Lessons from the vanguards for rapid evaluation

Advancing rapid evaluation: challenges and opportunities

Nuffield Trust | 29 January 2019

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Origins of the new care models

The NHS will take decisive steps to **break down the barriers in how care is provided** between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally.

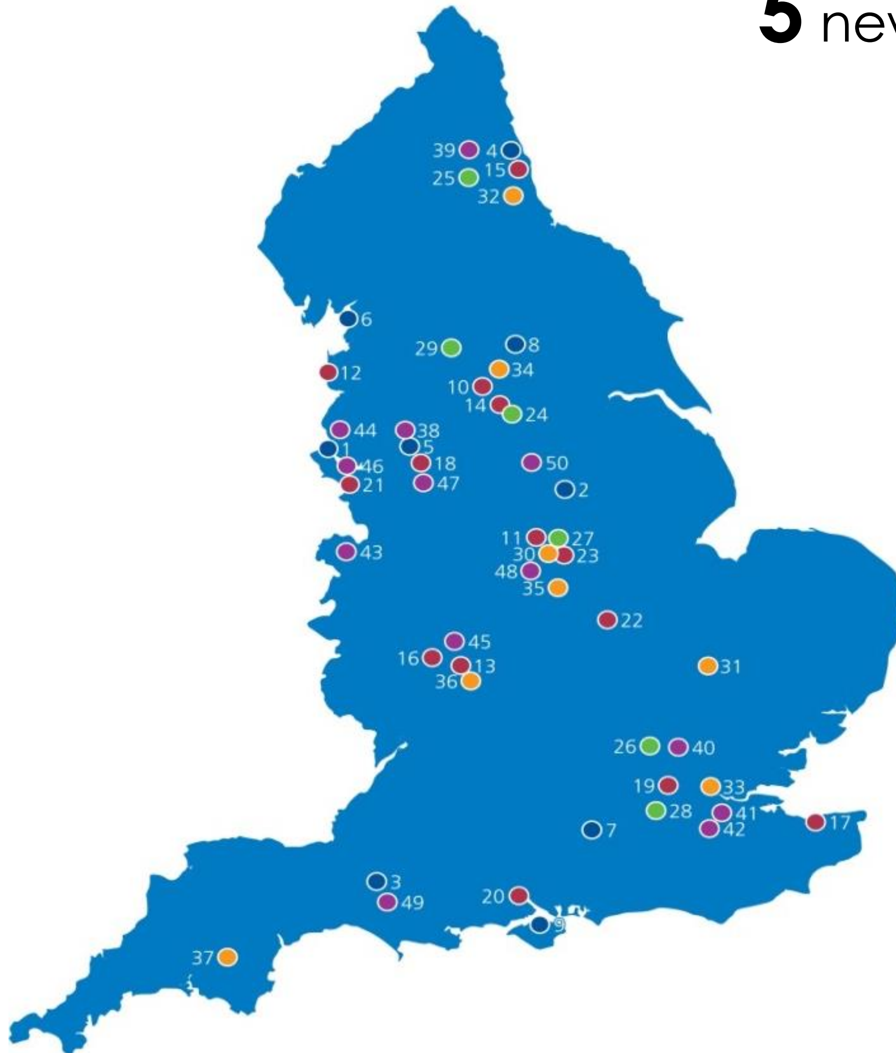
England is too diverse for a 'one size fits all' care model to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'. Different local health economies will instead be supported by the NHS national leadership to **choose from amongst a small number of radical new care delivery options**."

The new care models vanguards

During 2015, vanguards were selected to develop these new models. Vanguards were given national support to accelerate change, assess progress and demonstrate proof of concept.

"The purpose of becoming an initial site is not simply to address local needs, but to become a successful prototype that can be adapted elsewhere, designed from the outset to be replicated by subsequent cohorts."

