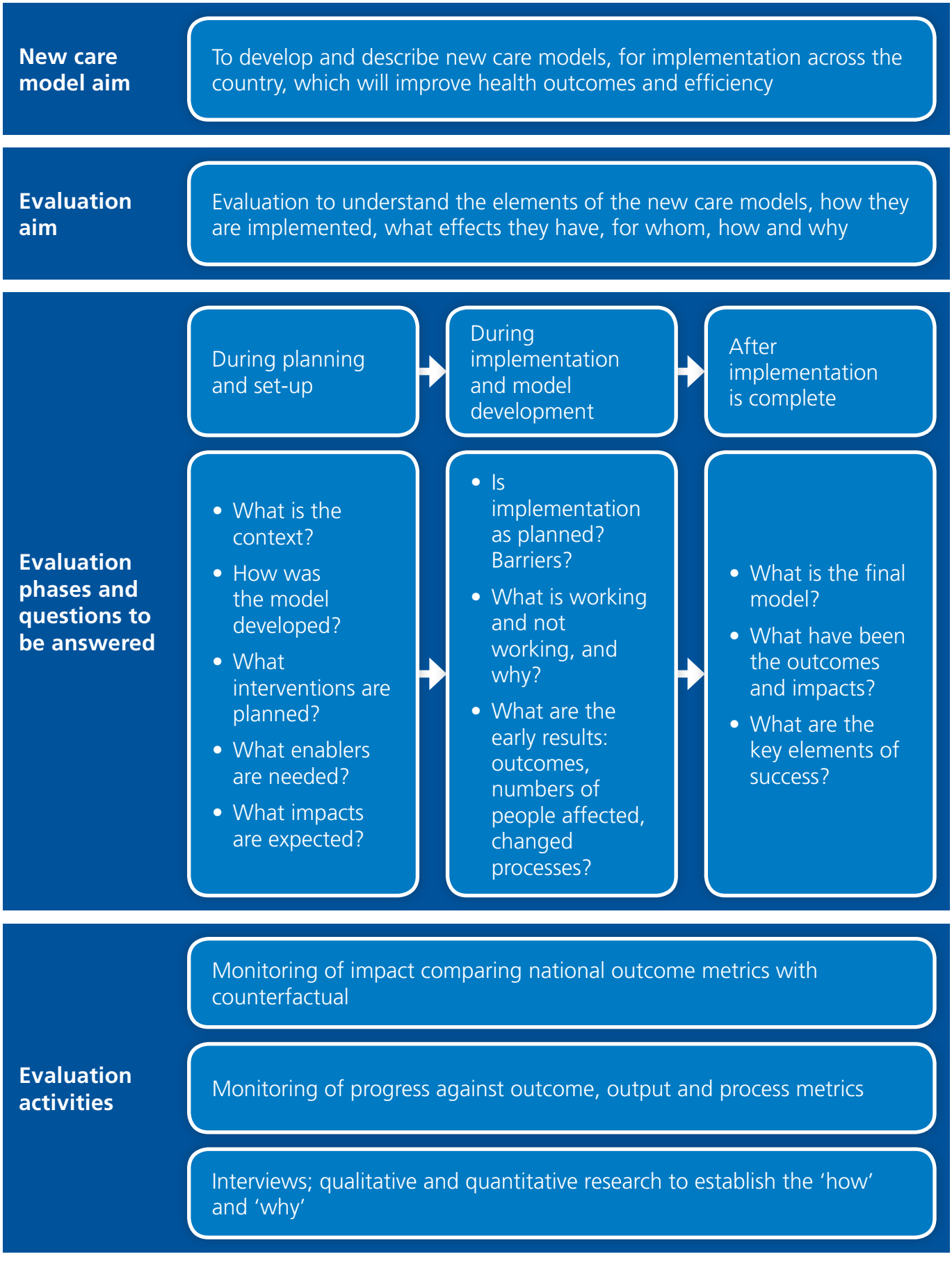


Figure 2: Evaluation needed across the lifecycle



4 Foundations of evaluation

The foundations of evaluation are well-designed care models – models that are designed around logic models and an understanding of the evidence about the effectiveness of the interventions and changes planned.

