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Executive Summary

West Wakefield Health & Wellbeing (WWHW), a federation of six GP practices, piloted the Multi-speciality Community Provider (MCP) model in GP practices in the West of Wakefield to test and deliver different models of care.

The model has included the development of services such as:

- Care Navigation: helping local people to access the care they need by ‘Care Navigators’ based in GP practices. These are mostly support and administrative staff who have the first contact with patients when they come into or call the surgery and who are trained to support patient choice through clear access criteria that has been developed and clinically signed off.

- Physio First: this allows patients to get a direct appointment with a Physiotherapist for an initial assessment without having to see the GP first.

- Pharmacists in General Practice: pharmacists who deliver medicine-related services, including medication reviews.

- Extended operating hours for GP services.

In order to assess the successes and challenges of the West Wakefield MCP Vanguard services, the qualitative evaluation aimed specifically to:

- Explore what key changes the Vanguard services have made to the day-to-day work life in individual practices;

- Map which components of the care model are really perceived to make a difference, why, how and to whom;

- Explore some of the unintended costs and consequences (positive or negative) associated with the new care model;

- Measure the impact the Vanguard model has had on patient experience within primary care.

NECS had previously been working with WWHW in developing metrics and dashboards for the New Care Model. Information is collated in this report with regard to lengths of stay, admissions and A&E attendances, Walk in Centre attendance rates and referral counts. A comprehensive picture can be built using information contained in this report alongside the suite of dashboards developed by WWHW. The overall picture indicates admissions for over 75s and A&E attendances have both shown a slight increase, whilst there has been quite a marked decrease in Walk in Centre attendances; this needs to be considered alongside national trends. The picture for referrals however is quite mixed and varies by specialty and network.
In-depth, semi-structured interviews were conducted with 23 individuals across 9 primary care practices spanning networks 6, 5, and 3 of the West Wakefield Vanguard practices. 720 patient surveys were collected during the course of 66 visits to 16 GP practices by Healthwatch Wakefield.

In addition, an evaluation was undertaken on the costs and effects (outcomes) of the HealthPod (‘real’ and ‘virtual’) and to inform the sustainability of the programme (Return on Investment).

The HealthPod was a pop-up primary care facility which offered health checks, wellbeing advice and assessments such as cardiovascular disease (CVD) risk, diabetes screening, atrial fibrillation (AF) screening and cholesterol tests in neighbourhood locations such as supermarket car parks. The ‘Real’ HealthPod was an inflatable igloo like structure whereas the ‘Virtual’ HealthPod utilised existing venues. The activities of the HealthPod included screening for various long term conditions such as atrial fibrillation (AF), hypertension and diabetes. The key objective of the HealthPod was to increase access to primary care services usually offered in GP surgeries (e.g. as part of the NHS Health Checks programme). A cost-consequence analysis (CCA) was used to identify the associated costs and outcomes (positive and negative) of the HealthPod.

In conclusion, the qualitative evaluation of staff and patient experience of the Vanguard pilot scheme across West Wakefield identified a number of barriers and facilitators to implementing new services in primary care practices. Many of the Vanguard aims and services were, in principle, welcomed by primary care staff and were seen to have the potential to improve patients’ experience of health care, particularly where timely access to relevant health professionals was concerned. Having physiotherapists and pharmacists in general practices were particularly welcome changes.

In practice, the implementation of Vanguard services encountered a series of challenges – ranging from organisational to political, to emotional. There were found to be a range of barriers to maximum implementation of Vanguard services, including uneven levels of awareness and knowledge of Vanguard and associated services both within and across primary care practices; insufficient training and information flow between commissioners and practice teams; and a reluctance to fully embrace the newly introduced services due to their pilot nature. WWHW noted the additional challenge of delivering change through a system-wide pilot within very short timescales.

Going forward, it is suggested that good and confident care navigation may have the potential to change practice cultures and patient expectations. Staff should be supported as best as possible to become good and confident care navigators. It is also suggested that physiotherapy and pharmacy in primary care should be consolidated, extended and adapted to best fit the purposes of individual practices and practice networks. In addition, GPs should, as best as possible, be acknowledged in their role as family doctors and that care must be taken that the introduction of multi-speciality services does, even unintentionally, translate into the fragmentation of health care.
Importantly, there is a need for NHS England and commissioners to understand the complexities surrounding the aim to save GP hours and some of the unintended adverse consequences the introduction of Vanguard services may have had on this aim.

The original “vision” was that GP hours saved by the initiative would be made available to put into Connecting Care Hubs, but these were not ready to put into GP practices. From the dashboards and the Health Economics evaluation the data suggests there has been some GP time saved, though this is not evident from the way in which services were being delivered as this time was not protected and demand is likely to fill any GP slots made available. Going forward, it is suggested saved time could be used proactively e.g. in the setting up of clinics for patients with long term conditions.

Finally, findings suggest that the implementation of change takes time and that this should be taken into account when designing new services and the aims, which underpin their design and implementation.
Introductions and Background

The New Care Models (NCM) programme is about testing new approaches to care, learning what is working and then spreading these models across the NHS. A central part of this commitment is to support evaluation at a local level. NHS England believes that it is only by evaluating the NCMs in the context within which they are being delivered, and in real depth, that they can truly understand what difference the programme is making for patients, their families, staff and the wider healthcare system. The overall approach for evaluating the NCM programme is multi stranded: local, national and independent evaluation.

“The new care model Vanguards are delivering real change for patients and staff. Working with clinicians and the people who use their services, they are developing a ‘blueprint’ for the future of NHS and care services across England. They’re being led locally, but with national support to help them move forward at pace and to unlock barriers that get in their way.”

Samantha Jones, Former Director – New Care Models Programme

Across England, 50 selected Vanguards have taken a lead on the development of new care models, acting as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system.

As one of 14 Vanguards specifically aiming to implement and provide multi-speciality community-based care, West Wakefield Health and Wellbeing Ltd wanted to identify and address gaps in care and quality; gaps in health and wellbeing; as well as finance and efficiency gaps in primary care across West Wakefield. Attempting to bridge these gaps, a number of MCP Vanguard system components, or products, were initially planned for 17 practices, but this was increased to being introduced in 18 practices across three networks primary care practices across West Wakefield. Specifically, these components include:

- Care Navigation (active signposting)
- Pharmacist in General Practice
- Extended Access
- Physio First
- HealthPod
- Information Hub and Response Centre Connecting Care
- Disruptive Prevention – Schools App Challenge
- Health Champions
- Community Anchors and Micro Commissioning
In addition to West Wakefield Health and Wellbeing Ltd GP practices network the Vanguard partners include:

- NHS Wakefield Clinical Commissioning Group (Practices within Networks 3 and 5 (see Appendix 7 for map of geographical area/s)
- Wakefield Council
- Wakefield District Housing
- South West Yorkshire Partnership NHS Foundation Trust
- Healthwatch Wakefield
- Mid Yorkshire Hospitals NHS Foundation Trust
- NOVA (voluntary community sector representative organisation)
- Novus Health
- Hodgson Physiotherapy Services
- Prescribing Support Services
- Spectrum Community Health
- Yorkshire Ambulance Service
- Local Care Direct

A multi-stream process evaluation has been carried out of the West Wakefield MCP Vanguard. Comprised of West Wakefield Health and Wellbeing Ltd, a formal network of GP practices in West Yorkshire, the Vanguard has been working to provide a larger, more diverse primary care team that delivers services ‘on the ground’.

The Vanguard articulated three hypotheses to test their programme of change;

**Hypothesis 1:** 50% of work done by GPs could be carried out by a more cost effective resource.
To test this hypothesis, the vanguard proposed to implement a combination of measures to extend the primary care team that can be access on site.

**Hypothesis 2:** 30% of elderly people admitted to hospital acutely for a short stay of between 0 and 5 days do not need to be admitted and could be cared for differently in an alternative setting.
To test this hypothesis, the vanguard set up a command, control and communications centre in a Hub with multi-disciplinary teams to pick up early signs of illness and respond proactively.
**Hypothesis 3:** 30% of patients occupying an acute hospital bed do not need to be there because their episode of acute care is over.

Testing the hypothesis that, at any one time, patients over 75 currently occupying an acute bed for a stay greater than 5 days could be discharged sooner with appropriate community / MDT support (intervention.)

These three hypotheses are underpinned by a number of logic models which comprise the metric set which will be used to evaluate the effectiveness of the programme.

Envisaged key benefits of the new care model therefore include;

- Released GP time.
- Patients being helped to access the right care at the right time.
- Increasing the number of ways to access services with the aim to support better self-management of health and wellbeing.
- Sharing information to help reduce hospital admissions and speed up discharge.

West Wakefield Health and Wellbeing Ltd recognises that there is considerable pressure on the local workforce and a high vacancy rate in the local community. Morale is accordingly low, there have been early retirements of GPs and recruitment to fill these positions has been difficult. The practice nurse workforce is experiencing a similar squeeze. GPs find themselves with an increased workload consisting of administration and other non-clinical demands.

In particular, one key aim was to alleviate some of the pressures currently experienced by GPs and key hypothesis of the evaluation was to explore whether GP workload could be decreased by distributing work to more cost effective providers and resources. Although this is not within the scope of this evaluation, there is more data available around this which indicates that the area has a high ratio of GPs:Population.¹

The West Wakefield MCP Vanguard Programme covers the three GP networks known as Network 3, Network 5 and Network 6 covering 165,000 patients in 18 independent GP Practices. Network 6 has formed a GP Federation - West Wakefield Health and Wellbeing Ltd which is the host and lead organisation for the Vanguard Programme. The qualitative evaluation took place across all three networks.

Evaluation Team

North of England Commissioning Support Unit (NECS) was commissioned to lead the multi-method approach to the evaluation with Dr Shona Haining, Head of Research & Evidence, and Ian Nicholson, Head of Clinical Commissioning Intelligence.

This was supplemented by experienced qualitative research from Dr Michaela Fay and health economics from Dr Angela Bate.

This allowed for a multi strand multi method approach to bring together the skills and evidence to answer the evaluation questions.

It was agreed that the patient experience evaluation and the qualitative element commissioned to Healthwatch Wakefield would share findings as the work progressed to bring added value to the evaluation. Nichola Esmond worked closely with the evaluation team throughout the project, hence bringing additional richness and depth to the findings.

Steering Group

A key factor in this evaluation was agreeing the evaluation questions and plans with the West Wakefield (WWHW) MCP Vanguard programme as the programme developed and evolved and as the evidence emerged. This was agreed and monitored by the steering group

This group consisted of:

- Dr Chris Jones, Programme Director, West Wakefield Health and Wellbeing Limited;
- Shajeel Ahmed, Consultant, NECS;
- Kate Brentley, Managing Director, West Wakefield Health and Wellbeing Limited;
- Dr Angela Bate, Health Economist NECS;
- Nichola Esmond, Chief Executive Officer, Healthwatch Wakefield;
- Dr Michaela Fay, Qualitative Researcher NECS;
- Dr Shona Haining, Head of Research and Evidence, NECS;
- Russell Houghton, Business Intelligence, West Wakefield Health and Wellbeing Limited;
- Ian Nicholson, Head of Clinical Commissioning Intelligence, NECS;
- Nicola Thackray, Senior Consultant, NECS;
- Alison Wake, Consultancy Manager, NECS (Chair).
Evaluation Plan

The identification of metrics and associated dashboard work delivered by NECS has provided a good platform for delivering on the key asks of NHS England to:

- Use logic models/hypothesis tree as a starting point;
- Examine the activity, process and outcome metrics which are of most importance locally;
- Consider the causation of any outcomes observed;
- Evaluate the impact of the programme on the resource use locally;
- Use a mixture of qualitative and quantitative approaches in the method;
- Be aware of the information governance, ethical and intellectual property implications of the studies being conducted.

Healthwatch Wakefield was commissioned in October 2016 to conduct an evaluation of the MCP Vanguard from a patient perspective. The evaluation incorporated seven of the MCP Vanguard work streams, comprising both primary care interventions and the integrated care project.

The evaluation aimed to answer the following question from a patient and carer perspective:

*What impact is the Vanguard 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?*

Evaluation of the integrated care work stream of the MCP Vanguard was primarily focused on people’s experiences of receiving care co-ordinated by the Waterton hub, which hosts the Connecting Care team comprising social care, community health and the voluntary sector.

As the Waterton hub had been in operation since 2015 and a comprehensive service user evaluation of Connecting Care had been conducted over the previous two years, the decision was taken to use the patient experience survey commissioned previously by NHS Wakefield CCG and Public Health which would otherwise have come to an end in September 2016. This allowed continuity of experience to be measured at the hub as the MCP Vanguard interventions were implemented. West Wakefield Health and Wellbeing Ltd were also keen to evaluate the experience of unpaid carers who were supporting family or friends receiving the Connecting Care service.
Evaluation Questions

There were a number of evaluation questions that were agreed at the start of the evaluation programme:

- How would you describe the context of the programme/population including an understanding of history, cultures, relationships, health inequalities, local and national policies and national legislation?

- 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 is the Vanguard performing against their expectations and how can the care model be improved?

- What impact is the Vanguard having on patient outcomes and experience, the health of the local population and 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 the 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 care model on the local health economy and beyond?

This report presents findings based on a process evaluation of the West Wakefield MCP Vanguard. Some of the findings may be specific to the region. Others are transferrable to other regions and will offer useful insight into the barriers, challenges, and successes of the development and implementation of new models of care across England. As such, this report should be read as a case study that provides – both from a health care provider as well as from a patient perspective – insights into how these groups have experienced and implemented aspects of the new care model.
Metrics

Metrics Process and Results

Prior to the evaluation, NECS were working with WWHW to help define metrics and build dashboards in order to track and share performance of the New Care Model. A process was agreed to define metrics using the logic model and hypothesis tree as a starting point. This led to agreement of data definitions and sources for the data, putting data flows in place and working with all interested parties on data sharing agreements where they were required.

The first drafts of the dashboards were produced and reviewed iteratively to ensure they reflected the requirements of WWHW and provided relevant data with charts where appropriate. The dashboards were assessed, revisited and metric definitions checked, changes agreed and implemented based on data being available. Some findings have led to further analysis being required, e.g. gaining an improved understanding of case mix.

Following is information taken from the dashboards at the end of March 2017 with key points for the full year and the most recent data for the specific month of March. It was suggested that confidence intervals could be added to the data tables below, however this has not been done as current figures are being compared to baseline figures and these are absolute actual numbers rather than a range.

Reduced length of stay for >75yrs from West Wakefield

This metric is intended to measure any reduction in bed days relating to non-elective emergency admissions for patients registered at any of the Vanguard practices, aged over 75, with a length of stay of 6-28 days. It is linked to a hypothesis, detailed in Appendix 6.

Current performance is showing a considerable increase, with latest data showing an increase of 1810 days (8.9%) for this metric. Most of this increase has been in the month of March with an increase of 518 on the March last year (29.8%)

All Networks have shown an increase but Network 6 is showing the smallest increase

<table>
<thead>
<tr>
<th></th>
<th>16/17</th>
<th>15/16</th>
<th>Diff</th>
<th>% change</th>
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<tbody>
<tr>
<td><strong>Full Year</strong></td>
<td>22085</td>
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<td><strong>Month of March</strong></td>
<td>2259</td>
<td>1741</td>
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<tr>
<td><strong>Full year - Network 3</strong></td>
<td>6171</td>
<td>4806</td>
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<tr>
<td><strong>Full year - Network 5</strong></td>
<td>7086</td>
<td>6716</td>
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</tr>
<tr>
<td><strong>Full year - Network 6</strong></td>
<td>8828</td>
<td>8753</td>
<td>75</td>
<td>0.9%</td>
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</tbody>
</table>
Reduction in Admissions for >75

This metric is intended to measure any reduction in non-elective emergency admissions for patients registered at any of the Vanguard practices, aged over 75. It is linked to a hypothesis, detailed in Appendix 6.

Current performance is showing an increase, with latest data showing an increase of 124 admissions (4.3%) for this metric.

Network 6 is the only one showing a slight decrease.

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<tr>
<td>Full Year - Network 3</td>
<td>789</td>
<td>774</td>
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<td>Full year - Network 5</td>
<td>950</td>
<td>836</td>
<td>114</td>
<td>12.6%</td>
</tr>
<tr>
<td>Full year - Network 6</td>
<td>1246</td>
<td>1251</td>
<td>-5</td>
<td>-0.4%</td>
</tr>
</tbody>
</table>

Reduction in A&E attendances from West Wakefield

This metric is based upon attendances from 9am-9pm.

Current position is showing an increase of 728 (1.8%).

Only Network 3 is showing a slight decrease (0.6%)

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<th>Diff</th>
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<td>40186</td>
<td>39458</td>
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<tr>
<td>Full year – 24 hours</td>
<td>53933</td>
<td>52850</td>
<td>1083</td>
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</tr>
<tr>
<td>Month of March – 09:00 to 21:00</td>
<td>3560</td>
<td>3532</td>
<td>28</td>
<td>0.8%</td>
</tr>
<tr>
<td>Month of March – 24 hours</td>
<td>4697</td>
<td>4686</td>
<td>11</td>
<td>0.2%</td>
</tr>
<tr>
<td>Full year for Network 3 – 09:00 to 21:00</td>
<td>9768</td>
<td>9828</td>
<td>-60</td>
<td>-0.6%</td>
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<tr>
<td>Full year for Network 5 – 09:00 to 21:00</td>
<td>14840</td>
<td>14516</td>
<td>324</td>
<td>2.2%</td>
</tr>
<tr>
<td>Full year for Network 6 – 09:00 to 21:00</td>
<td>15578</td>
<td>15114</td>
<td>464</td>
<td>3.1%</td>
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</table>

Walk in Centre attendances

Current position is showing a decrease of 2105 (8.2%).

All networks are showing a decrease year on year.

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<th>15/16</th>
<th>Diff</th>
<th>% change</th>
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</thead>
<tbody>
<tr>
<td>Full year</td>
<td>23633</td>
<td>25738</td>
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<td>-8.2%</td>
</tr>
<tr>
<td>Month of March</td>
<td>2042</td>
<td>2408</td>
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<td>-15.2%</td>
</tr>
<tr>
<td>Full year - Network 3</td>
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<td>Full year - Network 5</td>
<td>12431</td>
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<td>Full year - Network 6</td>
<td>5773</td>
<td>6419</td>
<td>-646</td>
<td>-10.1%</td>
</tr>
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</table>
Referral Counts

This metric has been based on new outpatient appointments (rather than true referrals), because this is all that can be derived from SUS data. Also the SUS data is at treatment function level, as opposed to the disciplines specified in the metric, and so a mapping exercise has been carried out between the two.

- Current data is showing increase of 162 referrals (3.8%).
- Only Mental Health is showing a decrease on 15/16 (16.2%)
- Only Network 3 is showing a decrease (1.6%)

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<th>16/17</th>
<th>15/16</th>
<th>Diff</th>
<th>% Change</th>
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</thead>
<tbody>
<tr>
<td>YTD</td>
<td>4427</td>
<td>4265</td>
<td>162</td>
<td>3.8%</td>
</tr>
<tr>
<td>Mar</td>
<td>539</td>
<td>324</td>
<td>215</td>
<td>66.4%</td>
</tr>
<tr>
<td>Cardiology YTD</td>
<td>1542</td>
<td>1496</td>
<td>46</td>
<td>3.1%</td>
</tr>
<tr>
<td>Elderly Care YTD</td>
<td>557</td>
<td>553</td>
<td>4</td>
<td>0.7%</td>
</tr>
<tr>
<td>Mental Health YTD</td>
<td>471</td>
<td>562</td>
<td>-91</td>
<td>-16.2%</td>
</tr>
<tr>
<td>Respiratory YTD</td>
<td>706</td>
<td>680</td>
<td>26</td>
<td>3.8%</td>
</tr>
<tr>
<td>Musculoskeletal YTD</td>
<td>1151</td>
<td>974</td>
<td>177</td>
<td>18.2%</td>
</tr>
<tr>
<td>Network 3 YTD</td>
<td>1331</td>
<td>1352</td>
<td>-21</td>
<td>-1.6%</td>
</tr>
<tr>
<td>Network 5 YTD</td>
<td>1323</td>
<td>1148</td>
<td>175</td>
<td>15.2%</td>
</tr>
<tr>
<td>Network 6 YTD</td>
<td>1773</td>
<td>1765</td>
<td>8</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

Information Governance

During the development of the dashboards there were a number of challenges in obtaining data with the datasets required being SUS, Walk in Centre, 111 and Out of Hours. At the beginning of the project, data was flowing to NECS and/or WWHW Ltd; this was patient level data allowing production of the metrics monitoring information. However, a new Data Sharing Agreement (DSA) between NHS Digital and Wakefield CCG came into effect on 14th October 2016 governing the use of SUS data, with a condition that NECS can only provide WWHW Ltd with aggregate data and small numbers suppressed and this resulted in some re-work on the dashboards.