“arguably the largest project on national health care delivery redesign in history”
Don Berwick



5 new care models in **50** vanguards:

9	Integrated primary and acute care systems
14	Multispecialty community providers
6	Enhanced health in care homes
8	Urgent and emergency care
13	Acute care collaboration

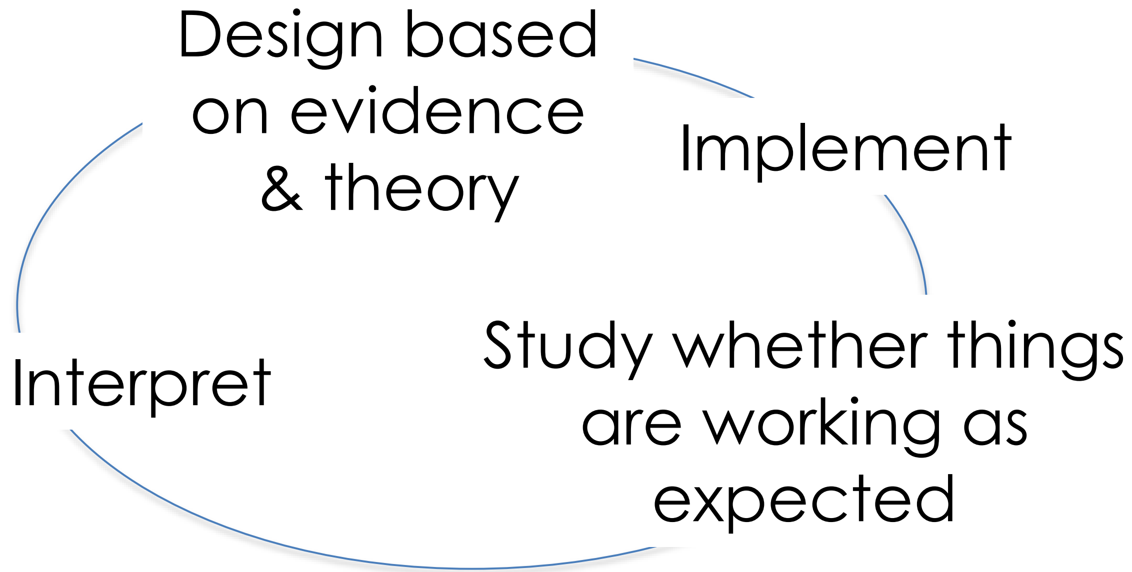
The aims of the programme called for a rapid approach to evaluation

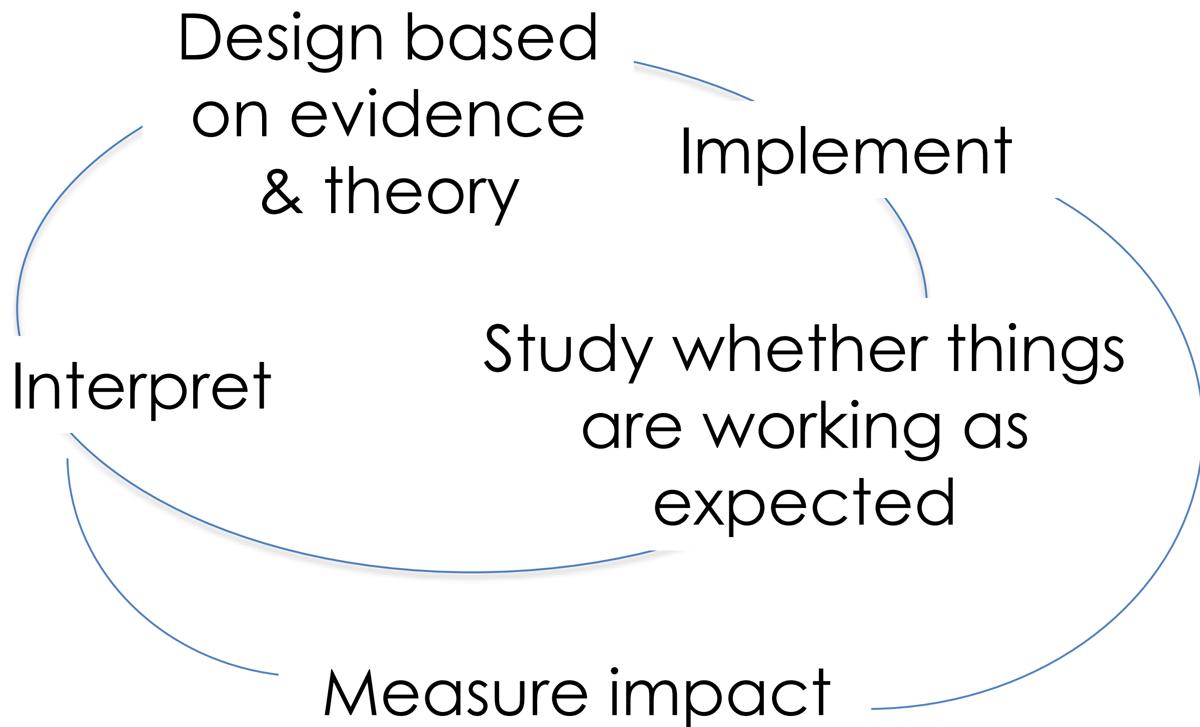
Evaluation is at the heart of the new care models programme.