4.1 Development of logic models

- Logic models (also known as impact or conceptual models) originate from the field of programme evaluation, and are typically diagrams or flow charts that convey relationships between contextual factors, inputs, processes and outcomes. They are designed to read from left to right illustrating pathways between inputs, strategies, outputs, and short-term, intermediate and longer-term outcomes. Logic models can provide a visual means of examining complex chains of reasoning and can be valuable in providing a 'roadmap' to illustrate influential relationships and components between inputs and outcomes. Previous experience from other large-scale programmes (such as the integrated care pioneers and Better Care Fund) suggests that having a clear logic model is one of the active ingredients for successful change.
- Logic models are also a planning tool. They can help to clarify thinking and reduce the scope for programme failure as a result of poor design and untested assumptions. Helping vanguards to develop logic models at this early stage will therefore help provide a basis for evaluation and programme development/improvement. The potential value of logic models will only be unlocked if key stakeholders use them as a programme management tool.
- These logic models will also provide a basis from which to create a coherent narrative in the business cases for 2016/17 and eventually enable vanguards to start thinking about key challenges such as outcomes-based commissioning, risk-sharing or risk-gaining and accountability of health and social care within the vanguard. We do not expect these logic models to be static, but to evolve from the initial version produced by vanguards in March 2016.

4.2 Understanding the evidence

- Initial vanguard visits and subsequent discussions have highlighted the breadth of interventions and the variation in the use of evidence to support these. A key enabler for both selecting the correct interventions, and developing the most effective approach to implementing these interventions, is ready access to the most up-to-date evidence.
- The new care models programme team is working with South East Clinical Support Unit to produce evidence summaries which will be used to support the development of the vanguards. The first of these will be produced by summer 2016. The evidence summary topics are being co-developed with the vanguards.

5 Metrics for multispecialty community provider, integrated primary and acute care system and enhanced health in care home vanguards

As part of the new care models programme support package we outlined an initial suite of national core metrics for each of the first three care models (enhanced health in care homes, integrated primary and acute care systems and multispecialty community providers) in October 2015. An updated set of metrics for these models was outlined in March 2016 (see appendix 2).

This set of metrics will be further expanded with the addition of enabler metrics that demonstrate how vanguards are progressing with implementing their models of care, such as single, integrated, shared, electronic care records.

This small set of national core metrics will be one of the pillars of the national evaluation. These metrics will help us draw conclusions about the impact of the totality of each vanguard's programme, and progress with implementing the enablers of the new care models. The aim is to report quarterly to vanguards on their progress against these metrics, with the report being issued as soon as possible after the reporting period. This information will facilitate rapid learning and improvement.

Alongside these national core metrics we will monitor and report on a broader set of metrics. These are local metrics chosen by vanguards and linked to their logic models (including output measures such as the number of patients affected), and bespoke analyses (e.g. the effect of interventions on specific patient cohorts and economic analysis of total cost across patient pathways).

After the intensive logic model support has been provided, we envisage vanguards being able to select a set of local metrics which will be specific to the vanguard and which ideally will relate to high value conditions and/or subsequent interventions through which progress can be tracked. We would like evaluators in vanguards to work with their programmes to define these local metrics and use them as part of the overall evaluation intelligence that is fed back to the new care models programme team to help in part with future review of the progress that the vanguard is making.

Where feasible, metrics should be aligned with those used elsewhere, such as the CCG IAF.

6 Metrics for urgent and emergency care and acute care collaboration vanguards

- In July 2015, eight urgent and emergency care vanguards were announced; in September 2015 a further 13 vanguards known as acute care collaborations were announced. Like other vanguards, they will be required to establish a set of core metrics.
- The Keogh review team is currently working with the urgent and emergency care vanguards to develop and test a suite of whole system outcome metrics.
- The acute care collaboration vanguards will also be encouraged to develop their own metrics based on their logic models. We will review these logic models and assess whether there are any suitable common outcome metrics.

7 Dashboard

The new care models programme team will report to vanguards on the national metrics quarterly, through a dashboard, based on data from routine national collections and from data gathered from vanguards where there are no or inadequate national metrics.

We issued the first version of the dashboard for multispecialty community provider, integrated primary and acute care system and enhanced health in care homes vanguards with data for two indicators – emergency admissions and bed-days – in October 2015. An updated version was released in November 2015. We will improve and extend this dashboard as a result of work to improve data accuracy and comments received.

Urgent and emergency care and acute care collaboration vanguard metrics will be added to the dashboard subject to review of logic models and agreement.

8 Understanding what is causing change

If evaluation is to support replication of successful care models it needs to provide information about why and how impacts are being achieved as well as about the impacts themselves. This sort of information is best collected locally.