NECS developed the dashboards accessing anonymised SUS, Walk in Centre and 111 data from the Yorkshire & Humberside Data Services for Commissioners Regional Office. Out of Hours data currently flows to another CCG and is not available, although no current metric relates to this is could potentially be helpful as supplementary information.

There have also been challenges in progressing patient segmentation work which was planned to take place alongside the dashboards and required pseudonymised patient level data. The DSA needed to be varied and NECS has worked with eMBED as the Business Intelligence provider in Yorkshire & Humberside to submit a joint application. The decision was taken to not pursue this further given the timing of this project.
EVALUATION PROGRAMME

The evaluation questions were developed in two methodological approaches:
- Qualitative Evaluation of Patient and Staff experience; and
- Quantitative Evaluation, focussing on the HealthPod.

Objectives of the qualitative evaluation

The findings presented here are based on the analysis of semi-structured qualitative interviews and survey work with both primary care staff and patients.

In order to assess the successes and challenges of the West Wakefield MCP Vanguard, the qualitative evaluation aimed specifically to:

- Explore what key changes the Vanguard components have made to the day-to-day work life in individual practices,
- Map which components of the care model are really perceived to make a difference, why, how and to whom,
- Explore some of the unintended costs and consequences (positive or negative) associated with the new care model,
- Measure the impact the Vanguard model has had on patient experience within primary care.

The qualitative evaluation was jointly delivered by Dr Michaela Fay, independent research consultant, on behalf of NECS (staff experience) and by Healthwatch Wakefield (patient experience).

The plan for the staff evaluation was for three stages:

- To evaluate primary care staff experience of individual Vanguard components, in particular care navigation, Physiotherapy, pharmacists in General Practice, and extended operating hours;
- To liaise with the stakeholder groups to evaluate how integrated they are; what works and what doesn't work (and why); what the barriers and enablers to implementation of Vanguard components are, and;
- To better understand the work cultures – organisational dynamics, professional identities and perceptions - into which Vanguard components were implemented and how they may have changed in the process.

Healthwatch Wakefield delivered the evaluation of the patient experience. This evaluation consisted of the following components:

- Primary care interventions: care navigation surveys were used to access patients in waiting rooms, focusing on Physio/Pharmacist clinics to seek permission from these patients to follow up with a phone interview.
- Visits to HealthPod and Extended Operating Hours clinic.
- Request for HealthPod visitors to follow up with phone interview.
In addition, Healthwatch Wakefield evaluated the Integrated Care Fusion Cell via the following evaluation components:

- Continuation of Connecting Care survey and referral routes through Waterton Hub;
- Carer survey conducted alongside where possible, using IntegRATE1 measure.

The findings of the Integrated Care components are presented in a separate report.

Surveys were designed for each element of the evaluation in partnership with West Wakefield, NECS and with patient involvement.

Activity around the evaluation plan has been to take a purposive approach to all elements of the programme for both staff and patient evaluation.

**Methods and Sampling - activity in response to evaluation requirements**

**Methods and Sampling - Staff Evaluation**

The following primary care staff groups were identified as most likely to have had direct experience of the impact of all or some of the Vanguard components:

- GPs
- Care navigation/reception staff
- Practice Managers
- Practice nurses
- Physiotherapists in primary care
- Pharmacists in primary care

The purpose of the interviews was to explore the following topics:

- Which Vanguard components have been implemented in the practice?
- How has day-to-day workload and workflow changed since implementation of Vanguard components?
- Which areas have seen the biggest change due to Vanguard (e.g. workload, workflow, roles of individual staff groups, patient expectations)?
- What was the practice’s motivation for the implementation of Vanguard projects and what were the associated hopes, expectations and reservations among practice teams?
- How has the workload and role of GPs in particular changed due to Vanguard projects?
- What help and support do practices need to effectively and sustainably implement changes associated with Vanguard projects.

This report reflects feedback from the complete set of staff interviews, which were undertaken during December 2016 - March 2017. In-depth, semi-structured interviews were conducted with 23 individuals across 9 primary care practices spanning networks 6, 5, and 3 of the West Wakefield Vanguard practices. (See table below). Interviews were conducted with representatives of the West Wakefield Physiotherapy provider as well as with patients who are registered at one of the West Wakefield practices. Several attempts to interview representatives of the pharmacy provider (Prescribing Support Services) were unsuccessful.
The breakdown of the number of interviews conducted per network/practice is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Position</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Orchard Croft</td>
<td>Practice Manager, Care Navigators (2), GP (1)</td>
<td>4 people</td>
</tr>
<tr>
<td>2</td>
<td>Middlestown</td>
<td>Practice Manager</td>
<td>1 person</td>
</tr>
<tr>
<td>3</td>
<td>Chapelthorpe</td>
<td>Practice Manager, GP (1)</td>
<td>2 people</td>
</tr>
<tr>
<td>4</td>
<td>Grove</td>
<td>GP (1)</td>
<td>1 person</td>
</tr>
<tr>
<td>5</td>
<td>Outwood Park</td>
<td>Practice Manager</td>
<td>1 person</td>
</tr>
<tr>
<td>6</td>
<td>Church Street</td>
<td>GP (1), Care Navigator (1), patients (2)</td>
<td>4 people</td>
</tr>
<tr>
<td>7</td>
<td>Prospect</td>
<td>Practice Manager, patient (1)</td>
<td>2 people</td>
</tr>
<tr>
<td>8</td>
<td>Maybush</td>
<td>Practice Manager</td>
<td>1 person</td>
</tr>
<tr>
<td>9</td>
<td>Almshouse</td>
<td>GP, triage nurse, Care Navigator, practice nurse, nurse assistant</td>
<td>5 people</td>
</tr>
<tr>
<td>10</td>
<td>Physiotherapy</td>
<td>Physiotherapists (2), representing Hodgson Physiotherapy</td>
<td>2 people</td>
</tr>
</tbody>
</table>

In order to ensure minimum disruption and maximum participation rate, most of the interviews were conducted by telephone at a time that was convenient to participants. Recruitment for staff interviews was facilitated by provision of contact details from Russell Houghton from West Wakefield Health and Wellbeing Ltd. and interviews were arranged by the researcher, following initial email and/or telephone contact. Not all practices took up the invitation to participate and so are not represented in the data. However, interviews with sufficient individuals were conducted to provide a valid qualitative sample and a satisfactory level of saturation.

A semi structured interview schedule was developed for the interviews with staff. Different staff groups were asked questions specifically relating to their professional role. A separate interview schedule was developed for patient interviews. Following verbal consent given interviews were audio-recorded, transcribed and anonymised and then analysed by the researcher using thematic analysis to identify the key themes arising from the interviews.

**Methods and Sampling - Patient evaluation**

The approach to the primary care patient evaluation has been purposive, with Healthwatch Wakefield staff attending GP practice waiting rooms in West Wakefield to talk to people directly. From December 2016 to March 2017 we spoke to 720 people during the course of 66 visits to 16 GP practices, as follows:

<table>
<thead>
<tr>
<th>Position</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care navigation</td>
<td>517 people</td>
</tr>
<tr>
<td>Physio First</td>
<td>66 people</td>
</tr>
<tr>
<td>Pharmacy in General Practice</td>
<td>66 people</td>
</tr>
<tr>
<td>Extended Operating Hours clinic</td>
<td>71 people</td>
</tr>
</tbody>
</table>

The purpose of the patient evaluation was to explore what impact the Vanguard is having on;

- patient outcomes and experience
- the health of the local population
- the way in which resources are used in the local health system
Healthwatch Wakefield staff were able to do the care navigation and the extended operating hours’ surveys with any person in the waiting room who agreed to talk to us. For the Physio First and Pharmacy surveys, we attended practices during the relevant clinic times (each practice offered a few hours a week at different times). We either spoke to people directly after their appointment or got their consent to telephone them at a later date to ask about their experience.

Some of the patient waiting rooms were not appropriate to conduct interviews due to lack of privacy, two practices would not allow our staff to conduct the interviews and some of the practices were either not implementing some of the Vanguard interventions or were operating a modified version.

The patient evaluation of each Vanguard work stream was achieved through bespoke questionnaires jointly developed by Healthwatch Wakefield, West Wakefield Health and Wellbeing and NECS, and designed to give people an opportunity to share their experiences and to contribute secondary data where possible to the rest of the evaluation.
QUALITATIVE EVALUATION

Care Navigation

**Key aims Vanguard component**
- To re-distribute 50% of work done by GPs to more cost effective resources (e.g. external services, Physiotherapist, pharmacist).
- To reduce the number of patients needing to access a GP.
- Conduct discreet conversation about the nature of the patient’s health problem and health care need.
- ‘Queue bust’ at reception by offering patients advice and actively signpost them to the most appropriate service/health care professional for their needs without the need to speak to a GP.
- Increase immediate access to trained people as well as digital resources that will empower patients to determine the best and most accessible solution to their needs.
- Improve patient experience through more timely access to the right care.
- Break down the traditional assumption that a GP appointment is the best go-to place for any and all problems.

**Summary key findings care navigation evaluation**
- Significant variation in whether and how care navigation is implemented in individual practices.
- Practices adapt care navigation to their own specific needs and requirements (‘take what you like, leave the rest’ approach) some signpost in-house only, others send patients to external services, and others operate a combination of the two.
- Mixed feedback on care navigation training.
- Reluctance to implement due to altered job description (feelings of ‘going above one’s station’ and making quasi clinical judgement of patients’ health needs)
- Discontent about having increased responsibility (positive and negative effects) at same pay.
- Can succeed in enabling patients to have more timely access to health professional (GP and/or other).
- Mixed levels of awareness of care navigation among both staff and patients (examples of how practices advertise such as posters in reception area.
- Some patient resistance to being asked questions about their health problem by receptionist.
Care navigation – staff experience

For the purposes of this evaluation the definition of care navigation was:

“The practice of reception or administrative staff offering patients an appointment with an appropriate health professional other than a GP, based on an assessment of their presenting issue”.

Across West and East Wakefield, 277 Care Navigators, based in GP practices, were trained to help local people to access the care they need. These are mostly the Reception, Support and Administrative staff who have first contact with patients when they come into or call the surgery, and they are trained to ensure patients are seen by the right person at the right time.

Effective navigation is a key element of delivering coordinated, person-centred care and support. Indeed, we found that care navigation is at the heart of the Vanguard programme, as many of the other Vanguard components are directly affected by whether, how and how successful surgeries’ reception staff actively signpost patients.

Overall, such active signposting was considered a positive development with much potential. Importantly, it is seen to offer a choice of clinicians and services to patients at little or no financial cost:

“you can divert someone off to an optician or a pharmacy rather than seeing a GP, I think that’s a really cost effective way of spreading patients or getting patients to where they need to be rather than needing money to do it…. “(GP)

How, why and with what specific end goal practices embraced care navigation differed significantly from practice to practice. For some, the aim may be to ‘redirect’ patients away from GPs in order to alleviate GP workload, for some the aim was to fully utilise in-house nurse triage (with patients potentially still ending up in a GP appointment), others still were more confident to routinely signpost patients to external services.

Skill set and training

Whereas the ‘old fashioned’ understanding of being a receptionist in primary care consists mostly of answering phone calls and arranging patient appointments with the next available GP, care navigation requires learning information and up-skilling with a re-think of roles and day-to-day tasks:

“I remember [our practice manager] doing the meeting and [she said] ‘right, whatever we’ve done before or however we’ve managed the appointments before just tear it up and just forget about it’ and we started afresh. And that’s how she actually put it”. (Care Navigator)

Starting afresh was noticeably easier when it goes hand in hand with staff turnover. One practice comments on how a recent wave of retirements and subsequent new appointments has made it easier for them to implement a culture change:
“the staff that was here pre-care navigation, they were the ones with quite a big barrier actually there. It’s funny you should mention that but a lot of them were sort of up nearly to retirement anyway. I think you used to get a lot of the doctors surgeries with people just behind reception booking appointments and that’s what people think, that’s all you did. So a lot of the staff that were changed over have actually left or retired. So the new staff that we’ve got in, this is all they’ve known” (admin staff)

“the admin team that we’ve got now, the new ones, they’ve never known any different. So they’re-, automatically when we do the training, we say to them ‘we must ask the patient what the problem is” (Admin Staff)

In order to equip care navigators with the necessary skill set, the Vanguard offers care navigation training and several practice managers we spoke to mentioned sending their staff to these training sessions:

“I think we’ve had four half day training sessions for our admin staff, who use templates to record everything they do” (Practice Manager)

“all staff are currently going through care navigation training. They’ve had two sessions already and they’ve got another session coming up later this month with a view to starting to look to implement care navigation and active signposting” (Practice Manager)

Care navigators themselves, were reluctant to describe care navigation training as such and, instead refer to it as an information session. Staff members did not feel up-skilled and prepared for different scenarios by the training:

“It weren’t really training as such, it was just ‘well this is the new service we’re starting up and you can navigate to these services’ but training-wise, it wasn’t like a training education. It was just saying ‘these are the new services where you can navigate patients to if they need to use it […] Yeah there were nothing said about different situations that you could possibly get. Like using examples ‘if patients ring up…’ there were nothing telling us whether that would be appropriate or not”. (Care Navigator)

“It wasn’t like we were being trained up on it. It was just ‘these are new services, if a patient rings up and wants something you can navigate them to see us rather than going through the doctor”. (Care Navigator)

Not feeling sufficiently up-skilled by the training sessions, several interviewees - care navigators as well as practice managers - have mentioned concerns around ‘going above one’s station’ when having to make judgement calls about a patient’s medical needs where previously they may have simply referred that judgment call to a GP:

“Yes, it’s a lot. It is a lot … And it’s us telling a patient. So a patient could go somewhere and come back and say ‘well the receptionist told me to come to you’ so not a health professional, not a doctor, it’s just a receptionist (Care Navigator)

These concerns are echoed by some practice managers:
"Because when do you say to a receptionist 'you’ve overstepped the mark'? 'Your job is to make an appointment for a GP, your job isn't to make a decision of whether that patient needs to go to Physio, to PEARS...without actually liaising with a clinician first". (Practice Manager)

**Increased work pressure**

Care navigation may, in fact, lead to increased workload pressure on reception staff, thereby not actually alleviating the burden on primary care teams but simply re-distributing the pressure.

A de-facto increase in care navigators’ workload may equally contribute to feeling more pressurised:

"then you’re getting in a deep conversation with them! (IV. laughs). In the old days you would just write the details down, put them phone down, get onto the next one. But now you’re getting in full blown conversation about trying to refer them somewhere else and not seeing a doctor. You could be on the phone ten minutes, pulling your hair out" (Care Navigator)

"they need to [care navigate] extremely quickly and without making the patient feel they’re just being nosy and want to know what the problem is. (GP)

Increased pressure on care navigators may also stem from having to make more complex decisions:

“Sometimes you think ‘well am I going above my station?’ (Care Navigator)

“Yeah sometimes you feel a bit….With some patients, in different situations, you feel a bit ‘hmm, is this going to work?’ and you do question yourself, a lot” (Care Navigator).

Individual staff make their own judgement calls when to navigate a patient away from a GP appointment and when not. Smoking cessation, physiotherapy appointments, eye or hearing tests are mentioned as more straightforward scenarios and care navigation works well for these:

“things like the smoking services, we get a lot of people ‘oh I want to stop smoking’, now at one point, they would come into see the doctor and the doctor would do a prescription but now there’s the NHS Stop Smoking services so we can offer those as well” (Admin Staff)

Where the issue at hand feels more sensitive, personal, or medically complex, care navigators are more reluctant to steer patients. This includes mental health concerns and sexual health issues:

“Like, for example, if someone wanted a termination of a pregnancy, people can actually self-refer themselves to Marie Stopes, so they were telling us we can navigate the patients to-, I could give them the number for Marie Stopes and they could do it themselves. Well I wouldn’t really feel comfortable telling a patient ‘if you want to terminate a pregnancy I can direct you somewhere else rather than seeing a doctor’. I know it’s a service but that is something that I wouldn’t be comfortable doing but that is my personal choice, that is me
personally. And I know it’s a service that is there and people aren’t aware that it is a service that they can self-refer into. But it wasn’t how we would do it” (Care Navigator)

When it comes to more complex concerns, patients may be more reluctant to share information with reception staff. This, in turn, leads some care navigators to be sensitive to the fact that patients may perceive them to pry:

“we wouldn’t pry. We just say ‘OK’. And if a patient doesn’t want to tell us what they want to be seen with we say “OK, we will just put ‘personal’.” (Care Navigator)

“contraception services, things like that, that people are a little bit ‘oh it’s personal, it’s private” (Care Navigator)

“then ‘we must ask the patient what the problem is’. You do get patients that do say ‘it’s private, it’s personal and I don’t want to tell you’ and that’s fine.” (Care Navigator)

Working as a practice team and having the backing of GPs, in particular, helps to increase both care navigators’ and patients’ confidence:

“You do get patients that do say ‘it’s private, it’s personal and I don’t want to tell you’ and that’s fine. And sometimes the doctors may actually say to the patients in the consultation ‘well, this could have been dealt with differently’ or ‘do you realise you could have gone to so-and-so for this?’ so I think we are getting the back-up of the GPs as well. They’re saying the receptionists aren’t asking what the problem is because we’re nosy and we want to know what the problem is, we’re asking what the problem is so that we can point you in the right direction” (Care Navigator)

**Increased confidence and a change in work culture**

Care navigation is described as most successful when staff are:

“feeling confident with the templates and the options available is key to the success of care navigation. And working within their capabilities and knowledge and experience”. (GP)

Confident care navigation increases patient confidence, too:

“But you’ve got to have the confidence in what you’re doing as well with care navigation. If you’re confident that you’re care navigating this person to the correct place then it comes across as well and [patients are] confident in going to somewhere else as well” (Care Navigator)

It has been noted that there is a positive element to increased responsibility and changes the work culture in a practice:

“Some of our reception staff are really confident and happy to explore the options with patients. […]I think, yeah, it gives them increased responsibilities within their work that makes them feel like they’re contributing to part of the system”. (GP)
Lack of pay increase

Increase in responsibility is not reflected in an increase in pay, however, and this has been noted repeatedly:

“But my girls have said to me ‘that’s fine but I want more an hour to do that job because I’m not a receptionist anymore, you want me to become a Care Navigator, two totally different roles’. (Practice Manager)

“to be truthful, I’d want at least 12 pound an hour to do that. My receptionists are on eight pound an hour. Because I haven’t been given the money to pay them extra to do Care Navigation” (Practice Manager)

If care navigation is well advertised and communicated, other Vanguard components can be better advertised, which, in turn, leads to maximum utilisation of new services, an increase in patient confidence and, over time, a change in user attitudes.

However, levels of awareness of care navigation varied among both staff and patients. Interviewees feel that if one aim of care navigating is to signpost patients to health professionals other than a GP, then patients need to be made fully aware of this in order to support this change. Some practices have tried to do this by adding information to their recorded telephone greeting; others have put up posters in the reception area. All agree that such changes take time and that not enough time was given to implement significant changes in attitudes and behaviour.

One staff member in a network three practice felt that there should have been more of an effort to advertise care navigation to the public and feels that this may indeed increase the pressure on primary care practices:

“it’s ‘doctor first’ and things like care navigation you’re trying to turn that round and create a ‘doctor last’ approach and patients need to be signed up to this and they need to be engaged in that process and there’s been no national-, if I didn’t work in general practice, as a member of the public, I’ve never come across care navigation. There’s no marketing or advertising, you know what I’m saying? We’re supporting this theory of care navigation but I can’t see that anybody’s doing that. It’s all on the head of the practice”. (Practice Manager)

This led some practice teams to conclude that:

“Yeah, it’s a good idea in principle but can you imagine the confrontation that we’re going to have to put up with when we tell a patient ‘no I’m sorry you can’t see a doctor because my protocol says that you can go to your chemist and self-train’...you know. We...we have to pick up the pieces of all these projects all the time and it’s so disheartening and it’s so...It’s no wonder the role of a receptionist is not a very enviable one and it just doesn’t attract recruitment because of the challenge that they’ve had to face day in, day out”. (Practice Manager)
Patient awareness of care navigation

Advertise Care Navigation and Vanguard components
- Phone messages / posters in practices
- GPs educating patients about available services
  - adequate training

Confidence
- Care navigators are more confident to signpost patients
- Patients are more confident to follow signposting advice / disclose relevant information
  - Patient awareness of available services

Change
- Maximum use of available Vanguard resources
- Decreasing Patients’ reliance on GP as main health carer
The findings of the patient evaluation confirm that there was, overall, relatively little awareness of care navigation among patients. Whilst patients may have been sent for appointments with an in-house Physiotherapist or pharmacist, they would have been unaware that they had been ‘care navigated’. This may be of little consequence, unless this unawareness clashes with some of the elements of care navigation, namely and most importantly, reception staff asking patients about the nature of their health problem and health care need.