The programme combines experimental discovery with standardisation. This calls for an innovative, sophisticated and multi-faced approach to measurement and evaluation.

Information needs to be available quickly to facilitate learning and improvement.

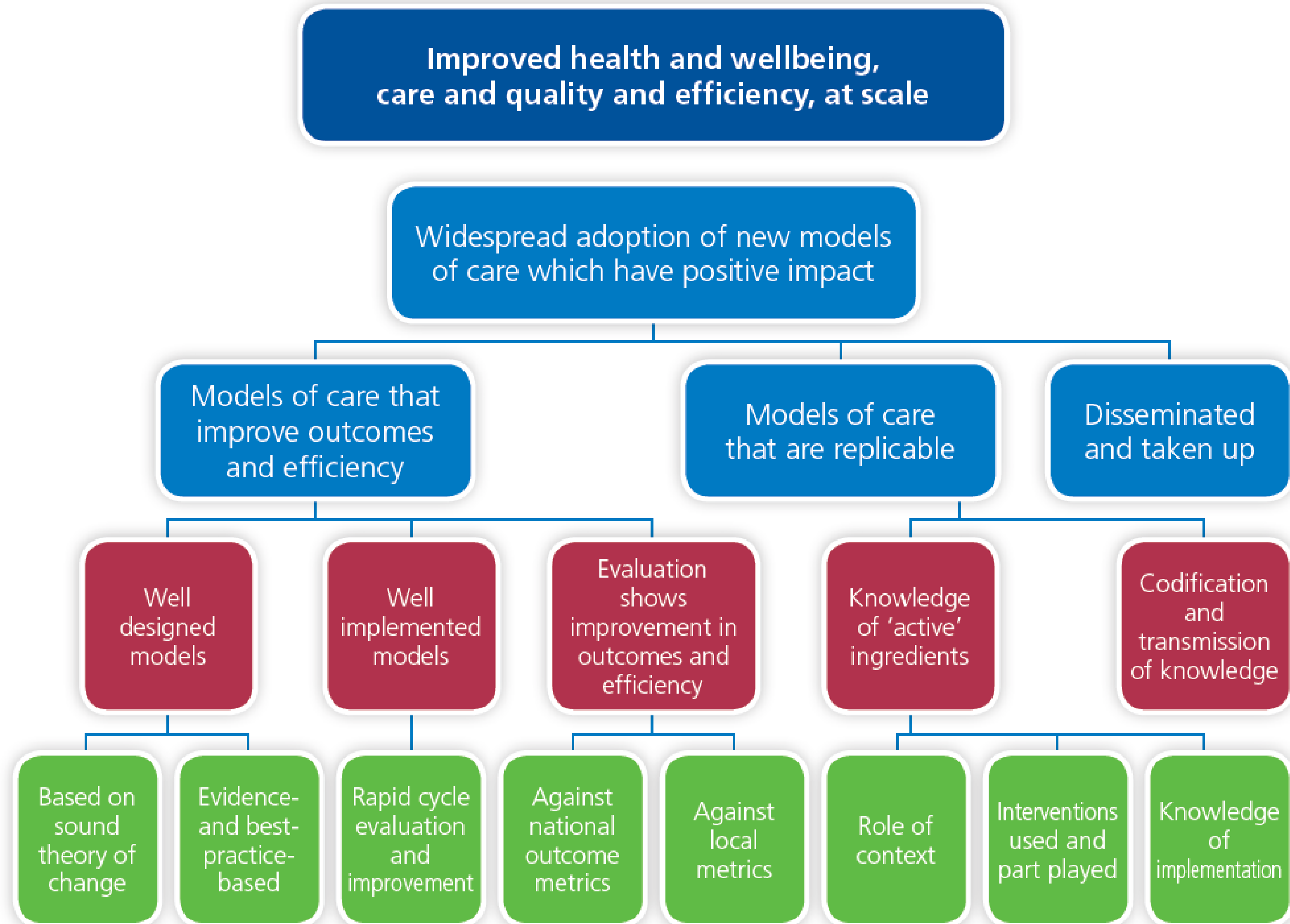
Information needs to be comparable with findings from other programmes to avoid contradictions.