8.1 Local evaluation

Local evaluation will provide another core pillar of the evaluation, and will need to be carefully designed in order to:

- Capture and evaluate the transformation changes delivered by the vanguards appropriately. Alongside knowing whether things have changed (through outcome metrics), it is important we understand how, and in what context, the changes have occurred.
- Understand the 'reach' of the vanguard locally. With this in mind, it is important to include output data such as the number of patients affected by changes made.
- Feed the information gathered into ongoing, on-the-ground delivery, so that services are continually improved.
- Share the learning gathered between the vanguards and more widely, to promote replicability and scale up. Doing so will also help to ensure that we tackle any barriers/issues collectively, for the benefit of the whole.
- Embed a culture of evaluation and knowledge sharing within the vanguard.

We have co-produced a local evaluation guidance document with the vanguards and subject matter experts. The guidance sets out how we will support the vanguards to undertake a local evaluation, a set of principles that should shape these evaluations and how the evidence generated through local evaluations should inform the national picture. It includes our plans to assure the quality of the data collected locally, so that it is robust, consistent and transferrable. It also sets out that local evaluations should utilise a mixed-methods and theory-driven approach; that they should examine the delivery, impact and change in resource use and costs locally; and, that patients and service users should contribute to the design and delivery of evaluations.

Intelligence from vanguards will be essential to the national evaluation to help us understand the 'active ingredients' that enable success, scale and replicability in each vanguard. We will therefore work closely with local evaluators to gather intelligence in a structured way and to define quality standards. We will contribute significant resource to each vanguard to help with local evaluation.

8.2 Independent programme evaluation

We plan to commission an independent evaluation of the process and summative programme. This will focus on the impacts of the programme (broadly defined) as well as the processes by which the programme was delivered; it will take place between years two and five.

We expect to assess the outcomes and unintended consequences of the new care models through the use of a mixed-methods approach. This study is also likely to assess the processes used to design and manage the programme. **The roles of the independent research team will be to:**

- Advise us on the design of the various evaluation activities and research so we get the most out of the resources invested.
- Undertake additional research with vanguards and the new care models programme team from an independent viewpoint. For example, although local evaluators will provide a constant stream of information, an independent evaluation team could take a more strategic view of what the vanguard is doing, obtained through visits and interviews.
- Synthesise the data and intelligence from national monitoring, and from local monitoring and evaluation, to interpret these and to draw conclusions. We believe it would be useful to have independent evaluation reports produced annually throughout the programme. These will provide input to new care models policy and design.

8.3 Health Data Lab

Our evaluation strategy includes a commitment to use a Health Data Lab which is being developed with the Health Foundation to strengthen our capability to measure the impact of NHS transformation programmes. The Health Data Lab will provide selected vanguards with the capability to rapidly evaluate the impact of specific interventions.

To do this the Health Data Lab will compare results in the areas or population groups affected by an intervention with the results that there would have been had there been no change – the so-called counterfactual. It will use a range of sophisticated approaches to establishing counterfactuals, including constructing matched controls, through access to national data.

The Health Data Lab will play an important role in the development of the new care models by improving the evidence base on the extent that interventions are achieving their aims. By providing regular information to sites participating, the Health Data Lab will enable these sites to adapt their approaches over time.

9 Communication – dissemination of findings and networking

We have established close working links with the new care models programme team and wider stakeholder groups, and will look to these groups to use the information provided by the evaluation to support transformation and improvement across the NHS. A key component of this will be for us (and those we commission) to provide information in a format and timescale that meets their requirements without compromising the validity of the results.

10 Oversight

Delivery is overseen by a new care models programme evaluation oversight group. The role of this group is to:

- Advise on the national and local evaluation strategies.
- Monitor delivery of the elements of the evaluation (e.g. production of logic models, metrics and national dashboard).
- Ensure risks to delivering a robust and timely evaluation are identified and managed.
- Make recommendations about the national support that vanguards need on measurement and evaluation.
- Advise on emerging issues and how to deal with them.

We will convene working groups involving the vanguards and subject matter experts to focus on areas which pose common challenges, or where there is benefit from standardisation. These groups will develop and recommend approaches and solutions which can be adopted by other vanguards. We have already used working groups to help us with the measurement of patient experience and the approach to local evaluation.