**Patient expectations as barrier to care navigation**

Arguably connected to the lack of advertisement and low levels of awareness, several interviewees identified patient behaviour and expectations as a key barrier to effective care navigation:

“I mean we’ve had resistance from patients when we’ve said to them about medication reviews ‘oh well we’ll give you a telephone appointment with the pharmacist’ ‘I don’t want to talk to the pharmacist, I want to talk to the GP’ ‘well no, actually, we’ve got a pharmacist, they’re a qualified pharmacist, they will talk to you’ ‘I DON’T want to talk to the pharmacist, I want to speak to the GP’.” (Practice Manager)

All practices were provided with posters and encouraged to inform their patients via their telephone messages. As the care navigation rolled out several practices have proactively addressed patients’ expectations by introducing voice messages on their telephone line, alerting patients to the fact that they may be asked a series of questions about the nature of their problem before being referred to the most appropriate service/staff member. Other practices have started putting information screens or posters up:

“We’ve got screens in reception areas saying ‘we’ve got services within the practice that you may-, may be better than seeing your GP’ so we’ve got the Physio, the pharmacist...” (GP)

There is, however, an opportunity to use changes in how patients are guided and signposted through the system to shape how patients engage with health care services:

“to be able to speak to a pharmacist, speak to a Physio, self-care, and I think it’s a big patient education programme really, of trying to get patients to look after themselves a bit better” (GP)

Like with other Vanguard elements, time and workload pressures are mentioned as barriers to implementing change. With regards to care navigation, staff have mentioned that whereas previously a phone call with a patient might have taken a few seconds, it can now take up several minutes and a significantly more complex decision making process:

“Some of our reception staff are really confident and happy to explore the options with patients. But obviously it’s difficult when the phone’s ringing off the hook as well; they need to do it extremely quickly and without making the patient feel they’re just being nosy and want to know what the problem is” (GP)
Staff feel that care navigation has the potential to ‘divert’ patients away from GPs, as one Practice Manager put it, but there was consensus that there is no direct equivalent between navigating patients and saving GP time/reducing GP workload.

**Saving staff time through care navigation?**

Practice staff feel, if anything, that the biggest beneficiaries of care navigation are the patients, as they are able to be seen more quickly by the most appropriate individual. For staff, on the other hand, workload – and, importantly – levels of responsibility are increased by having to signpost patients:

“Care navigation, for instance, because you’ve got staff answering telephones at eight o’clock in the morning and you’ve got 30 or 40 calls waiting to come in, it does not save any time because at the end of the day the girls haven’t got the time to do the care navigation because they’re constantly aware there’s another 20 calls waiting to be answered. If those calls were coming in five an hour, and they were on a steady stream, then yes you could divert say three of those. But then for those three that you’ve diverted you’re going to use up that time for the next three that come in that want to see the GP. So it doesn’t save GP time. It’s increased administrative time” (Practice Manager)

**Care Navigation – Patient Experience**

We were aware that patients would not know what care navigation was, so the term was not used during the interviews. The survey was designed to find this information in two ways:

- Were people at the practice to see someone different from the person they had rung up to see (Who are you here to see?  Who did you want to see when you contacted the practice?)

- Did people remember the practice staff specifically offering an alternative appointment (When you booked your appointment, did the reception staff suggest that you saw a different healthcare professional than the one you are here to see today?)

**Most people did not feel that any attempt had been made at care navigation**

92 (18%) of the 517 people interviewed said they remembered the practice staff attempting to signpost them to another professional and 38 people (7%) actually accepted the alternative appointment. Just over half of the people we talked to were at the practice to see their GP. Different means of delivering the care navigation, for example in the GP waiting room, many not have been perceived as care navigation;

- This tells us that around 40% of attempts to care navigate are successful.

- It also tells us that 82% of people we interviewed did not think that anyone had offered them an alternative, i.e. that they had not been care navigated.
**When it is accepted, care navigation does distribute appointments to other services**

For the 38 people who accepted the signpost to an alternative professional, the tables below demonstrate how care navigation redistributed the take up of appointments:

### Who did you want to see when you contacted the practice?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 GP</td>
<td>65.79%</td>
<td>25</td>
</tr>
<tr>
<td>2 Nurse</td>
<td>2.63%</td>
<td>1</td>
</tr>
<tr>
<td>3 Physiotherapist</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>4 Pharmacist</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>5 Don't know</td>
<td>15.79%</td>
<td>6</td>
</tr>
<tr>
<td>6 Other</td>
<td>15.79%</td>
<td>6</td>
</tr>
</tbody>
</table>

### Who are you here to see?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 GP</td>
<td>15.79%</td>
<td>6</td>
</tr>
<tr>
<td>2 Nurse</td>
<td>39.47%</td>
<td>15</td>
</tr>
<tr>
<td>3 Physiotherapist</td>
<td>26.32%</td>
<td>10</td>
</tr>
<tr>
<td>4 Pharmacist</td>
<td>15.79%</td>
<td>6</td>
</tr>
<tr>
<td>5 Don't know</td>
<td>2.63%</td>
<td>1</td>
</tr>
<tr>
<td>6 Other</td>
<td>0.00%</td>
<td>0</td>
</tr>
</tbody>
</table>

This demonstrates a reduction from 25 people who initially wanted a GP appointment to 6 people who had one. The 6 people who had a GP appointment had either not known who they wanted to see (5) or wanted to see a nurse (1) when they initially contacted the practice.

Some of the other things to note about redistribution include:

- Of those redirected, 42% (16) were redirected to Vanguard interventions, 39% (15) to the practice nurse;
- None of the patients signposted who accepted the alternative had originally requested an appt with Physiotherapist or pharmacist.
People who are ‘care navigated’ successfully are very positive about the experience;

- 97% said they were ok with being offered an alternative.
- 77% said they felt that enough effort had been made to find out what was important to them.
- 78% said they felt it was helpful for practice staff to signpost in this way.

“It’s a good idea, I didn’t have to wait for GP appointment, as that would’ve taken weeks.”

“Absolutely fine, it’s a good idea.”

“Yes, they do their best and are making improvements”

People generally think care navigation is a good idea even if they don’t actually accept it themselves.

Although the number of people who actually accepted care navigation was low, the majority of people said they would be ok with care navigation as a concept. 425 people told us they had not been signposted to anyone else when they booked their appointment at the practice. We described the concept of care navigation to these people and asked what they thought about the idea:

- 66% said they would be ok with being offered an alternative
- 82% acknowledged that they could see how it would be helpful for practice staff to do this

“Fine - if it means I can be seen on the same day then great. Works for me”

“Excellent idea”

“I think it’s a good idea. Saves GP time.”

Care navigation has to be appropriate to the situation and sensitive to people’s needs.

From an analysis of the comments that people made about this, the majority were variations on the theme of the appropriateness of the attempt to care navigate. In the table below, the green indicators are positive, yellow denotes uncertainty and red is negative.
### Themed summary of 301 patient comments about care navigation

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t mind or I think it’s a good idea</td>
<td>20.2%</td>
<td>61</td>
</tr>
<tr>
<td>As long as it’s appropriate or I’m seen more quickly then it’s OK</td>
<td>25.6%</td>
<td>77</td>
</tr>
<tr>
<td>O don’t know, or it depends</td>
<td>12%</td>
<td>36</td>
</tr>
<tr>
<td>I’m reluctantly OK with it</td>
<td>7%</td>
<td>21</td>
</tr>
<tr>
<td>I know when I need to see a specific professional (not necessarily a GP)</td>
<td>19.6%</td>
<td>59</td>
</tr>
<tr>
<td>I don’t want to explain me situation every time</td>
<td>7.3%</td>
<td>22</td>
</tr>
<tr>
<td>I’m not happy, I don’t think it’s appropriate, wouldn’t accept it</td>
<td>8.3%</td>
<td>25</td>
</tr>
</tbody>
</table>

Some people felt that care navigation might not always be appropriate at the time, but might sometimes be ok:

“*I didn't mind but I knew myself that I had to see a GP due to my condition. If people get seen more quickly, then fine.*”

“It depends on what the health concern is.”

“*Fine, but I knew that I had to see the GP.*”

“But other times it might be ok.”

Or that they might not like it, but they could see that others might:

“I don't want to explain my situation over and over. It's painful. It might be okay for others.”
Concerns about care navigation include confidentiality and the lack of training of Care Navigators.

Some people didn’t like the fact that care navigation is done by staff who are not clinically trained:

“I don’t think staff on reception should ask you.”

“Thought it was wrong, the receptionist has no right to know.”

“I would want to see my GP, receptionist isn’t medically trained.

“They are not qualified.”

People also indicated some concerns around confidentiality:

“They want to know your business and sometimes you need to talk in private.”

“Could be difficult. I made a request for female doctor for female issues and it was embarrassing to explain in open busy surgery and receptionist made me feel like I was being obstructive. Receptionists must accept that sometimes people are unable or unwilling to share.”

“Concerns that in queue - people can hear what you are saying. Not always easy.”
Recommendations for Care Navigation

- Further investigation could be done around the reasons why people don’t accept care navigation even though they might agree with it as a concept.

- Further investigation could be done around the reasons why care navigation doesn’t happen consistently.

- It would be useful to understand why our data shows only a small reduction in the demand on GP time, when we are aware this contradicts the quantitative data findings.

- More information needs to be made available for patients about the reasons for and benefits of care navigation.

- All staff in the practice need to be aware of the practice of care navigation and how to engage with it effectively.

- Practices should consider how to offer confidentiality within the waiting room or at the reception desk if asking patients for details about their presenting issue.

- Care navigation training should be more than a perceived information session and should be made freely and easily available.

- Care Navigators’ increase in responsibility and changes in day-to-day tasks should be reflected in their pay.
Physio First

Key aims of Physio First Vanguard component

- To provide patients with a physiotherapy appointment first instead of seeing the GP and enable patients registered with West Wakefield practices to have a direct 15 minute assessment and advice appointment with a practice-based MSK.

- Free up GP sessional time that can be spent with other patients with more complex health needs.

- To alleviate an estimate that around 20% of GP appointments were taken by otherwise well patients with minor MSK complaints (e.g. back pain) place on GP time.

- To provide rapid access to expert (MSK) advice without first needing a GP appointment.

Summary of key findings for Physio First

- Positive patient feedback. Patients like being seen quickly by a Physiotherapist and feel that they are getting something out of the appointments.

- Most useful for a specific patient group (acute).

- Issues arising from lack of awareness of specs of Physio First (‘Physio 2nd' syndrome and reception staff not fully explaining to patients the nature of appointment, i.e. 15 minute assessment, rather than full treatment).

- Takes workload off GPs.

- Not all practices were able to fill their Physio appointments (link to care navigation and awareness and the timings of the physiotherapists’ availability).

- The practice that utilised appointments most successfully has a triage nurse and shared clinical system which supported the spread of appointments across the week.

- Physiotherapists report GPs as barrier to their work (Physio 2nd, lack of trust).

- System could be improved by improving referral system and pathways (both in-house between Physios and GPs and external by giving Physios more range to refer patients onwards after triage appointment).

Similarly to care navigation, Physio First was generally described as a feature with potential and some positive impact.

A number of positive changes were associated with having a Physiotherapist in the practice.
Several interviewees have commented on the positive effects of Physio First. These include having quick and direct access to a Physiotherapy appointment in the practice rather than a separate location; the genuine possibility to divert some patients away from what may have been an unnecessary GP appointment; and the option to provide patients quick and easy access to the health care that is, at the time, most effective and appropriate to their need.

However, there were challenges associated with the Vanguard and the resource might not have been used to its full potential.

**Freeing up GP time**

GPs and Care Navigators alike acknowledge that musculoskeletal complaints make up a significant proportion of patients’ health complaints and having a Physiotherapist in-house can prevent unnecessary doctors’ appointments.

“I think one thing that’s worked really well is the Physio First where people with first or second complaint of a musculoskeletal issue go straight in to see a trained Physiotherapist. And I think that is potentially 25% of the GP’s work, with patients coming in with musculoskeletal problems”. (GP)

Whilst not sure there has been a de-facto reduction in GP workload due to Physio First, one GP acknowledged that is has introduced a degree of much appreciated flexibility. This in turn may contribute to alleviating some of the workload pressures.

“I would say that both of those things [Physio First and pharmacy] have had a real positive impact on us as a practice. I don’t think it’s saved hundreds and hundreds of GP hours, but what it has done is given us flexibility within the system to move things around” (GP)

The same GP comments that:

“What it does, it frees up appointments, which always get filled” (GP)

**Patients benefit from Physio First**

Regardless of the potential saving of GP time, there was consensus among participants that having access to an in-house Physiotherapist improves their patients’ experience and has, in turn, been appreciated by many patients. In that sense, the Vanguard component has been described as a success.

“And that opportunity to see a trained professional who can do, basically, a full Physio exam of the patient, probably better than a GP, sees the patient first. I think that’s one real success” […]
In particular, participants thought that patients appreciate being able to see a Physiotherapist in the GP practice. This amounts to patients feeling that their GP surgery has expanded and improved.

"some people that have actually gone to the Physio, we’ve had quite a few comments of ‘it’s a brilliant service, I didn’t know that this existed’. And because the Physio is actually working here from the surgery as well, they obviously take a room, then the patients don’t have to trail all the way over to the hospital […]. So that’s another…another plus side, is the fact that they're actually based here at the surgery, so it’s like a community, so they can just come, see the doctor and have a Physio appointment if needed as well” (Admin Staff)

Good care navigation improves Physio First

There are several things that contribute to breaking down barriers to the best use of Physio. Importantly, knowledge and awareness of the service and its specifications helps to confidently care navigate patients to it whilst raising awareness of what the service can and cannot provide. This, turn, helps to avoid the unexpected side effect of what can be named as the ‘Physio Second syndrome’ which may directly undermine the success of the Vanguard component.

“sometimes the patients say ‘no, I need to speak to a doctor’ but as soon as they speak to a doctor we can't put them back to Physio First because they've already had a contact with a patient” (Practice Manager)

Some practices have struggled with the signposting and referral requirements linked to Physio First and comment on the fact that appointments may be lost this way:

“if we send someone to Physio First that hasn't seen a GP or spoken to a GP and that patient then needs a referral, the Physio person they've seen sends a referral, a message to the doctor who then does a referral. But if we do it the other way, if a patient spoke to a doctor first, we can't then put them in with Physio First because they've already had contact with another professional” (Practice Manager)

How well Physio First is advertised and taken up depends, in part, on how well informed Care Navigators are of the specifications of the service and how competently they introduce the service to patients. One practice comments on how, in light of introducing care navigation, recent changes in their overall appointment system has helped them to make better use of the available services, such as Physio First:

“Well we recently changed appointments system from an older system that we had for a number of years, where patients rang in and got an appointment or (no appointment) basically. Now nearly every call is triaged by a doctor, the duty doctor, and patients are put in with the appropriate physician or nurse or Physio. So […] since we started this system […] think we have utilised the Physio First appointments much better. Up to then, a lot of the appointments were going wasted” (Care Navigator)
In addition to good care navigation, there is evidence that triage nurses have a positive impact on maximising the use of Physiotherapy appointments. One Physiotherapist we interviewed felt the practice size has an impact on a primary care team’s ability to fill all available appointments but feels that:

“it’s worked particularly well where you’ve had the triage nurses directing the patients, that’s probably the best way forward” (Physio Staff)

“where reception staff have been carefully advised on what’s appropriate then the referral is generally appropriate. If, it’s like [the practice] where I’m going, they use their triage nurses so the triage nurses will speak to the patient in the morning and then direct them to me in the afternoon face-to-face. That usually works very well”. (Physio Staff)

As with other areas of the MCP model, patients are identified as a barrier to implementing change:

“so one of the frustrations has been with Physio First, is getting people-, so they phone up. They disclose that it’s about a knee pain. The receptionist tries to care navigate them into a Physio First appointment and then-, but the patient is reluctant ‘no, I want to see doctor so-and-so please’ and everyone gets a bit frustrated” (GP)

In order to most effectively use the Physiotherapy appointments it’s necessary for patients to be adequately informed about what to expect. The Physiotherapy staff didn’t always find this to be the case and have said that they often see patients who expect to receive a full Physiotherapy treatment as part of their appointment because care navigation staff have failed to explain that Physio First is a triage/assessment appointment only.

**Knowing the specifications of Physio First improves impact**

Care navigation can only ever be as good as a staff member’s knowledge and awareness of available services. This is particularly evident with regards to Physio First which, as a service, has clear boundaries and specifications.

Whilst having access to an in-house Physiotherapist is generally considered a positive change by all, the specific requirement of Physio First can cause problems, from the point of view of Care Navigators, GPs, as well as Physiotherapists themselves. There is a sense among staff that precious resources are wasted this way. Physio First only works in the way it was designed when care navigation works in a particular way (and works well).

There were several mentions of the difficulty to avoid the phenomenon of “Physio second”.

“and like Physio First, that's pretty good, when it works but sometimes the patients say ‘no, I need to speak to a doctor’ but as soon as they speak to a doctor we can’t put them back to Physio First because they’ve already had a contact with a patient” (Care Navigator)

“Like if we’ve put them on to speak to a doctor, say, because they’ve decided that that’s what they want to do, then the Physio has told us that then that doesn’t mean that they can have Physio First because they’ve actually spoke to the doctor first about the problem. So then it’s not classed as Physio First. […] So they’re bouncing them back saying ‘sorry, we can’t see them because they’ve already spoken to another professional about it’. So
whether we’re doing it wrong or whether the Physio First is wrong I’m not sure” (Care Navigator)

This frustration is echoed by Physiotherapy staff themselves, with the addition that they tend to view GPs as one of the barriers:

“Where it doesn’t tend to work very well is when doctors get involved and start bunging in patients who really should just have been referred to Physio. It’s almost like they couldn't be bothered so they put them in to see us as a second opinion. Or they send someone in who’s had a problem for 12 months, multiple scans and say ‘I’m booking you in to see the Physio’ so they think they're coming along for a traditional 40 minute new patient assessment and sometimes they’re disappointed then when they arrive and find out that actually it’s a 15 minute advice session”. (Physio staff)

GP buy-in and avoiding the ‘Physio Second’ syndrome

Apart from good care navigation which has the potential to diminish barriers to patients’ uptake of Physio First appointments, good GP support of the Vanguard component is vital.

This, according to the Physiotherapy staff we spoke to, is not always present and GPs themselves may pose a barrier to the service’s success.

One of the key challenges associated with Physio First is the fact that it comes with specifications, i.e. it is aimed at acute patients only; it is initially a triage appointment; no prior contact with GP should have been made regarding the acute health problem; it is not aimed at complex patients with requirements for ongoing management, onward referrals, or prescription of medication:

“So the best patients that we get are the ones who have had an acute episode of something. Say they’ve been busy at the weekend, gardening all day Sunday, they go to bed feeling fine but when they wake up the next morning, suddenly they’ve got a stiff sore back. So what they used to do was ring the doctor and go ‘my back’s killing me’ and the reception staff would direct them to the GP. But actually what we’re doing is we’re trying to encourage reception staff with that case to direct them through to the Physio First team if they’re there that day or the following day. The GP doesn’t need to see them, we can see them and go ‘night, yeah you’ve done it, it’s an acute thing, it’s been flagged up, here are some exercises, here’s some advice on use of cold, warm, conditioning, simple analgesia, come back and see us in two weeks and see how you’re getting on’. So that’s when it works really well”. (Physio Staff)

“It’s not so good for chronic patients, patients who’ve ( ) for six months, because clearly they just need a referral to Physio. It’s not so good for multi-joint problems, so if they’re riddled with arthritis or multi-joint osteoarthritis. It’s better directed to single joint or single acute-ish onset. Anything within the last six weeks would be ideal. We don’t see anybody who’s had anything neurological, no strokes, no MS. We don’t do any respiratory stuff and we don’t advise under-18s. It’s for adults with musculoskeletal condition, preferably an acute standing, preferably nought to six weeks. The fresher we see them the better really”.