Design based
on evidence
& theory
Implement
Study whether things
are working as
expected
Interpret


Design based on evidence & theory
Implement
Study whether things are working as expected
Interpret
Measure impact

Evaluation design

Figure 1: Evaluation to support the aims of the programme



Independent evaluation

- Longer term
- Summative, including cost effectiveness
- National programme
- Four years, starting in year two

National evaluation

- Design and management
- National outcome metrics analysed
- Quarterly dashboard for vanguards
- Thematic reviews (eg risk strat) shared with national team and vanguards
- Synthesis of metrics and findings from vanguard evaluations
- National reports (soon!)

Vanguard evaluations

- Commissioned by vanguards
- Logic models
- Quarterly metric data submitted to national team
- Evaluation findings discussed locally and reports submitted to national team`

Facts and figures about vanguard evaluations

40 evaluations

400 local metrics submitted quarterly

200+ evaluation reports

600+ evaluation findings

How rapid evaluation results were used

North East Hants and Farnham – half yearly evaluation symposiums with leaders, clinicians, patient reps, presenting and discussing emerging findings.

Morecambe Bay similar with different format.

Many vanguards published reports locally e.g. Sutton; Dudley; NEHF.

All vanguards fed back results to senior staff through the programme's quarterly review process.

Did rapid evaluation make a difference?

Northumberland: Use of pharmacists in the acute home visiting service was stopped – no impacts on GP appointments or A&E activity, and patients preferred GP visits. Pharmacists within enhanced care teams, and newly qualified pharmacists within primary care were rolled-out following evaluation evidence.

Mid Notts: The evaluation for 'Call for care' indicated that approximately 30% of callers required some form of social care input so from March 2017 Call for care staff were co-located with the adult social care team one day a week.

Connected Care: The Single Point of Access clinical contact centre was discontinued following evaluation evidence.

Dudley: the Sense.ly 'self assessment' kiosk in GP clinics was discontinued due to slow uptake and not saving GP time.

National programme informed by feedback from national evaluation tam e.g. metrics on throughput, synthesised findings from local evaluations. Shaped thinking on health coaching and PAM.