11 Timeline

October 2015

- First draft of evaluation strategy published
- Initial core metrics set published
- First version of vanguard dashboard published

November 2015

- Updated version of vanguard dashboard published

December 2015

- First draft of local evaluation strategy published

March 2016

- Logic model provided by each vanguard
- Updated set of core metrics outlined

April 2016

- Vanguards monitored against core metrics

May 2016 onward

- First evidence summary produced
- Commissioning of programme evaluation
- Updated version of the evaluation strategy published

12 Contact

For further information, please email the operational research and evaluation team via England.ORET@nhs.net

13 Appendix 1: Map of vanguards

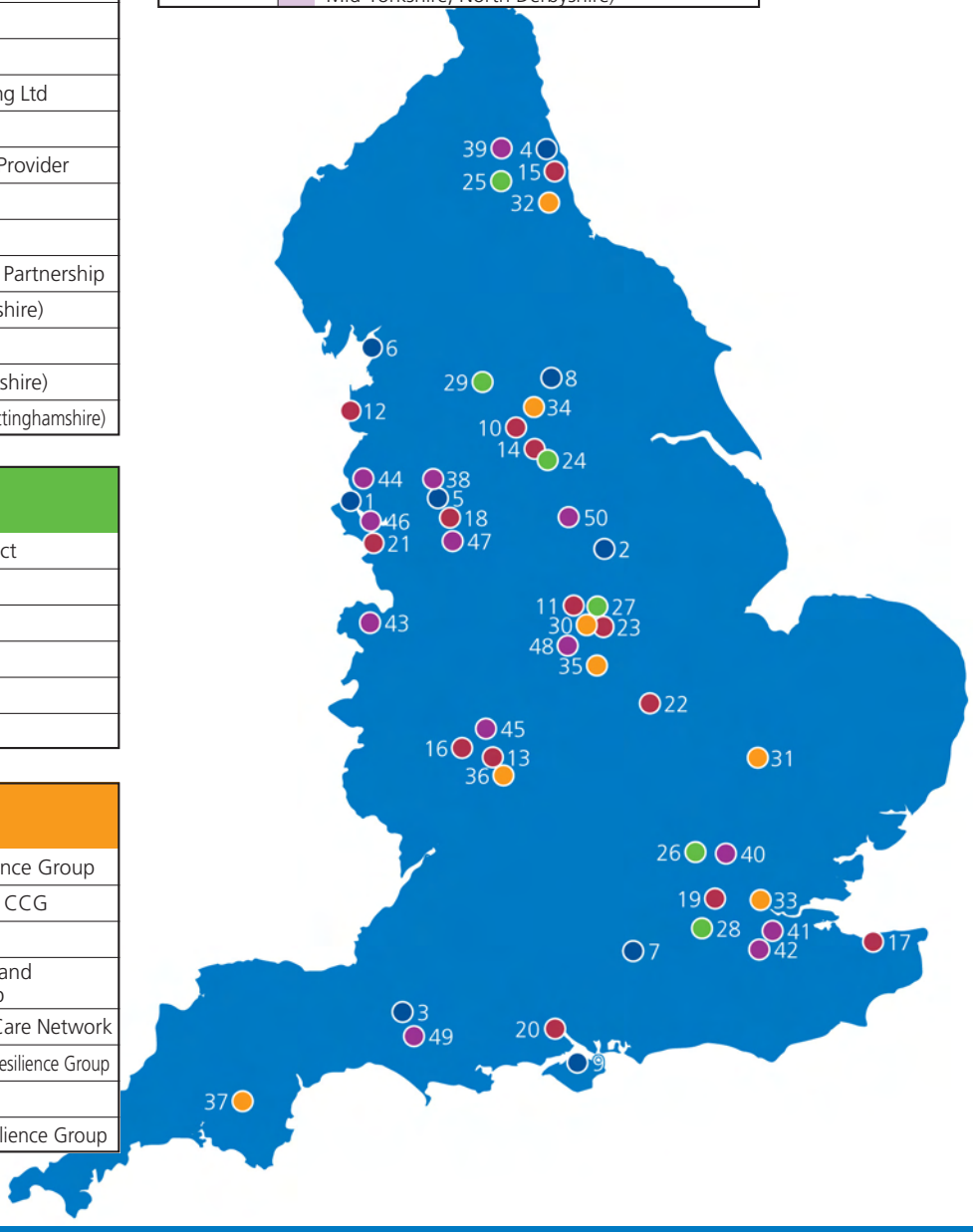
Care model		Applicant
PACS	1	Wirral Partners
PACS	2	Mid Nottinghamshire Better Together
PACS	3	South Somerset Symphony Programme
PACS	4	Northumberland Vanguard
PACS	5	Salford Together
PACS	6	Better Care Together (Morecambe Bay Health Community)
PACS	7	North East Hampshire and Farnham
PACS	8	Harrogate & Rural District CCG
PACS	9	My Life a Full Life (Isle of Wight)