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Physio staff feel that practice staff can get in the way of them doing their job according to the Physio First specifications. Alongside inconsistent care navigation, they consider GPs to be an obstacle:

“Physio First, that’s the clue! The clue is that you see the Physio First, we’re not called ‘third opinion’, you know, there’s no point putting a patient in with us that you’ve already spoken to on the phone, seen twice in surgery that week and then lumbered him with us on a Friday. The patient’s just getting more of the same. You’ve managed that patient into wherever, there’s no point managing them into another advice session, the patient is just going round in circles” (Physio Staff)

“Think like a GP”: Yes, quickly. So cut to the chase really. So you don’t go into the dull detail of everything. Just having to be a little bit quicker, a little bit smarter. And because we use System One we’ve got access to patient notes and ( ). So we can see what’s going on. And if it’s something that’s clearly inappropriate or out of our depth then we ask the GPs to step in” (Physio Staff)

GPs, on the other hand, would disagree with this assessment, referring to their role as a family doctor who takes a holistic approach to a patient which, they feel, may not be adequately addressed by referring patients to separate services which are designed to address health problems as isolated issues:

“The receptionist tries to care navigate them […] but the patient is reluctant ‘no, I want to see doctor so-and-so please’ and everyone gets a bit frustrated. But then when they actually come to see you, the context of the knee pain isn’t just that its knee pain, it’s that it’s a knee pain that their husband or wife has been nagging them about, or it’s causing difficulty at work where they’re quite stressed. Actually their main concern is that ‘this is quite a severe knee pain and I’ve got underlying cancer’. Or they need to legitimise their illness and get a sick note or what have you. The context - their ideas, concerns and expectations in their presentation with knee pain - is not one that will necessarily be met by a Physiotherapist alone” (GP)

In contrast, whilst being aware that many health problems are indeed outside their remit as Physiotherapists and therefore those patients should not be sent to Physio First appointments, Physio staff is of the opinion that:

“if they stick to the brief it works really well” (Physio Staff)
Physio First - patient experience

Overall, patients can be said to be very happy with the ability to see a Physiotherapist in their GP surgery.

A total of 66 interviews were completed with patients, and these were split between 11 different surgeries.

Of those patients we spoke to who were happy to disclose their reason for visiting the Physiotherapist (31) (47%):
- Most saw the Physiotherapist for back pain (40%);
- The next most common complaint was knee pain (10%);
- 50% saw the Physiotherapist for a variety of other varied reasons which included hip pain, injuries to various areas following falls, trapped nerves, shoulder injuries and arthritis.

Overall patient satisfaction with the experience of seeing the Physiotherapist in practice was very high with:
- 95% of patients were satisfied with the effort that was made to help them understand their health issues or concerns;
- 97% of patients satisfied with the level of information and advice that they received;
- 94% confident that the service met their needs;
- 88% ‘Very Happy/ Happy’ to have seen a Physiotherapist instead of a GP;
- 74% ‘Very Satisfied’ and 23% ‘Satisfied’ with their visit to the Physiotherapist.

Only 2 patients (3%) were ‘Very Unhappy’ to see the Physiotherapist instead of the GP but examination of their responses to other questions indicated they were ‘Very Satisfied’ or ‘Satisfied’ with their visit to the Physiotherapist and they made no comment about how the service could be improved so this may be an anomaly in the data.

63% of patients (41) felt that the appointment with the Physiotherapist was what they expected;

Of those who did not feel or did not know if the appointment met their expectations (37%) (24):
- 13% (3) felt that they just did not know what to expect;
- 13% (3) felt that they got more than they expected;
- 13% (3) felt that the appointment would be more “hands on” than just a consultation;
- 4% (1) had expected to receive further specialised treatment such as scans and tests rather than being told to continue with exercises.

Had the Physiotherapist not been available, most patients would have tried to see their GP for the problem (75%) and a much smaller proportion would have attended the walk-in centre (9%) or Accident and Emergency (6%).

Other options that patients who had not been able to access this service would have considered were aromatherapy, acupuncture, “other avenues”, occupational health and the private Physiotherapy/ healthcare;
If Physio First had not been available, what would you have done?

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<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Total</th>
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<tbody>
<tr>
<td>1 GP</td>
<td>75.00%</td>
<td>48</td>
</tr>
<tr>
<td>2 Nurse</td>
<td>0.00%</td>
<td>0</td>
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<tr>
<td>3 A&amp;E</td>
<td>6.25%</td>
<td>4</td>
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<tr>
<td>4 Walk-In Centre</td>
<td>9.38%</td>
<td>6</td>
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<tr>
<td>5 Call 111</td>
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<tr>
<td>6 Call 999</td>
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<tr>
<td>7 Other (please specify):</td>
<td>12.50%</td>
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There were many positive comments about the Physio First service. In particular, patients were impressed with the speed at which they had been seen following their initial contact with the practice, with the level of information and advice that they received and with the fact that they were saving GP time/ seeing someone specialised to deal with their problem:

“When I rang up to make the appointment for the knee, I thought that I would need to see a GP. It was really positive that I got to see a Physio straight away, on the same day.”

“I got a lot of helpful information and advice – much more than I was expecting.”

“I have seen the Physio a few times now. It has been good as I have been to see my GP before but my problem was not resolved. The Physio asked me lots of questions and told me lots of things about my back.”

They [the Physiotherapist] know what they are talking about. It has cut out the middle man, cut out the GP appointment – not having to waste their time.”

Regarding the information and advice that they received, patients particularly mentioned being pleased that this was provided electronically (either via email or links to videos of exercises they could refer to at home) as well as being provided with written information. Patients also valued being provided with information on pain relief and mentioned a general sense of the visit to the Physiotherapist having provided them with reassurance:

“I was given exercises and videos – sent by email – great I get videos – that’s really helpful. Felt I got a lot of information and help.”

“I’ve been able to ask questions – it was really good. [Physio] was able to put my mind at rest.”
“[I was] provided with some exercises to do in the meantime and information on painkillers. Things like painkillers – it's reassurance that you can take them for a longer time than it says on the box without it causing another problem.”

Patients also valued the fact that they felt that they could come back and see the Physiotherapist again if their problem continues:

“As I am coming back, I know that it can be taken a step further if required.”

Other general positive comments included “[My experience] was beyond expectations”, “I got more than I expected and it was really good”, “I am satisfied so far – they are really nice and helpful.”

When asked how the service could be improved, very few patients who answered (19 %) had suggestions. Where they did, they were focussed on several key themes.

Patients felt that the service could be better advertised in order to maximise its use:

“Explain the service to people so they know it’s there”

Whilst the aim of Physio First is for patients to see a Physiotherapist in their own GP surgery, some practices share Physio appointment. Two patients reported that they had not been given adequate information about the venue of their Physio assessment:

“I was told the wrong location for the appointment”

“Make it clearer where the appointment is and how to get there. Poor information as to where the appointment was.”

Crucially, some patients said that they would have preferred to see a GP first, and a Physiotherapist second, especially where the problem was more complex and required, at least to the patient’s understanding, further investigation:

“I would have preferred to see the GP first and then if I needed the Physiotherapist they could have referred me – feels a bit the wrong way around…”

“I knew I needed to see a Physio but would have preferred to see GP. I could have got sick note”.

“I feel I need further investigation and only the GP can do this.”

Other comments about any problems with the service were focussed around:

- Better communication –not being clear that the appointment was with a Physio;

“[I was told I was coming to see a nurse today – so presumed I would get pain relieved but haven’t]”
• A mismatch between patients’ expectations and experiences – some patients expecting to receive (or to be referred) for more specialist investigations or patients expecting to receive more “hands on” Physiotherapy rather than just a consultation;

“I have suffered with foot pain for two years. Although the Physiotherapist has been good, I would have liked further investigation.”

“I expected to actually receive some Physiotherapy….not just talk”

Lack of resolution of the problem they had presented with;

“I don’t know if the Physio will help me that much I think it will help me better manage my condition hopefully.”

• Still needing to see a GP – for sick notes and’ or prescriptions;

“I do need to come back to see the GP though as the Physiotherapist cannot give me a sick note and my prescription might need changing.”

• One patient commented on the length of the appointment being too short and another felt that the information they had been provided could have been better.

The majority of patients who answered (74%) had no suggestions for service improvement or, used the opportunity express their positive feelings about the service.

32 of 43 patients who commented specifically on this said that the service was as good as it could be:

“It was really good”

“It’s a really good idea – don’t get rid of it”

“I think that it works really well as it is. I rang today and got an appointment for today”

“Everything was straight forward and quick so quite happy”

Patients appreciate being seen quickly and locally and feel that this prevents them from wasting their GPs time:

“It was good that I didn’t ‘waste’ GP time and happy to see a Physio in practice, it was convenient”

“I like the fact that there is a tiered system so that the response depends on what your problem is and it is a better use of people’s time”

“My husband has recently received Physiotherapy but he had to go to the hospital. It would have been good for him to receive the Physiotherapy at the surgery like me. Having the Physio at the GP surgery is the best move the surgery has ever made”

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**Recommendations for Physio First**

- Booking systems and practices need to ensure that patients are directed clearly to the correct venue for their appointment.

- Consideration should be given to the role of the Physiotherapist and the ability to issue sick notes and undertake relevant prescribing.

- The service could be publicised more widely to patients, including the fact that it is an assessment appointment, not a Physiotherapy appointment.

- Consideration should be given to the fact that online booking options generally only offer GP appointments, which means diversion of patients to alternative professionals is then not possible.

- All staff need to be aware of the service and how to use it effectively, e.g. GP not referring to Physio First instead of the community Physiotherapy service.

- To ensure that the model is consistent and it is clear to all that Physio First appointments are for assessment rather than treatment.

- The model should be made more flexible and allow Physio assessment appointment even if GP contact has already been made.

It is understood that the service will be changed to a telephone Physio assessment and it will therefore be important to evaluate patient experience to compare with the face to face Physio assessment.
Pharmacy in General Practice

**Key aims of Pharmacy in General Practice Vanguard component**

- To integrate pharmacists into the day-to-day running of all 18 practices across MCP Vanguard at the rate of 0.5 sessions per 1000 registered patients to do work that would otherwise be done by a GP.

- To enable patients to better discuss their individual needs by increasing access (via care navigation/active signposting) to practice-based pharmacist.

- Desired results of pharmacy interventions include optimised medication, reduced prescribing errors, side effects, and poly-pharmacy.

- Patients requiring repeat prescriptions will save time by being able to access the practice-based pharmacist directly without having to see a GP.

- To save an estimated one hour of GP time, 45 minutes of pharmacist time is required in direct workforce channel shift, leaving GPs with more time to focus on more complex patients.

**Key findings of Pharmacy in General Practice evaluation**

- Uneven skill levels among pharmacists leads to uneven workload (re)distribution in practices.

- No even integration of pharmacists into practice team and day-to-day business and practices feeling that working with only 1 pharmacist would be more desirable.

- Depending on skill level of individual pharmacist, the service can be useful for medication reviews, repeat prescriptions and sick notes.

- Sick notes make up a significant part of GPs workload this can be alleviated by pharmacist though could be seen to impact on holistic care for patients.

- Patients with need for medication review are often more complex patients who prefer to see ‘their’ GP (family doctor) and are more reluctant to see a pharmacist. They tend to be the same patients who might be resistant to disclosing information to Care Navigators, therefore preventing care navigation.

- Overall, positive patient feedback from the range of professionals and patients whom were involved in this evaluation.

- Practices that have found good ways to integrate pharmacy staff into their team have had positive experience and found that it has helped to relieve pressure on GPs.
Like Physio First, pharmacy in general practice was considered a potentially positive change for both GPs and patients. Like Physio First, there were some barriers to overcome which some practices managed better than others. Where there was ambivalence or reluctance towards this Vanguard component, it was based on several key concerns:

- Lack of continuity of pharmacy staff means that different pharmacists drop in and out of the practice;
- Not all pharmacists were felt to have the same level of skill and expertise, including in relation to their prescribing roles;
- Like with other Vanguard components, primary care staff’s awareness and knowledge of the service varied and this lead to fluctuations in uptake and utilisation between practices.

Where pharmacy was not taken up as well as it could have, interviewees express regret as it was felt that having a pharmacist “in situ” could be a great asset and genuine help.

“the idea is brilliant, I just think it was-, there’s no continuity with it” (Practice Manager)

**Challenges of Pharmacy in General Practice**

**Lack of continuity of pharmacy staff**

Most interviewees said, as a practice team, they struggled with the fact that the pharmacy Vanguard component did not provide them with the same pharmacists who, over time, would become part of the team. Instead, the set-up of the Vanguard component meant that different pharmacists were sent to practices at different times. This lack of continuity caused frustration and a certain level of hit-and-miss when it comes to fully utilise the service:

“I’m getting three different pharmacists in, who all work totally different, so I’m having to spend time moaning at them because they’re all doing different things […] So there is no continuity and that isn’t saving time”. (Practice Manager)

Indeed, where practices were provided with one and the same pharmacist over a longer period of time, problems disappeared:

“So, at the beginning, it was complicated and it seemed to be more work for us because we were sending it to the pharmacy, he’s then sending it to the doctor, he’s then sending it to us to do. But now, with us just having the one pharmacist in everyday, we don’t experience those problems anymore and it’s ironed out a lot of those problems” (Care Navigator)

Another Care Navigator confirmed this:

“it was a bit complicated at first, we did have two or three coming in. Which then some pick up and do-, they all work differently obviously, but with (the same pharmacist) being in every day now, we know what he can do, what he can’t do, what he’s happy with, what he’s not happy with. So it’s a lot better”. (Care Navigator)
When there is staff consistency, teams are able to integrate the pharmacist in their day-to-day workflow and build up a system of tasks the pharmacist can take on that addresses the needs of the practice.

“if they were just coming in once a week for a couple of hours, they didn’t get to know us and we didn’t get to know them” (Care Navigator).

**Variable levels of skill and expertise**

Aside from having to adjust to different pharmacists all the time, practices not being able to use the pharmacists most effectively, was exacerbated by reported variation in pharmacists’ skill levels. This was best summarised by one Care Navigator we interviewed who said:

“one of them is absolutely fantastic, he’s brilliant, the middle one is OK but he gets on, the last one, my GPs end up going over his work” (Care Navigator)

**Benefits of pharmacy in general practice**

There is evidence that where practices have overcome these teething problems, having a pharmacist in-house has been of genuine benefit both for staff and patients. Positive effects started to be experienced once practice teams got to know ‘their’ pharmacist or pharmacists; had a sense of what they can and cannot do; and, consequently, effectively care navigate patients to a pharmacist.

Once hurdles were ironed out, there are many positives to having a pharmacist in the practice. One practice, in particular, has really made an effort to integrate their pharmacist into the team and has worked up a workflow system that has positive effects for everybody in the practice:

“We know what we can pop on his list and we know what he can deal with. And he has a packet as well and we’ve put all sorts of different queries in his packet. So he comes down, he speaks to all the admin team, and he’s actually working with the admin team as well because he works where we actually take the phone calls for appointments. So that’s handy, if we’ve got someone on the phone that’s got a prescription query, instead of them ringing back or putting them on a list, sometimes he’s able to deal with it straight away. So that’s brilliant from the patient’s perspective; they can actually get something sorted straight away, rather than waiting weeks or days for it to be organised” (Care Navigator)

**Medication reviews and prescriptions**

The main benefit practices felt from having access to a pharmacist was with regards to medication reviews and prescriptions:

“I think one of the big things that we’ve noticed are the changes in the prescribing and prescriptions with us having a pharmacist on site. Which has taken a lot of the pressure off […] So as well, with us having the pharmacist coming through every day, we’re able to then put work onto the pharmacist, the authorisation of medication and the adding of repeat medication, also discharge letters, discharge policy” (Practice Manager)
Pharmacists taking over medication reviews and supporting discharge processes usually assigned to the GP is seen to work particularly well for patients with long-term conditions:

“So pharmacists and medication reviews: a pharmacist for somebody with a series of long term conditions who’s on a set of polypharmacy that’s predominantly prophylactic, that’s fine, they can do that really rather well” (GP)

In addition to medication reviews, issuing sick/fit notes makes up a significant portion of GP workload. Pharmacists are currently not able to issue these directly for patients, but some GPs feel that is could be helpful if they could. Other GPs interviewed felt, however, that extending the remit of pharmacy to include the issuing of sick/fit notes would pose the danger that the wider bio-psycho-social context which necessitates the need for a sick/fit note in the first place may be missed or misunderstood. They feel that allowing pharmacists to issue sick/fit notes would further fragment care and should rightly be within a doctor’s remit.

**Saving GP time and relieving work pressure**

Several interviewees agreed that having a pharmacist in-house takes pressure off GPs and has the potential to free up GP appointments:

“any queries we can send to the pharmacy and nine times out of ten they are able to deal with them without actually having an appointment and booking through the GP. So as the office supervisor that’s one of the main advantages that I’ve found, in the surgery, which then frees up quite a lot of appointments for the GPs, so that’s one of the big positives, we’ve found here” (Practice Manager)

Interviewees find that simple medication queries or repeat prescriptions do not need to be done by a GP and can, instead, successfully and quickly be processed by a pharmacist:

“the in-house pharmacist that we have and that’s really helpful I think (P2. agrees). Because it takes a lot of pressure off the doctors just for general medication queries. So whereas before, when we didn’t have that, doctors’ time was still being spent on these medication queries and now that’s been freed up so they can now spend other time on like seeing patients and stuff. But now the in-house pharmacist, they’re speaking to the patients about the medication queries and talking them through it. So that’s working, that’s really good. I do think that’s really good” (Care Navigator)

**GPs as barrier**

Similar to other Vanguard components, GPs themselves may pose a barrier to maximum utilisation and implementation of the service. This applies, in particular to more complex patients and those areas where it is felt that the expertise and role of a GP as a family doctor/general practitioner adds value and benefits.

GPs are resistant to the idea that care of the more complex patients – particularly those with mental health problems or chronic pain – can and should be ‘compartmentalised’.
“somebody who’s on an antidepressant for the last year, or is on…..risperidone to help with their behaviour in a care home - which isn’t good practice - or….on pregabalin for chronic pain. And I could go on...these are things that require consistency, continuity and a proper review in the context of somebody’s co-morbidity. And pharmacists really struggle to do that. That’s what general medical practitioners do”. (GP)

Patients as barrier

Like with the other Vanguard components, patients may also show, at least initial, reluctance to accept the service:

“I mean we’ve had resistance from patients when we’ve said to them about medication reviews ‘oh well we’ll give you a telephone appointment with the pharmacist’ ‘I don’t want to talk to the pharmacist, I want to talk to the GP’ ‘well no, actually, we’ve got a pharmacist, they’re a qualified pharmacist, they will talk to you’ ‘I DON’T want to talk to the pharmacist, I want to speak to the GP’. So it is about patient education, and I don’t think there is enough” (Practice Manager)

Awareness

Interestingly, practice staff themselves may be unaware of the skills a pharmacist can potentially bring to their team and this is something that could be addressed in future:

“we didn’t realise how qualified these people are, it’s like, been a learning curve for us - we didn’t know what they could do or couldn’t do. But they can deal with such a lot that we’ve realised they’ve taken a lot of the time from the GPs. And I think it’s probably taken a while for the GPs to get used to the pharmacists being here as well. But they just say ‘send things to pharmacy’ or ‘meds need sorting - send it to pharmacy’. So obviously they’ve got 100% faith in them or they would hang onto the work and they wouldn’t probably share it out” (Admin Staff)

Pharmacy in General Practice – patient experience

A total of 66 interviews were completed with patients, and these were split between 5 different surgeries.

There were initial difficulties in gathering data for the pharmacy evaluation which resulted from difficulties in identifying a practice where the scheme was being carried out in a consistent way – this is reflected in the small numbers of practices visited and the number of surveys completed at some practices. In many practices, the pharmacist was carrying out their work over the telephone which restricted access to patients.
Case study – Outwood Park Medical Centre

A component of evaluation was carried out at one practice (Outwood Park Medical Centre) which had developed a specific and individual model. This model may not reflect what other practices do but allows for a case study approval with transferable learning into the other models of delivery. This evaluation therefore largely reflects patient experience at this one practice. However, where relevant, experience at other practices is highlighted.

- The unique features of the Outwood Park model included:
  - the pharmacist seeing patients in practice (rather than solely working over the telephone);
  - the pharmacist having additional qualifications (Appendix A) that enabled them to prescribe medications and issue sick notes;
  - the pharmacist carrying out a ‘dual’ role of both ‘Medication Review’ and ‘Triage’ for minor ailments.

The Pharmacist working in the Outwood Park model described above was very clear that, in their opinion, the effectiveness of the service was dependent upon several key elements:

- Positive relationship between GPs and pharmacist (good communication, professional respect;
- Face to face appointments of a minimum of 15 minutes;
- Pharmacist able to undertake Physiological measurements e.g. blood pressure.