Conclusion 1: impact evaluation

Quality of evidence on impact was poor

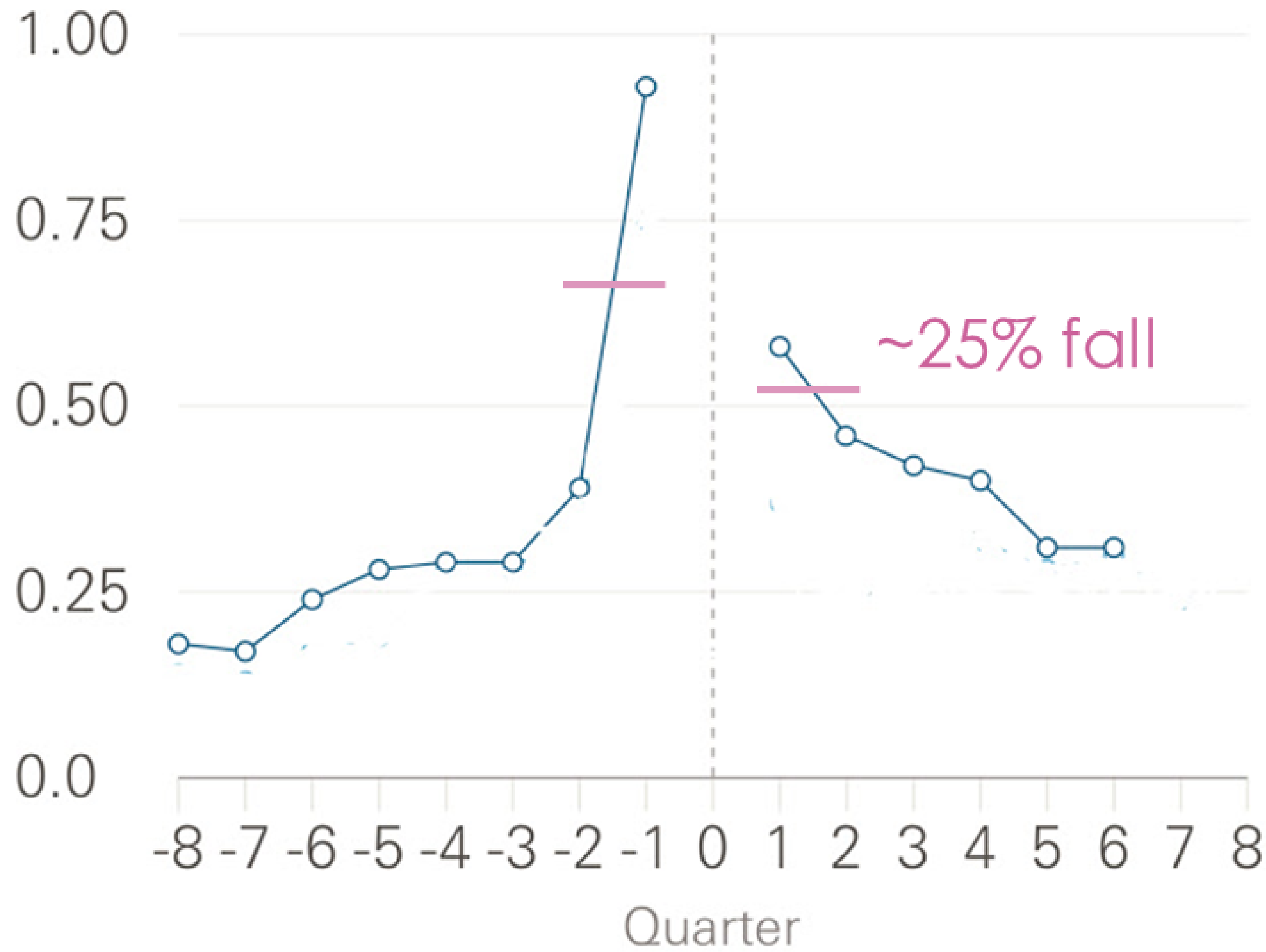
Most study designs flawed

Specialist expertise need

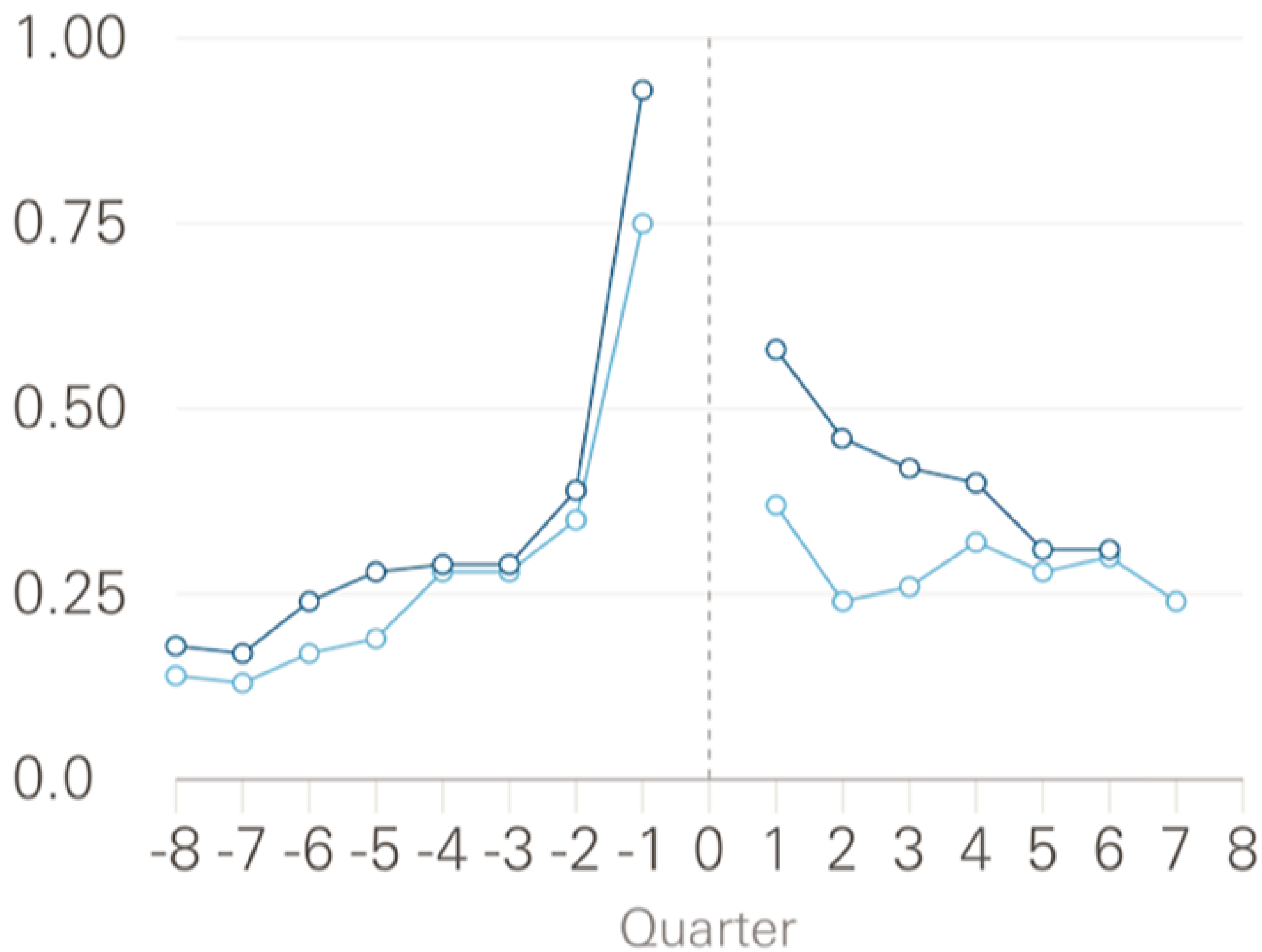
Robust studies came out too late to influence early cycles

Unless culture is right, can be the source of contention

Introduction of multidisciplinary team reduces emergency admissions by 25%



Emergency admissions
1.00
0.75
0.50
0.25
0.0
~25% fall
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7 8
Quarter


ICT patients
Matched control patients
Emergency admissions
1.00
0.75
0.50
0.25
0.0
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7 8
Quarter

Conclusion 2: data

Over reliance on hospital utilisation data

Getting access to data led to delay

Patient experience data: variety of approaches to questions, how data collected and analysis

Conclusion 3: capability and culture

Most successful when the vanguard culture was open and non-defensive

Most successful when evaluators combined consultancy skills, knowledge of evaluation and data

Overall

Rapid evaluation did inform implementation within the vanguards

But programme didn't produce replicable care models

- 1000 flowers
- Inability to identify role of interventions and context

Was this possible given programme design?