Care model		Applicant
MCP	10	Calderdale Health & Social Care Economy
MCP	11	Wellbeing Erewash
MCP	12	Fylde Coast Vanguard
MCP	13	Modality (Birmingham & Sandwell)
MCP	14	West Wakefield Health and Wellbeing Ltd
MCP	15	All Together Better Sunderland
MCP	16	Dudley Multispecialty Community Provider
MCP	17	Whitstable Medical Practice
MCP	18	Stockport Together
MCP	19	Tower Hamlets Integrated Provider Partnership
MCP	20	Better Local Care (Southern Hampshire)
MCP	21	West Cheshire Way
MCP	22	Lakeside Healthcare (Northamptonshire)
MCP	23	Principia Partners in Health (Southern Nottinghamshire)

Care model		Applicant
Care Homes	24	Connecting Care - Wakefield District
Care Homes	25	Gateshead Care Home Project
Care Homes	26	East and North Hertfordshire CCG
Care Homes	27	Nottingham City CCG
Care Homes	28	Sutton Homes of Care
Care Homes	29	Airedale & Partners

Care model		Applicant
UEC	30	Greater Nottingham System Resilience Group
UEC	31	Cambridgeshire and Peterborough CCG
UEC	32	North East Urgent Care Network
UEC	33	Barking and Dagenham, Havering and Redbridge System Resilience Group
UEC	34	West Yorkshire Urgent Emergency Care Network
UEC	35	Leicester, Leicestershire & Rutland System Resilience Group
UEC	36	Solihull Together *for better lives*
UEC	37	South Devon and Torbay System Resilience Group

Care model		Applicant
ACC	38	Salford and Wigan Foundation Chain
ACC	39	Northumbria Foundation Group
ACC	40	Royal Free London
ACC	41	Foundation Healthcare Group (Dartford and Gravesham)
ACC	42	Moorfields Eye Hospital NHS Foundation Trust
ACC	43	National Orthopaedic Alliance
ACC	44	The Neuro Network (The Walton Centre, Liverpool)
ACC	45	MERIT (Mental Health Alliance for Excellence, Resilience, Innovation and Training) (West Midlands)
ACC	46	Cheshire and Merseyside Women's and Children's Services
ACC	47	Accountable Clinical Network for Cancer (ACNC)
ACC	48	East Midlands Radiology Consortium (EMRAD)
ACC	49	Developing One NHS in Dorset
ACC	50	Working Together Partnership (South Yorkshire, Mid Yorkshire, North Derbyshire)



14 Appendix 2:
Core metrics document

New care models evaluation: Core metrics

Release version: 4.0.0
Release date: 26 May 2016

Introduction

We are developing sets of core metrics to track these impacts as soon after they occur as possible, to facilitate rapid learning and improvement. There will be around six core metrics for each care model type corresponding to the three challenges set out in the Five Year Forward View: Care and quality; health and wellbeing; and finance and efficiency.

Efficiency metrics

All new care model vanguards are ultimately looking, as part of their drive to improve efficiency, to reduce hospital emergency admissions and to shift care from hospitals to the community, so we will use the following two metrics:

- Emergency admissions derived from secondary user service (SUS)/hospital episode statistic (HES) data.
- Total beddays, derived from SUS/HES data. As for emergency admissions we will also look at the rate per head of registered population.

Population figures are taken from Health and Social Care Information Centre (HSCIC) at the beginning of the quarter i.e. 2015 Q3 (October to December 2015) is taken from October 2015 extract to give the most accurate snapshot of population figures in this moment of time.

Care and quality metrics

The following metrics are included:

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

For both the above metrics, we have taken the number of responders where their GP or nurse was 'very good' or 'good' at involving them in decisions about their care and displayed this as a percentage of total responders for whom this applies.

- Care plan (Q37). We have calculated the number of responders who did help put their written care plan together and displayed it as a percentage of the total responders who have a written care plan.

Health and wellbeing metrics

The following metric is taken from the GP Patient Survey:

- Quality of life (Q34). We have calculated and displayed the average of the EQ5D score.