Of all the patients reviewed (66), of those who were happy to disclose their reason for visiting the pharmacist (83%):

- 61% attended for a medication review. This had usually been identified on a patient’s repeat prescription and they had then contacted the practice for an appointment and had been booked in to see the pharmacist. Most patients had done this via phone call. It was not clear how patients would be booked in to see the pharmacist if they tried to book an appointment online;
- 33% attended as an alternative to seeing a GP. Of these, 53% came due to a minor ailment. 47% for an undisclosed problem;
- 6% attended for other specific problems which included – an ongoing issue, a Blood Pressure Check and advice about Vitamin D intake.

Had the pharmacist not been available, most patients felt that they would have tried to see their GP for their problem (71%), while 11% felt that they would have attended the walk-in centre, 2% would have tried to see the practice nurse.

Other options that patients who had not been able to access this service would have considered were waiting to see medical staff, visiting the pharmacist at the local chemist, self-medication/ run out of medication and seeking advice from family and friends.
If Pharmacy in General Practice had not been available, what would you have done?

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<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Total</th>
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<tbody>
<tr>
<td>1 GP</td>
<td>70.77%</td>
<td>46</td>
</tr>
<tr>
<td>2 Nurse</td>
<td>1.54%</td>
<td>1</td>
</tr>
<tr>
<td>3 A&amp;E</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>4 Walk-In Centre</td>
<td>10.77%</td>
<td>7</td>
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<tr>
<td>5 Call 111</td>
<td>0.00%</td>
<td>0</td>
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<tr>
<td>6 Call 999</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>7 Other (please specify):</td>
<td>21.54%</td>
<td>14 answered</td>
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</table>

54% of patients felt that the appointment with the pharmacist was what they expected;

- Of those who did not feel or did not know if the appointment met their expectations (46%), 14 (50%) made specific comments:
  - 9 (64%) of these patients did not know what to expect;
  - 3 (22%) got more than they expected;
  - “I actually got more than I thought. I thought just BP test but also talked about diet as already on medication”;
  - “A prescription for antibiotics has been sent straight to the chemist”;
  - 2 (14%) felt unsure about seeing a Pharmacist rather than a GP.

Overall patient satisfaction with the experience of seeing the pharmacist in practice was very high with:

- 98% being satisfied with the effort that was made to help them understand their health issue or concern;
- 97% being satisfied with the level of information and advice that they received;
- 95% being confident that the service met their needs;
- 85% Very happy/ Happy having seen the Pharmacist rather than a GP;
- 83% were ‘Very Satisfied’ with their visit to the Pharmacist.

There were many positive comments about seeing the pharmacist in Practice.

Patients frequently compared their experience of seeing the pharmacist with that of seeing a GP. Comments were made expressing surprise at what the pharmacist was able to do, about the pharmacist being the expert on medications, on the service saving GP time and also on the service enabling them to be seen quicker than waiting to see a GP:
“With a GP I am concerned that I am wasting their time. The pharmacist answered all my questions thoroughly – didn’t rush me – this is very important to me. Felt less rushed than when I was going to see a GP. GPs have a lot on their plate – they are great but busy.”

“If I hadn’t been able to see the pharmacist, I would have had to wait to see a GP – the receptionist told me that there were no appointments – I would have gone without my HRT.”

“I would be guided by the pharmacist if I needed to see a GP. Pharmacists are the experts on medication.”

Patients felt that the pharmacist was able to spend more time with them, that they felt listened to and felt that the pharmacist had been very thorough.

“More time has been spent with me than usual, not rushed, it felt calm, she is a nice lady and very thorough. I’ve not been fobbed off.”

“I was in a bit of a dilemma as I wasn’t sure what authority a pharmacist would have. They covered everything. She had access to all my notes. I am very satisfied.”

Some patients expressed a feeling that seeing the pharmacist had been more effective for them than seeing a GP for their problem.

“Finally yes [I feel confident that the service has met my needs]. Seeing the pharmacist has made the difference. This has been going on for 2 years”

“[The service] couldn’t be improved. The Pharmacist was relaxed so I was relaxed. Now that I know there is a pharmacist in Practice I would come back if I had any concerns about medication. Pharmacists know more about the medication side of things.”

Pharmacists being able to provide sick notes reduced the need for some patients to make further appointments with a GP. Had this not been the case, seeing the pharmacist would arguably have increased the time spent on the patient by professionals and by the patient in multiple appointments;

“I expected less. It was a medication review and she gave me a sick note as well so I don’t have to see a GP.”

There were far fewer comments about problems with the service or, the way that the service could be improved. When people were not satisfied, it was largely to do with their problem not being sorted out and/ or still having to make an appointment to see a GP or other healthcare professional:

“Nothing to do with the pharmacist – she was very good – but I now have to make another appointment to see a GP and come back for that. It is difficult to get an appointment when you need one – luckily I don’t come very often and it’s not urgent but if I did I don’t know how I would go on.”
“It was a waste of time... I thought he would be able to alter my medication. It was a waste of time as the pharmacist did not do anything – he just listened.”

“Being able to have a blood test straight after the appointment, instead of having to make another appointment to come back.”

Other comments were regarding waiting times (in clinic) with some patients unhappy about the time they had been waiting (that day) to see the pharmacist. This contrasts with the level of satisfaction from patients at the pharmacist having more time to spend with them.

Although patients expressed satisfaction with seeing the pharmacist for their current problem, they still wish to see a GP/ have the option to see the GP for other problems.

“If it was something more serious, I would have wanted to see a GP. I knew for what it was that it would be ok to see the pharmacist.”

Patients also felt that the service should be publicised better.

“Make people more aware of this service, it’s great”

Finally, a range of other issues were identified including patients not actually being aware they were seeing a pharmacist until their appointment and medication reviews being quicker when done at the pharmacy.

Some patients identified that they had received dietary advice from the pharmacist as an alternative/ adjunct to medication. In each case this was to support lowering of cholesterol. Dietary advice was also provided on a printed sheet of paper which, although containing accurate information, was not attractive and could be improved to communicate the messages more clearly.


**Recommendations for Pharmacy**

- The model at Outwood Park should be considered good practice, in particular that the pharmacist was well integrated into the practice, was seen as an equal and useful partner with the right qualifications, attended practice meetings and there was good two way communication.

- Qualifications required for pharmacists working in the scheme should be clear and standardised. Consideration could be given to pharmacists’ ability to provide fit notes if that is possible.

- Job descriptions should be standardised and could include specific pharmacy qualifications and possibly also nutrition training, Physiological measurements and interpretation/ action and the ability to take blood.

- Appointments should be a minimum of 15 minutes and could be face to face, not by telephone.

- Consideration should be given to the fact that online booking options generally only offer GP appointments, which means diversion of patients to alternative professionals is then not possible.

- The patient information sheets that are provided could be made more attractive and user friendly e.g. nutrition.

- The service could be publicised more widely to patients.

- To investigate the potential to link in to NHS Health Checks.
Summary Physio/Pharmacy

As with pharmacy, several staff groups found it difficult to work with/share patients with professionals who are not part of the practice team. Potentially detrimental effects of the ‘drop in-drop out’ nature of both Physio First and Pharmacy are that:

- Physiotherapists and pharmacists lack a more nuanced understanding of the practice culture, practice organisation and patient population (there is a link here to understandings of what GPs should do/holistic approach to patients), and

- Variations in skill levels of staff belonging to external service providers.

The latter point seemed to have been more of an issue with regards to pharmacy than to Physio.

Overall, both Physio First and pharmacy in primary care can be described as ‘when it works it works really well and when it doesn’t work, it really doesn’t work’:

“I would say that both of those things [Physio and pharmacy] have had a real positive impact on us as a practice. I don’t think it’s saved hundreds and hundreds of GP hours, but what it has done is given us flexibility within the system to move things around” (GP)
Extended Operating Hours

**Key aims of Extended Hours Vanguard component**

- GP practices opened into the evenings and Saturday morning
- To establish a unified model of extended primary care access across MCP Vanguard’s three GP networks for patients registered with any of the associated practices.
- Allowing registered patients equal ability to access urgent and/or routine appointments in the evening and at weekends as close to their home as is feasible based on resources available and demand on the system.
- To improve the ability of GP appointments for those patients who may not be able to attend appointments during core hours (08:00 – 18:30).
- It is expected that access to primary care during out of hours periods reduces urgent care demands.
- To deliver more responsive care closer to patients’ home with a local GP (not necessarily the patient’s regular GP practice) who has full access to the patient’s records.

**Key findings for Extended Hours evaluation**

- Patients like it (flexibility, no need to take time off work).
- The Healthwatch survey showed this service is mostly used by working people, however, data from clinical systems shows that 25% of users are aged 0-15 years.
- Patients express concern for GPs workload due to extended work hours.
- Most out of hour appointments are routine appointments.
- De-facto workload increase for GPs, appointments are filled with overspill that cannot be addressed during core hours.
- Using 111 as the gateway caused under-utilisation as the WWHW was a relatively small service within a much larger footprint, meaning that this was not a common referral point when patients called with a GP problem.
- Underutilised – reluctance to advertise for fear of increased workload.
- Concerns around duplication of workload due to patients not necessarily seeing a GP in their regular practice and then having to return for an in-hours appointment.
Extended Hours – Staff

Staff are quick to acknowledge that, from patients’ point of view, having access to a doctor outside of core working hours is potentially beneficial. It gives patients more flexibility when to be seen and reduces the need to take time of work.

However, they are doubtful whether extending operating hours in primary care reduces visits to A&E departments or, indeed, whether those appointments are being used for urgent appointments. Patients, they feel, use the appointments to see their GP outside the hustle and bustle of regular hours or as an “opportunity to catch up” (GP).

GPs themselves feel the extra hours are simply “an overspill for things [we] can’t fit in [our] working week” (GP) therefore leading to a de-facto increase in work time and workload.

Relatedly, one Practice Manager said that:

“Out-of-hours, I think has given false hope to GPs that they will not-, or the majority of GPs, that they will not have to work till eight o’clock at night. And by that being funded by Vanguard, it’s given false hope to GPs” (Practice Manager)

Consequently, like with other Vanguard components, some staff were reluctant to fully advertise the service to patients for fear of them getting used to the extra resource and this, in turn, leading to additional, unmanaged and under-resourced workload:

“If you advertised it, OK, ‘Ta da! We’re open Saturday and Sunday! Come and make use of it!’ people would. But my view is that it would just be a distraction. It would spread the capacity over seven days into routine care when it’s actually needed in urgent care”. (Practice Manager)

In addition, staff have concerns around the continuity of care and fear that those patients who see a GP during extended hours may simply bounce back for an additional appointment, especially where follow-on care such as referrals are needed:

“It would ruin continuity. It would lead to repetition of work because, well, you can’t refer people for example! So they’ve still got to come back and see their normal GP and get referred”. (Practice Manager)

Whilst staff and patient experience of the other Vanguard components largely mirror each other, it can be said that extended operating hours is the area where the two experiences/opinions differ most significantly and where staff reluctance clashes with patient enthusiasm.
Extended operating hours (EOH) – patient perspective

The EOH service was under-utilised.

71 people were interviewed at 15 evening and weekend clinics from December 2016 to March 2017. The service was often poorly attended during our visits, we occasionally saw only 4 people during a 2 hour clinic.

However, this meant that access to an appointment was very quick - most people (90%) were seen either on the same day or the day after they booked an appointment.

“Walked in and got this appointment.”

“Use the service more effectively; it’s never busy, seems like it’s not being utilised to its potential.”

Referral routes through NHS 111 were not very effective and the EOH service became a very localised offer

Despite the fact that the service had been set up originally to accept referrals only through NHS 111; most people told us that they had been referred to EOH by their GP practices (73%). We are aware that this was an issue that West Wakefield worked with NHS 111 and NHSE to overcome, but with no improvement.

The EOH service is based at Ossett Health Village and 65% of the people we spoke to were registered already at Ossett Health Village which suggests that it was not very widely utilised by other practices with West Wakefield. However this does represent 30% of the GP federation population
The service does appear to divert people from A&E or walk in centres, particularly if they go through NHS 111

If the Extended Operating Hours Clinic had not been available, what would you have done? Tick any that apply:

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<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Response Total</th>
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</thead>
<tbody>
<tr>
<td>1 Gone to A&amp;E</td>
<td>14.49%</td>
<td>10</td>
</tr>
<tr>
<td>2 Gone to Walk-In Centre</td>
<td>36.23%</td>
<td>25</td>
</tr>
<tr>
<td>3 Gone to the Pharmacy/Chemist</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>4 Waited for a GP appointment</td>
<td>30.43%</td>
<td>21</td>
</tr>
<tr>
<td>5 Visited NHS Choices website</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>6 Contacted NHS 111</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>7 Contacted the GP Out of Hours Service</td>
<td>1.45%</td>
<td>1</td>
</tr>
<tr>
<td>8 Nothing</td>
<td>10.14%</td>
<td>7</td>
</tr>
<tr>
<td>9 Don't know</td>
<td>1.45%</td>
<td>1</td>
</tr>
<tr>
<td>10 Other (please specify):</td>
<td>5.80%</td>
<td>4</td>
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Analysis of the 19 people who were referred to the EOH service by NHS 111 shows that 84% said they said they would otherwise have accessed urgent care services – either A&E or the walk in centre.

“This service means I did not have to attend A & E and waste their time”

People who accessed the service were very happy with it. They quote quicker and easier access to a doctor as the main reasons for their satisfaction. 97% of people who had an EOH appointment were satisfied or very satisfied with the service and 91% said they didn’t have to wait at all. The fact that it offered much better access to GP appointments was seen as definite benefit for people, with 31 of the 68 comments relating to improved access.

It is important to note in this context that, perhaps inadvertently, out of hours appointments may cater to patients’ preference to see a GP rather than a different health professional as all extended hours appointments are automatically GP appointments.
The service is particularly good for working people

Most people (92%) accessing the extended operating hours service were aged between 16 and 66. The highest represented age group was 26-45 year olds (65%) which correlates with the fact that a high number of people (23) said that the service was good for them specifically because it was outside working hours.

“Evenings are more convenient – hard to get time off. Brilliant idea.”

“Later and evening appointments mean no time off work.”

The service needs to be publicised better for patients

Most suggestions for improvement were about promoting the service better so that it’s used more.

“I didn’t know about it, so that could be better.”

Recommendations for Extended Hours

- This service should definitely be continued in some form, it is particularly good for people who work.

- Continue to ensure that NHS 111 refers appropriately, but don’t use this as the only route for referral.

- Publicise the service both to patients and to primary care staff.

- Ensure that it is resourced for the long term so that patients and staff have faith in it.

- Ensure that referrals to the service are appropriate and consistent across the district.
HealthPods / pop-up primary care.

**Key aims of HealthPod as a Vanguard component**

- The HealthPod was a pop-up primary care facility to offer health checks, wellbeing advice and assessments such as cardiovascular disease (CVD) risk, diabetes screening, atrial fibrillation (AF) screening and cholesterol tests in neighbourhood locations such as supermarket car parks. The ‘Real’ HealthPod was an inflatable igloo like structure whereas the ‘Virtual’ HealthPod utilised existing venues.

- The key objective of the HealthPod was to increase access to primary care services usually offered in GP surgeries (e.g. as part of the NHS Health Checks programme). In particular, it was intended to bring services to ‘hard-to-reach’ groups who may benefit from such services, such as (a) middle-aged men (b) ethnic minorities (particularly people of South Asian origin) (c) the gypsy/traveller community.

**Key findings of HealthPod evaluation**

- People liked the HealthPod and found the health and wellbeing checks very useful.
- Over a third of people interviewed came specially to visit the HealthPod.
- It was not possible to find out whether people followed up the advice they were given.

32 people were interviewed at HealthPod sessions from December 2016. Activity was very limited over the winter period as the pod was not suitable to be taken out in low temperatures, so on a few occasions a ‘virtual HealthPod’ session took place where the staff were available for health checks but the physical pod was not present.

**Key messages**

- Most people who visited the HealthPod really liked it. 71% gave the HealthPod 5/5 for satisfaction rating and the rest gave it 4/5.

- 12 people, over a third, said they had come specifically to visit the HealthPod. Most people (65%) told us they had heard of the HealthPod when passing rather than being aware that it was going to be present at the location.

- Every person we interviewed had had a health and wellbeing check, and said they had found the information and advice provided at the HealthPod useful. One person went specifically to find out what her BMI was after her GP had said she had high blood pressure.

- The HealthPod design does not include a door so the space is not very private, however 94% said they thought there was sufficient privacy for the purpose of their visit.

- One of the aims of the evaluation was find out whether people who had been given specific advice at the HealthPod visit would follow that advice. Unfortunately only 7 people indicated that they had been given advice to follow up and nobody gave us permission to contact them at a later date.
Practice staff described the HealthPod as an “expensive commodity”. It may improve patient satisfaction but staff are doubtful whether it has the potential to a) reach the intended patient population and b) improve health outcomes:

“The HealthPod, yes, the patients have loved it but it’s a very expensive commodity. Has it gained anything? Patient satisfaction perhaps, yeah, because they’ve loved it. [...] Because they’ve been able to bob in and have their blood pressure taken, have a chat with somebody. So from a patient-feel-good perspective they’ve loved it. Has it actually helped with picking up patients?...The amount of patients that have gone I’d say no, not many. Because you’ll find that the patients that go are the well patients anyway” (Practice Manager)

In part, staff feel that the HealthPods haven’t worked as well as they could have because of lack of advertising:

“I think they were there the other day, a Hub [sic] was there with a gentleman outside it. The thing is, I don’t think it’s very well advertised and people are sort of like ‘oh what’s that for? What’s that all about’ and you say ‘well go and have a look, it’s regarding your health and your well-being and that’. But I don’t think it’s very well advertised and people don’t really know much about it or why it’s there or what it’s for”. (Care Navigator)

To prove this latter point, it is worth mentioning that, among interviewed staff, ‘Pod’ and ‘Hub’ was used interchangeably, pointing towards a lack of awareness and understanding of the nature and function of either of the resources:

“They set up the Hub [sic] just at a little street fair that we have in my local village. And actually that did quite well because a lot of people were ‘ooh, what’s this?!’ so they’re straight in there getting their blood pressure taken and everything like this. But certainly, I think in the summertime time we do get quite a lot because they do like a general health check and blood pressure and things like that and then they send them through to us and we data input it onto patient’s record. And in the summertime we had quite a lot of dealings with this but then it sort of like dwindled down a little bit in the winter. So I don’t know whether, obviously it’s more out and about, with it being a Hub [sic], out and about in summer rather than winter. But know, not a lot of people actually know it exists, that’s what it is….so I don’t know whether that’s working or not”. (Admin Staff)

The HealthPod has now been decommissioned and will not form part of the Vanguard in year 3 and beyond. This is due to the high cost of running, the perceived duplication of the service with other health check initiatives in the district and the lack of evidence that people followed up health advice when given.
Discussion

Implementing Vanguards

“Everyone is interested in innovation in healthcare. Innovation promises better ways of organizing and delivering treatment, improvements in the clinical and cost-effectiveness of services, and reductions in the burdens of illness [...] Most research on healthcare innovation focuses on the outcomes of innovations - measuring their impact and exploring their effects - but this doesn't always tell us the things that we need to know. Researchers try to help healthcare providers by quantifying outcomes and comparing the effects of these innovations. [In order to] understand implementation and integration [of innovation] we need to focus on the […] processes that lead to innovations becoming embedded in everyday work”.

In this light, we were able to identify a number of issues that contribute to either enabling or hindering the successful and sustained implementation of organisational change in general and Vanguard services in particular. They include:

- Communication and consultation between commissioners, primary care teams and patients;
- An understanding of how best to achieve buy-in to proposed changes;
- The mechanisms of patient expectation management;
- An understanding and acceptance of the role of GPs as family doctors and the associated holistic approach to patients, and:
- An understanding that, when it comes to introducing change, one size does not fit all.

Introducing change: Communication, consultation and collaboration

There is a large evidence base that suggests that organisational change is most lasting when it is introduced in consultation with those it is aimed at and takes into consideration specific and real needs of recipients. Many of the primary care staff we spoke to during the course of this evaluation did not find this to be the case. Interviewees felt that there was an overall lack of consultation; that patchy information was provide often at the last minute; and that individual needs for resources and systems change of each practice were not recognised or acknowledged.

Some participants commented that there was little consultation with practices, prior to Vanguard implementation. The challenge of the pace of implementation of the Vanguard work may have meant this was variable:

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“there was little or no consultation really. [...]. Or if there was any, it would be a large document, shared at the last minute to say [‘are you happy?’]” (GP)

“a lot of what’s happened or happening, people didn’t feel very consulted about” (Practice Manager)

In addition, interviewees felt that the top-down nature of bringing Vanguard components into practices meant that:

“the MCP Vanguard brought in a lot of external people, not familiar to the six practices, from all sort of-, from all parts of the system. [...] perhaps they didn’t engage as positively as they could have done. All of which I think is true. What really happened is that trust between that programme management office and the practices got eroded over time”. (GP)

Practice teams may feel left alone and without the necessary resources to implement changes, even though, in principle they would be happy to embrace them:

“Again, I think in principle it’s a good idea but I think it’s very unfair for the onus of that to be put onto practice staff. [...] Because what happens is that these services or these projects are implemented locally and its practices that get the backlash from patients. [...] So they enforce this implementation on practices and it’s us that have to have the face-to-face battles with patients, day in, day out, because of a change that’s been enforced without any national support” (Practice Manager)

Such perceived lack of support can potentially lead to an unhelpful ‘us versus them’ mentality, adding further barriers:

“But they think that it’s us as a practice that are trying to make their lives difficult. And it’s the same with care navigation. Yeah, it’s a good idea in principle but can you imagine the confrontation that we’re going to have to put up with when we tell a patient ‘no I’m sorry you can’t see a doctor because my protocol says that you can go to your chemist and self-train’...you know. We...we have to pick up the pieces of all these projects all the time and it’s so disheartening” (Practice Manager)

Rather than focusing on working with practices on a number of relevant issues, participants felt that:

“They were just feathering their own nest” (Practice Manager)

Applying specifically to the particular context of West Wakefield, several interviewees considered West Wakefield Health and Wellbeing Ltd to be a profit-making enterprise. 4 This knowledge left participants to think that motivations and objectives may not be entirely genuine or in their best interest:

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4 West Wakefield Health and Wellbeing is a limited company. They are a GP federation of six neighbouring GP practices in Wakefield, West Yorkshire. As a group of doctors, practice manager and other healthcare professionals, they work together and invest in new services to provide the best possible healthcare for their patients.
“so decisions seemed to be made with other objectives that didn’t have, at their heart, the best interests of the six practices in the Federation if you know what I mean. It was almost as though the Federation was just the vehicle, not the purpose” (GP)

“They needed to listen to more of the naysayers. They needed to hear the challenge. But I think that’s very hard; when what you’re doing is trying to market your brand and your vision, the last thing you want is somebody...pricking holes in your balloon”. (Practice Manager)

“I think it was a belief from the leadership that they needed to create a strong brand and identity - and there was too much focus on marketing that. Not just locally but in fact across the whole country and with the Centre, of which I must say they did a remarkably good job. But not sitting down and reflecting on the function, you know, what they’re actually trying to do, that was going to make a difference and look different and model-, new models of care. And that brand identity was coupled with what I believe to be a desire to create products. And so at the end of all this, there would be products that the Federation could market and benefit from” (Practice Manager)

What is Vanguard? Information, awareness and relevant advertisement

Awareness of the Vanguard projects and associated buy-in differed significantly from practice to practice.

Some of these variations can be explained by the fact that practices have joined the programme at different points. Consequently, some practices were, at the time of being interviewed, more established in the process of change than others.

Beyond this, however, there were instances of surprising lack of knowledge of Vanguard even among network 6 practices. These can best be explained by communication flow and advertising.

As one Practice Manager put it:

“I’m not sure whether [my staff] would understand it as Vanguard. I mean they know that we have Physio at the practice, they know that we deliver on extended hours and some of the projects that you named earlier. But I’m not sure whether or not they’d associate that as part of Vanguard” (Practice Manager)

Without a certain level of guaranteed knowledge and awareness of Vanguards and Vanguard components it may not only be difficult to achieve genuine buy-in and implement any sustainable change but also leaves individual practices to feel like engaging with proposed changes is one more thing to do with precious little resources, rather than experiencing the proposed change as a potential resource in itself.

“if I didn’t work in general practice, as a member of the public, I’ve never come across care navigation [for example]. There’s no marketing or advertising, you know what I’m saying? We’re supporting this theory of care navigation but I can’t see that anybody’s doing that. It’s all on the head of the practice” (Practice Manager)
**Patient expectations**

Ultimately, Vanguards are aimed at changing patients' experience of their healthcare.

Much of the work primary care teams do on the ground and day-to-day revolves around managing patient expectations. As such, they measure when, how, and how pro-actively on-going changes are communicated to patients.

Interviewees felt that there was a relative lack of Vanguard advertisement from ‘above’ and it was mainly down to them as practice teams to manage the supply and demand of Vanguard components to their patients.

Some participants said – being fully aware that funding for additional resources such as Physiotherapists and pharmacists would come to an end - they were reluctant to advertise Vanguard components to their patients for fear of raising expectations which they then would not be able to fulfil.

This may create a cycle of under-utilisation: Patients are unaware of services such as Physiotherapists or pharmacists in their GP surgery; therefore they may be reluctant to accept them when offered; once awareness rises, patients may begin to embrace and expect these new services and grow accustomed to them (e.g. pharmacy and Physiotherapy where we have observed high levels of patient satisfaction); practices are reluctant to reach a point where patients get used to the additional services as they fear the backlash when, further down the line, the service is stopped.

“this is going to come to an end, and then we’re going to lose the bits of the programme that make a difference. Physio First and Pharmacist, for example, is just going to disappear, it’s going to get switched off” (Practice Manager)

“Because that’s the nature of the beast with the NHS; any service you put out there - and yeah, it runs brilliantly for three, six, 12 months - then patients become aware of it and the more patients become aware of it, the more they want out to it. So the patients ask more, so they demand more of that service - because you can’t hide the service, you can’t pretend it doesn’t exist! It becomes oversubscribed then”. (Practice Manager)

Indeed, evaluating the success of some services may be skewed by the fact that they have not been advertised or used to their full potential in anticipation of their ending. Staff are fearful of the additional work of patient expectation management they will be faced with once certain services will be stopped:

“I’ll be sat here dealing with complaints all day saying ‘you used to have this Physio (…) and now you’ve stopped it” (GP)
This sentiment was echoed by one of the Physiotherapists we interviewed:

“I mean we actually had a patient two weeks ago who actually phoned up their GP and specifically asked not to see the doctor, they wanted to come and see the Physio at Physio First. And it’s took us two years to get to the point where the patients are now asking for it! But that’s good because the penny’s dropped - [And now the money’s stopped!] Well there you go, there’s the irony!” (Physio staff)

A Practice Manager mentions the absence of consultation and agency many primary care teams experienced

“Yeah, it happens all the time yeah. Patients are unhappy about changes in the services that are enforced upon us that we don’t have any control over”. (Practice Manager)

**The need for patient re-education**

Many of the people we spoke to felt that managing patients’ expectations goes beyond managing supply and demand of available resources. Participants felt that a culture shift is required.

“the only way to relieve the pressure on Primary Care is to get patients more educated about how they use Primary Care”. (Practice Manager)

As evidenced throughout, patient expectations of health care services and the associated roles of both doctors and patients themselves are seen as barriers to successfully implement organisational changes.

Interviewees mentioned the ‘24-hour culture’ that has been established among the wider public

“It’s more of a ‘here and now’ and 24 hour culture. That’s what’s changed. You know, patients a few years ago were quite happy to have an appointment with somebody in two weeks’ time or three weeks’ time. They want it now, today, at a specific time. They don’t want to come out of work, they want us to work at 6:30 in the evening so that they can finish work and come and see us”. (Practice Manager)

Some interviewees feel that there has been a generational shift in how patients perceive primary care and that this puts a strain on the health care system

“perhaps a generation before where people might ask their parents or...or ask grandparents what to do with ‘oh I’ve burnt my finger, what shall I do?’ that sort of thing! Rather than immediately picking up the phone and seeking medical advice”  (Care Navigator)

“Whereas I think a lot of the younger generation tend to use the doctors as like a drop-in like ‘oh I’ve got back ache, I’ll go to the doctor’ or ‘I’ve got earache, I’ll go to the doctor’ ‘oh I’ve got chicken pox, I’ll go to the doctor. And with the amount of people and patients that we’ve got on the list, and the resources we’ve got, we just can’t see all these people, it would just be a total meltdown” (Care Navigator)
However, primary care teams want to be supported in re-educating patients and feel it should be a shared responsibility to do so.

“Yeah I don’t think it’s just our responsibility to re-educate patients. I think we need the backing of the NHS in general. The government. The policy makers. The people that are the brains behind all these projects. They need to support what they’re trying to do by helping to re-educate patients and not put all that onus on us” (Practice Manager)

Interestingly, these sentiments are not directly echoed by patients themselves who, generally, express gratitude for their primary care teams and a genuine awareness of not wanting to put undue burdens on them.

There are indications, however, that – given enough time - patient expectations do shift.

“there were barriers in place right at the beginning that the patients have now got used to, us asking what the problem is. And they’re quite happy to give us that information. […] most of them now, because they’re used to the system and a lot of them are regulars - and we do have our regulars - they’re quite happy to tell us what it is” (Care Navigator)

**Health Champions**

Whilst we only had detailed feedback on health champions by one practice, findings indicate that, for certain patient groups – in particular those who are more vulnerable and in need of social and well as health care - having health champions in the practice may have a positive impact.

“we have Health Champions now that come into the surgery. To help patients-, sort of like the lonely and the vulnerable who just come to the doctors for a chat because it’s ‘oh I haven’t seen the doctor for a couple of weeks and I’ve got a bit of an ache and a pain’, things like this. So we’ve got these Health Champions in that are running like coffee mornings, a craft group, things like this[...] And they come in every fortnight. And the Health Champions, they’re all patients here, and what they’ve done is set up this singing group so they have someone come in - because singing is quite good for people, especially with depression and dementia and things like that. So it’s like gearing towards these people that feel lonely and isolated. And they also do chair-based exercises which are really, really good. And they have an arthritis support group coming in as well. […] And one of our administrators, she’s in charge of the Health Champions now, we’ve created her another role so that she’s actually involved with them as well. So that it’s like communication between us and the Health Champions to see what’s going on, what patient needs are as well. So that’s worked out really, really well has that” (Care Navigator)

In fact, health champions are seen to have the potential to replace some of the expectations often associated with a GP’s role.

“I think it’s helped a lot for the patients that are isolated and just come-, I remember years ago one of the doctors went out to visit a patient and the patient said ‘can you nip to the supermarket and get mi shopping on the way in’. So for things like that, that’s what they’ve been using the old fashioned doctors for, more of the sort of social aspect, just to keep in
touch. If there’s nobody around them, it’s just a little bit of a link to the outside world to keep them involved. So I think this has been a brilliant service actually” (Care Navigator)

Like the introduction of health champions, some of the Vanguard components themselves – care navigation, as indicated in the following quote – are seen as having the potential to aid re-educating patients. But again, there is an emphasis on the time it takes for changes to take root

“So I think care navigation has been successful in that it is slowly educating the patients that do come to the practice regularly to perhaps think of alternatives, or gives them the option to choose other alternatives rather than immediately deferring to the GP” (Care Navigator)

The General Practitioner as family doctor is a concept at odds with the MCP Vanguard approach

Signposting patients and educating them away from a ‘doctor first’ approach can be useful and effective in alleviating some of the pressures on primary care teams. Is can also improve waiting times and access to the most relevant health care professional.

However, these Vanguard characteristics are at odds with the idea of the general practitioner as a family doctor, an idea that is present, valued, and defended by a number of participants we spoke to. GPs are adamant that compartmentalised care does not allow for fully understanding a patient within their bio-psycho-social context

“people forget what a generalist medical practitioner brings to a consultation. When-, so one of the frustrations has been with Physio First, is getting people-, so they phone up. They disclose that it’s about a knee pain. The receptionist tries to care navigate them into a Physio First appointment and then-, but the patient is reluctant ‘no, I want to see doctor so-and-so please’ and everyone gets a bit frustrated. But then when they actually come to see you, the context of the knee pain isn’t just that it’s knee pain, it’s that it’s a knee pain that their husband or wife has been nagging them about, or it’s causing difficulty at work where they’re quite stressed. Actually their main concern is that ‘this is quite a severe knee pain and I’ve got underlying cancer’. Or they need to legitimise their illness and get a sick note or what have you. The context - their ideas, concerns and expectations in their presentation with knee pain - is not one that will necessarily be met by a Physiotherapist alone”. (GP)

“somebody who’s on an antidepressant for the last year, or is on…..risperidone to help with their behaviour in a care home - which isn’t good practice - or….on pregabalin for chronic pain. And I could go on…these are things that require consistency, continuity and a proper review in the context of somebody’s co-morbidity. And pharmacists really struggle to do that. That’s what general medical practitioners do”. (GP)

GPs may feel that Vanguard components simultaneously demote them whilst, at the same time, putting more pressure on them

“We’ve become the “Care Navigators” now, which we shouldn’t be. We should be actually seeing patients face-to-face but we’ve had to do that in order to, like you said, take control and to….you know, to keep the patients happy” (GP)
“I think it is challenging for GPs because if the easy stuff is diverted elsewhere, they see the more and more complex patients. And if you’ve got back-to-back complex patients all day long! It’s particularly draining I think. So yeah, I mean although it gives the practice, or our group of practices, the different options, it means the GP’s job often becomes more difficult because they’re seeing the more complex patients more of the time without a break with someone coming in saying ‘I’ve got a cold’ ” (GP)

Patients, likewise, are reluctant to let go of the idea of a doctor who ‘knows you’ and ‘knows your family’ – especially where mental health problems are concerned:

“because one of the medications that I’m on, is an antidepressant and he wanted to talk about putting it up and I said ‘I don’t want you to do anything. I want it leaving until I speak to my GP, I need to speak to him about it’. And he said ‘that’s fine’. I said ‘because there’s some personal things I need to discuss” (Patient)

“if it’s a bit more personal and maybe having to do with your mental health, you would just rather see your GP? [Oh yeah, and my GP, my own GP. Oh definitely]. Because you feel they know you and they’ve known you for a long time and-…..[Yeah and they know why I went on medication and things like that. I know it’s awful…you know, when I’ve cried and my GP looked after my mum…and all the things there….and my dad. And of course they know the issues, so yeah]” (Patient)

Saving GP time? Re-distributing versus reducing workload

Key aim of the MCP care model was to alleviate GPs workload pressure and save GP time. Our evaluation indicates that the day-to-day tasks of GPs may indeed change with the introduction of Vanguard components. Whether, how, and where GP time is saved, however, deserves unpacking.

It is important to get a better understanding of how GP work changes, whether time is being saved, and, if so, what the saved time is being filled with.

One sentiment that was repeatedly expressed is the fact that Vanguard-related changes have meant that administrative workload has increased for both GPs and Care Navigators

“Care navigation, for instance, because you’ve got staff answering telephones at eight o’clock in the morning and you’ve got 30 or 40 calls waiting to come in, it does not save any time because at the end of the day the girls haven’t got the time to do the care navigation because they’re constantly aware there’s another 20 calls waiting to be answered. If those calls were coming in five an hour, and they were on a steady stream, then yes you could divert say three of those. But then for those three that you’ve diverted you’re going to use up that time for the next three that come in that want to see the GP. So it doesn’t save GP time. It’s increased administrative time” (Practice Manager)

The findings from the evaluation suggest that GP time is not so much ‘saved’ as re-allocated and used for different tasks. In some instances the effects of this can be positive, in particular for patients, as access to the appropriate health professional may have been facilitated and speeded up:
“So, it isn’t freed-up time. But what it is, is improved quality, arguably and patient experience, in that they get things done in a more timely way”. (Practice Manager)

In other instances, interviewees feel, it make GPs workload heavier because the nature of health complaints and types of patients GPs see changes as a consequence of Vanguards being implemented:

“It doesn’t improve the efficiency with which we see patients and our experience in consultations. If anything, it’s made it worse; a quick medication review would be a relatively stress free consultation - that might now get filled with somebody presenting with a new problem, or a more complex follow up. And that’s one of the things to bear in mind, as we signpost and care navigate people to more appropriate points of contact that aren’t doctors, you’re left with more complex medicine, still within ten minutes […]You don’t get the easy quick wins [ ]. It makes it more stressful” (GP)

Some interviewees were cynical about the notion that ‘time saved’ = ‘money saved’ = ‘success’ and urged for a more nuanced exploration and understanding of the pressures currently faced in primary care:

“So don’t try and count time saved; try and get a much more holistic assessment of what the quality improvement looks like, on having in-practice pharmacists. But there isn’t a simple equation: put pharmacists and Physiotherapists and a medical health practitioner in surgery and you could lose one or two GPs - No. It can’t be done”. (GP)

“it’s very difficult to evaluate and say ‘Vanguard's freed up our time’. I’m still doing my paperwork and admin work after 6:30 in the evening and I’ve always done that because during the day you don’t get any chance at all. There’s always something to do. So, it’s not like it’s given us several hours of free time to say ‘oh yeah, this is because we’re dealing with fewer patients’. Unfortunately it’s not that black and white” (GP)

Summarising an overall sentiment shared by most interviewees, one GP exclaims that, whatever time may be freed up or used differently

“it’s time we didn’t have in the first place!” (GP)

One size does not fit all – tailored interventions may have more impact than disruptive innovation

Evaluation findings:
• How and where GP time may be saved through organisational change,
• How the role of GPs as family doctors shapes patient expectations and work cultures, and;
• The barriers encountered during the process of implementing change suggest that tailored interventions may have a bigger and longer lasting impact than disruptive innovation. As demonstrated throughout this report, this sentiment was expressed by many of the interviewees, staff and patients alike.
Different patients require different care and approaches. Whereas irregular attenders with straightforward and acute or temporary health problems may be well served by being referred to an in-house Physiotherapist, for example, or repeat prescription may easily be taken care of by an in-house pharmacist, long-term patients with complex condition, frequent attenders, and patients with health anxiety or unexplained symptoms may be better off in the continuous care of a GP.

Equally, primary care teams differ with regards to their work cultures, patient populations, resources, and specific needs.

Change, and the need for change is contextual and one size rarely fits all. As one Practice Manager put it;

“And what works in London is not going to work up North. You know, and what works up North is not going to work in the Midlands. You have to look at it from an area point of view”. (Practice Manager)
Summary of Findings for Qualitative Evaluation

The findings from both strands of the qualitative evaluation (carried out by NECS and Healthwatch Wakefield) can be summarised as follows:

- Timely and constructive communication about interventions and new services to staff and to service users is essential for the successful implementation of Vanguard components but understanding this needs balancing with the external drivers for implementation of change.

- Awareness of and attitudes towards the care model – driven significantly by communication between West Wakefield Health and Wellbeing Ltd and the participating primary care practices - may have influenced implementation, sustainability, and trust.

- Concerns around the pilot nature of Vanguard services leads to staff’s reluctance to fully promote services to patients for fear they will not be maintained.

- Centrally held funding may have affected take up from practices.

- We have encountered a degree of suspicion of the MCP care model across all staff groups – in particular towards the lack of an evidence-base for some of the interventions.

- The top-down Vanguard culture of ‘disruptive innovation’ may have contributed to the overall high degree of suspicion and resistance among staff groups.

- A ‘Consult first, collaborate, introduce tailored change second’ approach may produce higher levels of buy-in.

- There is a need to take local contexts into account when implementing change. A perceived ‘one size fits all’ approach to Vanguard introduction may have posed barriers to buy-in and successful implementation.

- How GPs see their professional role influences the extent to which Vanguard components are welcomed and implemented. Many GPs consider their professional role to be that of a ‘family doctor’ which includes taking a holistic approach to individual patients’ overall well-being and health care needs. The new care model approach might undermine this role by compartmentalising the care patients receive.

- The perception of primary care staff that Vanguard components fragment health care services may be diametrically opposed to the care model’s aim to integrate services across the community.

- Whether and how the implementation of the new care model components may alleviate the workload pressures GPs experience cannot easily be answered. There is evidence that suggests workload pressure may have increased due to workload re-distribution which leaves GPs to see disproportionate numbers of complex patients.
• There is evidence that, following a period of adjustment, patients are happy to see a variety of health professionals other than their GP.

• We found there to be generally high levels of patient satisfaction with some of the Vanguard components - Physiotherapy and pharmacy, in particular. Patients are likely to refer back to a GP if their concern is personally, socially, or medically more complex.

• Not all organisational changes are necessary to communicate to patients but the more ‘on board’ patients are, the more likely successful implementation may be.

• Long term sustainability and implementation of a new care model requires patient re-education and more awareness raising of available services, how and when to access them.

• Professional roles of staff groups may change due to Vanguards being implemented and these changes may, in turn, have an effect on organisational cultures and structures.

• Changes in professional roles and responsibilities should be reflected in salary changes (e.g. skilled up Care Navigators) in line with national guidelines.

• Based on findings that emerged from Connecting Care surveys, it may be said that poorer outcomes were being recorded for patients/service users from Connecting Care at Waterton hub. However, this may have been affected by changes taking place in the hub during the period of the evaluation.

With regards to individual Vanguard components, we identified a range of barriers and potential solutions:

• Care navigation:
  o ensure consistency in awareness and application
  o raise patient awareness of care navigation in order to shape practice culture

• Physiotherapy:
  o provide patients and staff with clarity and consistency of what Physiotherapy in primary care can and cannot do.
  o extend Physiotherapists’ skills be able to refer on and, where appropriate prescribe,

• Pharmacy:
  o ensure consistency in staffing and skills which, in turn, will increase a sense of partnership and integration into the practice

• Extended operating hours
  o these should be publicised more concisely and consistently
  o be aware that centralising appointments may lead to duplication of work, i.e. patients still going back to their ‘regular’ GP for clarification and reassurance.

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5 Source: Healthwatch Wakefield Connecting Care Report
QUANTITATIVE EVALUATION - Health Economic Evaluation

HealthPod Evaluation.

Introduction:

The HealthPod was a pop-up primary care facility which offered health checks, wellbeing advice and assessments such as cardiovascular disease (CVD) risk, diabetes screening, atrial fibrillation (AF) screening and cholesterol tests in neighbourhood locations such as supermarket car parks. The ‘Real’ HealthPod was an inflatable igloo like structure whereas the ‘Virtual’ HealthPod utilised existing venues. The activities of the HealthPod included screening for various long term conditions such as atrial fibrillation (AF), hypertension and diabetes. The key objective of the HealthPod was to increase access to primary care services usually offered in GP surgeries (e.g. as part of the NHS Health Checks programme). In particular, it was intended to bring services to ‘hard-to-reach’ groups who may benefit from such services, such as (a) middle-aged men (b) ethnic minorities (particularly people of South Asian origin) (c) the gypsy/traveller community.

Specifically, the anticipated benefits of the HealthPod proposed by West Wakefield were to:

- Increase detection of hypertension (in middle aged men)
- Increase detection of AF (e.g. in middle aged men)
- Increase detection of diabetes

(taken from the Wakefield Vanguard Logic Model)

At the start of the evaluation process there were discussions on the data that was available and the associated benefits of a Health Economics evaluation. The decision was taken by West Wakefield to focus this element of the evaluation on the HealthPod as this would be most useful to the Vanguard.

Due to the limited data available linking the HealthPod dashboard to primary care data, a number of assumptions have been employed in this analysis and data has been extrapolated from national data sets. None of the assumptions used in this analysis has been tested for reliability.

Aim:

To evaluate the costs and effects (outcomes) of the HealthPod (‘real’ and ‘virtual’) and inform the sustainability of the programme (Return on Investment).

Methods:

A cost-consequences analysis (CCA) was used to identify the associated costs and outcomes (positive and negative) of the HealthPod. CCAs have been recommended for evaluating complex interventions with multiple health and non-health benefits that cannot be captured in a single measure or common unit (NICE 2013). As such, CCAs allow many outcomes, beyond health outcomes, to be compared. CCAs are therefore able to capture wider dimensions of resources use and benefit.
Data and Analysis:

Costs
Costs were determined from the perspective of the commissioner. A costing pro-forma was sent to West Wakefield Ltd to identify resource use and associated fixed and variable costs in the provision of the HealthPod (see Table A1). Annual expenditure data April 2016-Feb 2017 was used to complete the pro-forma. Fixed costs were not adjusted for depreciation (for example on computing equipment) nor were costs discounted into the future as it was not clear what time frame the programme covered. Instead the running costs for Year 2 were estimated by assuming that all fixed costs would be attributed to Year 1 costs and not be payable again in Year 2.

Outcomes
Outcomes were identified through consultation with key stakeholders at West Wakefield Ltd. The outcomes of interest were:

- Increased detection rates for Atrial Fibrillation, Hypertension and Diabetes
- Prevention of Stroke through early detection AF and Hypertension at the HealthPod
- Prevention of Diabetes (Type 2) through early detection of pre-diabetes at the HealthPod

The West Wakefield Ltd HealthPod Dashboard was the primary dataset used for the analysis. The raw data (non-identifiable) was extracted into an excel spreadsheet. The data recorded all HealthPod activity from 01/04/2016 to 28/02/2017 including parameters on the location and date of HealthPod events, basic patient demographics, services received by patients, and findings from some of the services (relating to atrial fibrillation, diabetes, and cholesterol tests for e.g.). For the majority of the time that the HealthPod was in operation patient data recorded on the Dashboard could not be linked to general practice data.

There was consequently no systematic follow-up on whether patients presented in primary care following an adverse result detected in the HealthPod and whether this result was replicated in general practice and treated accordingly. In December 2016 the HealthPod started linking patient data through SystmOne (an integrated patient clinical software system). The data recorded on SystmOne included parameters on patients referred to primary care, attendance in primary care, receiving drug treatment following primary care consultation, and diagnosis coding by primary care. For the time that SystmOne was in operation data were recorded for only 38 patients. The data from SystmOne were therefore used with caution in the analysis as described below.

Atrial Fibrillation (AF):
- Detection:
The HealthPod dashboard data recorded those patients who were screened for AF and the screening result in terms of AF detected or AF not detected. SystmOne did not record any data for patients with AF attending primary care. For the purpose of this analysis it has therefore been assumed that 100% of patients in whom AF was detected in the HealthPod would present at in primary care and that AF would be verified in 100% of these patients. Detection rates at the HealthPod were calculated as the number of patients recorded as with AF as a percentage of those screened. These were compared to the prevalence detection rates recorded in the Quality Outcomes Framework (QOF) for Wakefield CCG in 2015/16.
Stroke Risk:
As AF is a significant risk factor for stroke, patients in whom AF is detected should, according to NICE guidelines, be assessed for their stroke risk (using the NICE recommended guidance) and be treated accordingly (NICE 2014). No data were recorded on the Dashboard or SystmOne to indicate if patients with AF were assessed for their stroke risk, the outcome of this, or if they were prescribed any medication. Data on the numbers of patients assessed for stroke risk and treated are available through the QFF returns by CCG. QOF returns for 2015/16 for Wakefield CCG indicate that the percentage of patients with atrial fibrillation in whom stroke risk was assessed using the NICE recommended guidance was 94.2%; and that the percentage of patients that were identified with AF and as at risk of stroke, that were treated accordingly was 79.7%. No data were available on the numbers of patients recorded as at risk of stroke from the total of those assessed (using NICE recommended guidance). It is possible to model this data using existing models of stroke risk such as the CHA2D52-VASc risk score (Lip et al. 2010), QRISK2 (QRISK2 2016), or the Framingham Heart Study risk score calculator (Framingham Heart Study 2017). The parameters in these models however include a number of medical and lifestyle variables for which no data were available on the patients who attended the HealthPod through the Dashboard or SystmOne. Modelling the HealthPod population, extrapolating lifestyle estimates from a matched UK population to calculate the stroke risk of the HealthPod population in whom AF was detected was beyond the time and scope of this evaluation. Given the lack of data available to calculate the stroke risk for the HealthPod patient population in whom AF was detected, to estimate the number of patients in whom strokes were prevented from the detection of AF at the HealthPod, it was assumed that patients would not present elsewhere and an age-related attributable risk of stroke from AF (Wolf et al. 1991) was applied to the Dashboard data (refer to Table 2).

Hypertension:
Detection
The HealthPod Dashboard data recorded those patients who had their blood pressure checked. The result of the blood the pressure check was not recorded on the Dashboard. SystmOne data recorded patient level data on whether high blood pressure detected at the HealthPod, presentation of the patient at primary care, and whether high blood pressure was recorded in primary care and medication prescribed. These data were used to calculate the detection and medication rates of hypertension at the HealthPod. In addition, due to the small and possibly biased SystmOne data set, national estimates were taken from the underlying data in the NHS Health Check ready reckoner tool (V.9 28th May 2014). The estimates used in this analysis were: age and gender related estimates on the numbers of patients requiring further investigation for hypertension following detection of raised blood pressure, age and gender related estimates on the percentage of patients requiring anti-hypertensive drugs, the take up rate of anti-hypertensive drugs, and the compliance rates of anti-hypertensive drugs. Detection rates at the HealthPod were calculated as the number of patients having hypertension, estimated using the SystmOne and NHS Health Check data as a percentage of those screened. Patients were considered to have hypertension if they were prescribed anti-hypertensive medication. The detection rates were compared to the prevalence detection rates recorded in the QOF for Wakefield CCG in 2015/16.
• **Stroke Risk**
As hypertension is a significant risk factor for stroke, NICE recommends that patients with hypertension (coded as above 140/90mmHg) are treated with anti-hypertensive drug therapy and are regularly monitored to ensure that blood pressure is controlled. This analysis used the data from SystmOne and the NHS Health Checks (as above) to estimate the numbers of patients who received anti-hypertensive medication and complied with the medication. In this analysis it was assumed that compliance with the medication will control blood pressure in 100% patients. To estimate the number of patients in whom strokes were prevented from the detection of hypertension at HealthPod, it was assumed that patients would not present elsewhere and an age-related attributable risk of stroke from hypertension (wolf et al. 1991) was applied to the data (refer to Table 2).

**Diabetes:**

• **Detection**
The HealthPod Dashboard data recorded those patients who had their HBA1C checked and the results of the screening in terms of whether the patient was considered to be pre-diabetic (HbA1c between 42-48 mmol/mol) or suspected diabetic (HbA1c >48 mmol/mol). SystmOne did not record any data for patients with suspected diabetes attending primary care. For the purpose of this analysis it has therefore been assumed that 100% of patients in whom diabetes was suspected would present in primary care to have their diabetes formally diagnosed. Diagnosis rates for diabetes were taken from the underlying data in the NHS Health Check ready reckoner tool (V.9 28th May 2014) (see Table 2). Gender-related estimated on the proportion of patient diagnosed with diabetes were applied to the Dashboard data to calculate diagnosis rates (refer to Table 2). Detection rates for diabetes at the HealthPod were calculated as the number of patients diagnosed with diabetes as a percentage of those screened. These were compared to the prevalence detection rates recorded in the QOF for Wakefield CCG in 2015/16 (NHS Digital 2016).

• **Diabetes Risk**
In order to significantly reduce the chance of developing diabetes, NICE recommends that adults with a high risk of developing diabetes (Type 2) (i.e. those identified as pre-diabetic 42-47mmol/mol) are referred into an intensive lifestyle change programme (NICE 2012). This analysis used data from the NHS Health Checks reckoner tool (V.9 28th May 2014) including the take-up rate of lifestyle intervention and the compliance rate of lifestyle intervention to estimate the numbers of patients who received and complied with lifestyle intervention. In order to calculate the number of patients in whom diabetes progression was prevented through the detection of pre-diabetes at the HealthPod, estimates on reducing the risk of developing diabetes through lifestyle intervention (NICE 2012, Gillies 2007) were applied to the data (refer to Table 2).

The parameters and values used in the data analysis described above are listed (see Table 1-2 below)
Table 1. A summary of the HealthPod Dashboard data descriptors and parameters used in the analysis

<table>
<thead>
<tr>
<th>Data label</th>
<th>Description</th>
<th>Parameters</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID</td>
<td>Unique patient identifier</td>
<td>1-3692 (some of these numbers are missing)</td>
</tr>
<tr>
<td>Gender</td>
<td>Gender of patient</td>
<td>Male, Female, not recorded</td>
</tr>
<tr>
<td>Age</td>
<td>Age of patient</td>
<td>4-96, not recorded</td>
</tr>
<tr>
<td>AF screening</td>
<td>Patient has been screened for AF</td>
<td>AF screened, blank (=not screened)</td>
</tr>
<tr>
<td>Blood pressure check</td>
<td>Patient had blood pressure checked</td>
<td>Blood pressure checked, blank (=not checked)</td>
</tr>
<tr>
<td>HBA1C</td>
<td>Patient had HbA1c test</td>
<td>HbA1c, blank (=not checked)</td>
</tr>
<tr>
<td>Alternative provider</td>
<td>Patient asked if they would have visited an alternative health professional if they had not visited the HealthPod</td>
<td>GP, Nurse, Other Health Professional, None</td>
</tr>
<tr>
<td>HbA1C screening</td>
<td>Results of HbA1c screening test</td>
<td>48&gt; suspected diabetic, 42-48 pre-diabetic</td>
</tr>
<tr>
<td>AF screening2</td>
<td>Results of AF screening</td>
<td>AF detected, AF not detected, blank</td>
</tr>
<tr>
<td>Virtual/HealthPod</td>
<td>HealthPod set up where patient presented</td>
<td>HealthPod, Virtual HealthPod, blank</td>
</tr>
<tr>
<td>Age Band</td>
<td>Age-band of patient</td>
<td>0-9, 10-19, 20-29, 30-39, 40-49, 50-59, 60-69, 70-79, 80-89, 90-99, blank</td>
</tr>
<tr>
<td>Age Band 2</td>
<td>Age band of patient used for deeper analysis</td>
<td>&lt;40, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85-89, &gt;90, blank</td>
</tr>
<tr>
<td></td>
<td>No data were recorded on ethnicity or any lifestyle factors such as smoking, alcohol consumption, or weight.</td>
<td></td>
</tr>
</tbody>
</table>
## Table 2. A summary of the additional data used in the analysis by question, value and source

<table>
<thead>
<tr>
<th>Question</th>
<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detection of AF</td>
<td>What is the risk of developing a stroke following AF?</td>
<td>Age related attributable risk of stroke see Appendix A2</td>
</tr>
<tr>
<td></td>
<td>What is the detection rate of AF for Wakefield CCG?</td>
<td>AF prevalence 2015/16=1.83%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS Digital QOF Recorded disease, prevalence and achievements CCG level Oct 2016</td>
</tr>
<tr>
<td>Detection of Hypertension</td>
<td>What proportion of patients have a raised BP at the HealthPod which requires further investigation?</td>
<td>55%</td>
</tr>
<tr>
<td></td>
<td>SystmOne data (supplied by West Wakefield Ltd)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What is the proportion of patients who present in primary care to have BP reassessed?</td>
<td>57%</td>
</tr>
<tr>
<td></td>
<td>SystmOne data (supplied by West Wakefield Ltd)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What is the proportion of patients who have BP verified and receive drug treatment?</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>SystmOne data (supplied by West Wakefield Ltd)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What proportion of patients tested require further testing due to high blood pressure detected?</td>
<td>A3</td>
</tr>
<tr>
<td></td>
<td>NHS Health Check data ready reckoner tool (V.9 28th May 2014)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What proportion of patients will receive anti-hypertensives</td>
<td>A3</td>
</tr>
<tr>
<td></td>
<td>NHS Health Check data ready reckoner tool (V.9 28th May 2014)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What proportion of patients will comply with medication?</td>
<td>83%</td>
</tr>
<tr>
<td></td>
<td>NHS Health Check data ready reckoner tool (V.9 28th May 2014)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What is the detection rate of hypertension for Wakefield CCG?</td>
<td>Hypertension prevalence 2015/16=15.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS Digital QOF Recorded disease, prevalence and achievements CCG level Oct 2016</td>
</tr>
<tr>
<td></td>
<td>What is the risk of developing a stroke following hypertension?</td>
<td>Age related attributable risk of stroke see Appendix A2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wolf et al. 1991</td>
</tr>
<tr>
<td><strong>Question</strong></td>
<td><strong>Value</strong></td>
<td><strong>Source</strong></td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>Detection of diabetes</td>
<td><strong>What proportion of patients with raised HbA1c are diagnosed with diabetes?</strong></td>
<td>Males =2% Female=0.9%</td>
</tr>
<tr>
<td></td>
<td><strong>What proportion of pre-diabetics take up lifestyle intervention?</strong></td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td><strong>What proportion of patients comply with lifestyle intervention?</strong></td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td><strong>What is the reduction in the rate of incidence of developing diabetes in patients complying with lifestyle intervention?</strong></td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td><strong>What is the detection rate for diabetes for Wakefield CCG?</strong></td>
<td>Diabetes prevalence 2015/16=7.15%</td>
</tr>
</tbody>
</table>
Results:

Costs:
Table 3 presents the breakdown of costs identified for the HealthPods. Where costs could not be directly attributable to either the ‘real’ or ‘virtual’ HealthPod they were apportioned in relation to the number of patient contacts seen in each HealthPod (these are given below in “Outcomes”) or, in the case of fixed costs or costs which were not divisible between sites (i.e. computing equipment), they were wholly apportioned to each HealthPod.

Table 3. A breakdown of HealthPod costs and expenditure

<table>
<thead>
<tr>
<th>Cost</th>
<th>Unit cost (£)</th>
<th>Quantity</th>
<th>Fixed/ Variable</th>
<th>Attributable to ‘real’ or ‘virtual’ HealthPod</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inflatable costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HealthPod Inflatable and Pump</td>
<td>4,216.80</td>
<td>2</td>
<td>Fixed</td>
<td>Real</td>
</tr>
<tr>
<td>Inflatable cleaning</td>
<td>288.00</td>
<td>1</td>
<td>Annual</td>
<td>Real</td>
</tr>
<tr>
<td>Inflatable assessment</td>
<td>24.00</td>
<td>20</td>
<td>Per-site</td>
<td>Real</td>
</tr>
<tr>
<td>Additional room hire</td>
<td>380.65</td>
<td>1</td>
<td>Annual</td>
<td>Real</td>
</tr>
<tr>
<td><strong>Staff costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Council Staff (including staff, fuel, transport)</td>
<td>290.00</td>
<td>140</td>
<td>Annual</td>
<td>Real</td>
</tr>
<tr>
<td>Clinical Manager and assistant (including on-costs and expenses)</td>
<td>76,236.00</td>
<td>1</td>
<td>Annual</td>
<td>Both (apportioned 78:22 ‘real’: ‘virtual’ HealthPod)*</td>
</tr>
<tr>
<td>Overtime (Saturday and Sunday)</td>
<td>16,433.00</td>
<td>1</td>
<td>Annual</td>
<td>Both (apportioned 78:22)</td>
</tr>
<tr>
<td><strong>Clinical costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>clinical equipment (MYDiagnostick, scales, BP monitor, Height Chart)</td>
<td>2000.00</td>
<td>2</td>
<td>Fixed</td>
<td>Both (1 each)</td>
</tr>
<tr>
<td>tests conducted (Diabetes, Cholesterol, gauze, gloves, lancets, pipets, etc.)</td>
<td>6600.00</td>
<td>1</td>
<td>Annual</td>
<td>Both (apportioned 78:22)</td>
</tr>
<tr>
<td>Clinical Waste</td>
<td>385.50</td>
<td>1</td>
<td>Annual</td>
<td>Both (apportioned 78:22)</td>
</tr>
<tr>
<td><strong>Other equipment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IT equipment (laptop, tablet, dongle)</td>
<td>1,780.00</td>
<td>1</td>
<td>Fixed</td>
<td>Both (apportioned wholly to each)</td>
</tr>
<tr>
<td>Promotion</td>
<td>2,160.00</td>
<td>1</td>
<td>Annual</td>
<td>Both (apportioned wholly to each)</td>
</tr>
</tbody>
</table>

The costs in Table 3 were used to calculate the total annual cost of the ‘real’ and ‘virtual’ HealthPods and the estimated running costs for the ‘real’ and ‘virtual’ HealthPods in Year 2. These results are presented in Table 4.
Table 4. Total annual cost for the ‘real’ and ‘virtual’ HealthPods.

<table>
<thead>
<tr>
<th>Costs</th>
<th>Total annual costs for ‘real’ HealthPod (£)</th>
<th>Estimated Year 2 costs for ‘real’ HealthPod (£)</th>
<th>Total annual costs for ‘virtual’ HealthPod (£)</th>
<th>Estimated Year 2 costs for ‘virtual’ HealthPod (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inflatable costs</td>
<td>9,582.25</td>
<td>1148.65</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Staff costs</td>
<td>112,881.48</td>
<td>112,881.48</td>
<td>20,387.18</td>
<td>20,387.18</td>
</tr>
<tr>
<td>Clinical costs</td>
<td>7,448.69</td>
<td>5448.69</td>
<td>3,536.81</td>
<td>1,536.81</td>
</tr>
<tr>
<td>Other equipment</td>
<td>3,940</td>
<td>2,160.00</td>
<td>3,940</td>
<td>2,160.00</td>
</tr>
<tr>
<td>Total</td>
<td>133,852.42</td>
<td>121,638.82</td>
<td>27,863.99</td>
<td>24,083.99</td>
</tr>
</tbody>
</table>

Outcomes:
The HealthPod was active from 01/04/2016 to 28/02/2017. During this time 3518 people visited the HealthPod with 2748 attending the ‘Real’ HealthPod and 746 attending the ‘Virtual’ HealthPod. HealthPod events have been held at a wide range of venues, including workplaces, shops and market places, mosques, GP surgeries, and a gypsy/traveller site.

The majority of patients (3271, 93%) who attended the HealthPod were reported to have claimed that they would not have considered seeing an alternative health professional (GP, Nurse, or Other) if they had not visited the HealthPod (Table 5).

Table 5. Number of patients in ‘real’ and ‘virtual’ HealthPods reporting where they would have sought care if they had not visited the HealthPod

<table>
<thead>
<tr>
<th>Alternative to HealthPod</th>
<th>‘Real’ HealthPod</th>
<th>‘Virtual’ HealthPod</th>
<th>HealthPod location not recorded</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>80</td>
<td>20</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Nurse</td>
<td>102</td>
<td>15</td>
<td>0</td>
<td>117</td>
</tr>
<tr>
<td>Other Health Professional</td>
<td>26</td>
<td>4</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>None</td>
<td>2540</td>
<td>707</td>
<td>24</td>
<td>3271</td>
</tr>
<tr>
<td>Total</td>
<td>2748</td>
<td>746</td>
<td>27</td>
<td>3518</td>
</tr>
</tbody>
</table>
The data presented in Table 6 shows that, from those who reported their gender or whose gender was recorded, 1508 (43%) patients who attended the HealthPod were male and 1969 (57%) were female. The majority of patients were aged over 50 (n=2471, 70%), with the greatest number in the 60-69 age band (n=845, 24%).

Table 6. Age and gender of patients attending the HealthPod.

<table>
<thead>
<tr>
<th>Age range</th>
<th>'Real' HealthPod (n)</th>
<th>'Virtual' HealthPod (n)</th>
<th>Total (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>male</td>
<td>female</td>
<td>male</td>
</tr>
<tr>
<td>0-9</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>10-19</td>
<td>22</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>20-29</td>
<td>84</td>
<td>92</td>
<td>13</td>
</tr>
<tr>
<td>30-39</td>
<td>110</td>
<td>150</td>
<td>32</td>
</tr>
<tr>
<td>40-49</td>
<td>147</td>
<td>208</td>
<td>61</td>
</tr>
<tr>
<td>50-59</td>
<td>212</td>
<td>256</td>
<td>83</td>
</tr>
<tr>
<td>60-69</td>
<td>246</td>
<td>412</td>
<td>85</td>
</tr>
<tr>
<td>70-79</td>
<td>225</td>
<td>298</td>
<td>65</td>
</tr>
<tr>
<td>80-89</td>
<td>86</td>
<td>128</td>
<td>26</td>
</tr>
<tr>
<td>90-99</td>
<td>2</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>1134</td>
<td>1573</td>
<td>367</td>
</tr>
<tr>
<td>Gender unreported</td>
<td>41</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

*totals in age bands include those patients whose HealthPod attendance location was not recorded.

The most frequently provided services in the HealthPod that are of interest to this evaluation are shown in Table 7. Atrial fibrillation (AF) screening was provided to 1783 (51%) patients, blood pressure checks were provided to 2077 (59%) patients, CVD risk checks were provided to 1611 (46%) patients, and diabetes screening was provided to 228 (6%) patients.

Table 7. Services provided at the HealthPod

<table>
<thead>
<tr>
<th>Services provided</th>
<th>'Real' HealthPod (n)</th>
<th>'Virtual' HealthPod (n)</th>
<th>Total (n)</th>
<th>HealthPod location not recorded (n)</th>
<th>Grand total (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrial Fibrillation screening</td>
<td>1313</td>
<td>466</td>
<td>1779</td>
<td>4</td>
<td>1783</td>
</tr>
<tr>
<td>Blood pressure checks</td>
<td>1731</td>
<td>322</td>
<td>2053</td>
<td>24</td>
<td>2077</td>
</tr>
<tr>
<td>CVD risk checks</td>
<td>1310</td>
<td>284</td>
<td>1597</td>
<td>17</td>
<td>1611</td>
</tr>
<tr>
<td>Diabetes screening (HBA1C)</td>
<td>128</td>
<td>98</td>
<td>226</td>
<td>2</td>
<td>228</td>
</tr>
</tbody>
</table>
These services are evaluated in turn below. For the purposes of the report, the results are analysed by HealthPod location in order to compare the ‘virtual’ and ‘real’ HealthPod. As such any data that was not recorded to either the ‘real’ or ‘virtual’ HealthPod has been omitted from the analysis.

**Atrial Fibrillation (AF)**

- Detection

Table 8 presents the results for the number of patients detected with AF by age at the ‘real’ and ‘virtual’ HealthPod. In total 1779 patients were recorded as screened for AF at either the ‘real’ HealthPod (n=1313) or the ‘virtual’ HealthPod (n=466). Of those screened, AF was detected in 27 patients an overall detection rate of 1.52%. The detection rates at the ‘real’ HealthPod were 1.75% (23/1313) and at the ‘virtual’ HealthPod 0.86% (4/466). Given that the majority of screening was conducted in the over 50’s age group and that detection of AF was isolated to this age group and above, the focus of subsequent analysis was restricted to the age group 50-99 years. Analyses of detection rates for this age range are presented in Table 9. These results indicate that the detection rates for AF for this age range were 1.63% (27/1652) overall and 1.87% (23/1230) at the ‘real’ HealthPod and 0.95% (4/422) at the ‘virtual’ HealthPod were. The QOF recorded disease prevalence rate for AF for Wakefield CCG in 2015/16 was 1.83%.

**Table 8. Number of patients detected with AF by age at the ‘real’ and ‘virtual’ HealthPod**

Noting that no information was collected by the HealthPod on patients’ pre-existing conditions which was available to evaluate. Each diagnosis was therefore considered as “new” which may well over inflate the detection rates.

<table>
<thead>
<tr>
<th>Age Band</th>
<th>'real' HealthPod</th>
<th>'virtual' HealthPod</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AF screened (n)</td>
<td>AF detected (n)</td>
<td>AF screened (n)</td>
</tr>
<tr>
<td>0-9</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>10-19</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>20-29</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>30-39</td>
<td>18</td>
<td>11</td>
<td>29</td>
</tr>
<tr>
<td>40-49</td>
<td>58</td>
<td>30</td>
<td>88</td>
</tr>
<tr>
<td>50-59</td>
<td>196</td>
<td>78</td>
<td>274</td>
</tr>
<tr>
<td>60-69</td>
<td>453</td>
<td>147</td>
<td>600</td>
</tr>
<tr>
<td>70-79</td>
<td>405</td>
<td>140</td>
<td>545</td>
</tr>
<tr>
<td>80-89</td>
<td>168</td>
<td>55</td>
<td>223</td>
</tr>
<tr>
<td>90-99</td>
<td>8</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>1313</td>
<td>23</td>
<td>466</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1779</td>
</tr>
</tbody>
</table>
• Stroke Risk

Table 9 presents the results of the numbers of patients screened for AF and detected as having AF in the over 50’s age group and the results for the estimated number of patients in whom a stroke maybe prevented through detection of AF at the HealthPod, assuming all patients with AF were optimally managed. Overall the estimated number of the patients in whom a stroke was prevented was 3.76; 3.38 patients in the ‘real’ HealthPod and 0.38 patients in the ‘virtual’ HealthPod.

Noting that no information was collected by the HealthPod on ethnicity or any lifestyle factors such as smoking, alcohol consumption or weight, this could not be included in the analysis model (see Table 1). Given the lack of data available, it was assumed that patients would not present elsewhere and an age-related attributable risk of stroke from AF (Wolf et al. 1991) was applied to the Dahsboard data (Table 2).

Table 9. Number of patients detected with AF in the over 50’s and estimated numbers of patients in whom a stroke is prevented by HealthPod location

<table>
<thead>
<tr>
<th>Real HealthPod</th>
<th>AF screened (n)</th>
<th>AF detected (n)</th>
<th>Attributable risk of stroke*</th>
<th>Stroke prevented (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-59</td>
<td>196</td>
<td>1</td>
<td>0.015</td>
<td>0.015</td>
</tr>
<tr>
<td>60-69</td>
<td>453</td>
<td>1</td>
<td>0.028</td>
<td>0.028</td>
</tr>
<tr>
<td>70-79</td>
<td>405</td>
<td>11</td>
<td>0.09</td>
<td>0.99</td>
</tr>
<tr>
<td>80-89</td>
<td>168</td>
<td>10</td>
<td>0.235</td>
<td>2.35</td>
</tr>
<tr>
<td>90-99</td>
<td>8</td>
<td>0</td>
<td>unavailable</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1230</td>
<td>23</td>
<td></td>
<td>3.38</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Virtual HealthPod</th>
<th>AF screened (n)</th>
<th>AF detected (n)</th>
<th>Attributable risk of stroke*</th>
<th>Stroke prevented (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-59</td>
<td>78</td>
<td>0</td>
<td>0.015</td>
<td>0</td>
</tr>
<tr>
<td>60-69</td>
<td>147</td>
<td>2</td>
<td>0.028</td>
<td>0.056</td>
</tr>
<tr>
<td>70-79</td>
<td>140</td>
<td>1</td>
<td>0.09</td>
<td>0.09</td>
</tr>
<tr>
<td>80-89</td>
<td>55</td>
<td>1</td>
<td>0.235</td>
<td>0.235</td>
</tr>
<tr>
<td>90-99</td>
<td>2</td>
<td>0</td>
<td>unavailable</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>422</td>
<td>4</td>
<td></td>
<td>0.381</td>
</tr>
<tr>
<td>Total**</td>
<td>1652</td>
<td>27</td>
<td></td>
<td>3.76</td>
</tr>
</tbody>
</table>

*refer to Table A2  
** figures are rounded
Hypertension:

Detection

Table 10 presents the results for the number of patients by age and gender who had blood pressure checks conducted at the ‘real’ and ‘virtual’ HealthPod. Blood pressure checks were conducted on 2053 (patients at the HealthPods, 1731 in the ‘real’ HealthPod and 322 at the ‘virtual’ HealthPod. In total blood pressure checks were conducted on 1149 (58%) women and 904 (60%) men. 1602 (78%) of blood pressure checks were conducted in the over 40’s age band. Given the small numbers of blood pressure checks conducted in the over 90’s age group and low hypertension rates in the under 40’s age group, the focus of subsequent analysis is on those aged 40-89.

Table 10. Number of patients who had blood pressure checks by age and gender at the ‘real’ and ‘virtual’ HealthPod

<table>
<thead>
<tr>
<th>Age Band</th>
<th>‘real’ HealthPod</th>
<th>‘virtual’ HealthPod</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (n)</td>
<td>Female (n)</td>
</tr>
<tr>
<td>&lt;40</td>
<td>173</td>
<td>221</td>
</tr>
<tr>
<td>40-44</td>
<td>47</td>
<td>70</td>
</tr>
<tr>
<td>45-49</td>
<td>80</td>
<td>90</td>
</tr>
<tr>
<td>50-54</td>
<td>96</td>
<td>110</td>
</tr>
<tr>
<td>55-59</td>
<td>71</td>
<td>79</td>
</tr>
<tr>
<td>60-64</td>
<td>78</td>
<td>106</td>
</tr>
<tr>
<td>65-69</td>
<td>63</td>
<td>132</td>
</tr>
<tr>
<td>70-74</td>
<td>62</td>
<td>80</td>
</tr>
<tr>
<td>75-79</td>
<td>25</td>
<td>57</td>
</tr>
<tr>
<td>80-84</td>
<td>26</td>
<td>30</td>
</tr>
<tr>
<td>85-89</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>&gt;90</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Total (n)</td>
<td>725</td>
<td>1006</td>
</tr>
</tbody>
</table>

Analyses of hypertension detection rates are presented in Tables 11 and 12. These results indicate that the overall detection rates at the ‘real’ HealthPod for hypertension for this age range were 7.84% (103.85/1325) using SystmOne estimates and 7.69% (101.93/1325) using NHS Health Check estimates. The overall detection rates at the ‘virtual’ HealthPod for hypertension for this age range were 7.84% (20.61/263) using SystmOne estimates and 8.3% (21.84/263) using NHS Health Check estimates. The QOF recorded disease prevalence rate for hypertension for Wakefield CCG in 2015/16 was 15.3%.
Table 11. Estimated number of patients detected as having high blood pressure at ‘Real’ HealthPod by age and gender

<table>
<thead>
<tr>
<th>‘Real’ HealthPod</th>
<th>SystmOne data estimates (Table 2)</th>
<th>NHS Health Check data estimates (A3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age Band</td>
<td>Blood pressure (BP) check (n)</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-44</td>
<td></td>
<td>47</td>
</tr>
<tr>
<td>45-49</td>
<td></td>
<td>80</td>
</tr>
<tr>
<td>50-54</td>
<td></td>
<td>96</td>
</tr>
<tr>
<td>55-59</td>
<td></td>
<td>71</td>
</tr>
<tr>
<td>60-64</td>
<td></td>
<td>78</td>
</tr>
<tr>
<td>65-69</td>
<td></td>
<td>63</td>
</tr>
<tr>
<td>70-74</td>
<td></td>
<td>62</td>
</tr>
<tr>
<td>75-79</td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>80-84</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>85-89</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Total * (n)</td>
<td></td>
<td>552</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-44</td>
<td></td>
<td>70</td>
</tr>
<tr>
<td>45-49</td>
<td></td>
<td>90</td>
</tr>
<tr>
<td>50-54</td>
<td></td>
<td>110</td>
</tr>
<tr>
<td>55-59</td>
<td></td>
<td>79</td>
</tr>
<tr>
<td>60-64</td>
<td></td>
<td>106</td>
</tr>
<tr>
<td>65-69</td>
<td></td>
<td>132</td>
</tr>
<tr>
<td>70-74</td>
<td></td>
<td>80</td>
</tr>
<tr>
<td>75-79</td>
<td></td>
<td>57</td>
</tr>
<tr>
<td>80-84</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>85-89</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>Total * (n)</td>
<td></td>
<td>773</td>
</tr>
<tr>
<td>All</td>
<td></td>
<td>1325</td>
</tr>
</tbody>
</table>

* figures are rounded
Table 12. Estimated number of patients detected as having high blood pressure at ‘Virtual’ HealthPod by age and gender.

<table>
<thead>
<tr>
<th>'Real' HealthPod</th>
<th>SystmOne data estimates (Table 2)</th>
<th>NHS Health Check data estimates (A3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age Band</td>
<td>Blood pressure (BP) check (n)</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-44</td>
<td>15</td>
<td>8.25</td>
</tr>
<tr>
<td>45-49</td>
<td>29</td>
<td>15.95</td>
</tr>
<tr>
<td>50-54</td>
<td>31</td>
<td>17.05</td>
</tr>
<tr>
<td>55-59</td>
<td>17</td>
<td>9.35</td>
</tr>
<tr>
<td>60-64</td>
<td>15</td>
<td>8.25</td>
</tr>
<tr>
<td>65-69</td>
<td>14</td>
<td>7.7</td>
</tr>
<tr>
<td>70-74</td>
<td>4</td>
<td>2.2</td>
</tr>
<tr>
<td>75-79</td>
<td>7</td>
<td>3.85</td>
</tr>
<tr>
<td>80-84</td>
<td>5</td>
<td>2.75</td>
</tr>
<tr>
<td>85-89</td>
<td>6</td>
<td>3.3</td>
</tr>
<tr>
<td>Total *(n)</td>
<td>143</td>
<td>78.65</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45-49</td>
<td>6</td>
<td>3.3</td>
</tr>
<tr>
<td>50-54</td>
<td>14</td>
<td>7.7</td>
</tr>
<tr>
<td>55-59</td>
<td>10</td>
<td>5.5</td>
</tr>
<tr>
<td>60-64</td>
<td>7</td>
<td>3.85</td>
</tr>
<tr>
<td>65-69</td>
<td>10</td>
<td>5.5</td>
</tr>
<tr>
<td>70-74</td>
<td>14</td>
<td>7.7</td>
</tr>
<tr>
<td>75-79</td>
<td>16</td>
<td>8.8</td>
</tr>
<tr>
<td>80-84</td>
<td>17</td>
<td>9.35</td>
</tr>
<tr>
<td>85-89</td>
<td>16</td>
<td>8.8</td>
</tr>
<tr>
<td>Total *(n)</td>
<td>120</td>
<td>66</td>
</tr>
<tr>
<td>All</td>
<td>Total *(n)</td>
<td>263</td>
</tr>
</tbody>
</table>

*figures are rounded
Stroke Risk

Table 13 and 14 present the results of the estimated number of patients in whom a stroke maybe prevented due to the detection, medication and management (compliance) of hypertension in the ‘real’ HealthPod and ‘virtual’ HealthPod. The estimated number of patients who avoided a stroke in the ‘real’ HealthPod was 42.33 using the SystmOne estimates and 41.02 using the NHS Health Check estimates. The estimated number of patients who avoided a stroke in the ‘virtual’ HealthPod was 8.03 using the SystmOne estimates and 8.23 using the NHS Health Check estimates.

Table 13. Estimated number of patients by age and gender in whom hypertension is detected, medicated and managed and a stroke is prevented in the ‘real’ HealthPod

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Male (n)</th>
<th>Female (n)</th>
<th>All (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hypertension detected and medicated and managed</td>
<td>Hypertension detected and medicated and managed</td>
<td>Attributable risk of stroke**</td>
</tr>
<tr>
<td>40-44</td>
<td>3.06</td>
<td>4.06</td>
<td>4.55</td>
</tr>
<tr>
<td>45-49</td>
<td>5.20</td>
<td>1.93</td>
<td>5.86</td>
</tr>
<tr>
<td>50-54</td>
<td>6.25</td>
<td>2.98</td>
<td>7.16</td>
</tr>
<tr>
<td>55-59</td>
<td>4.62</td>
<td>5.54</td>
<td>5.14</td>
</tr>
<tr>
<td>60-64</td>
<td>5.07</td>
<td>6.99</td>
<td>6.895</td>
</tr>
<tr>
<td>65-69</td>
<td>4.098</td>
<td>8.84</td>
<td>8.59</td>
</tr>
<tr>
<td>70-74</td>
<td>4.03</td>
<td>10.69</td>
<td>5.20</td>
</tr>
<tr>
<td>75-79</td>
<td>1.63</td>
<td>4.31</td>
<td>1.69</td>
</tr>
<tr>
<td>80-84</td>
<td>1.69</td>
<td>4.48</td>
<td>1.95</td>
</tr>
<tr>
<td>85-89</td>
<td>0.26</td>
<td>0.69</td>
<td>1.24</td>
</tr>
<tr>
<td>Total</td>
<td>35.91</td>
<td>46.88</td>
<td>35.91</td>
</tr>
</tbody>
</table>

* Figures are rounded

** Calculated by multiplying the final columns in the SystmOne and NHS Health Check estimates respectively in Table 11 by medication compliance rates estimated from NHS Health Check data (see Table 2)
***refer to Table A2. Attributable risk is not given for ages 40-49. Figures were imputed from the 50-59 age band and are italicised.
1 estimated from SystmOne
2 estimated from NHS Health Check

Table 14. Estimated number of patients by age and gender in whom hypertension is detected, medicated and managed and a stroke is prevented in the ‘virtual’ HealthPod

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hypertension detected and medicated and managed (n)</strong></td>
<td><strong>Hypertension detected and medicated and managed (n)</strong></td>
<td><strong>Attributable risk of stroke</strong></td>
<td><strong>Stroke prevented (n)</strong></td>
</tr>
<tr>
<td>40-44</td>
<td>0.976</td>
<td>0.141</td>
<td>0.488</td>
</tr>
<tr>
<td>45-49</td>
<td>1.89</td>
<td>0.699</td>
<td>0.488</td>
</tr>
<tr>
<td>50-54</td>
<td>2.02</td>
<td>0.961</td>
<td>0.488</td>
</tr>
<tr>
<td>55-59</td>
<td>1.11</td>
<td>1.33</td>
<td>0.488</td>
</tr>
<tr>
<td>60-64</td>
<td>0.976</td>
<td>1.34</td>
<td>0.532</td>
</tr>
<tr>
<td>65-69</td>
<td>0.911</td>
<td>1.97</td>
<td>0.532</td>
</tr>
<tr>
<td>70-74</td>
<td>0.260</td>
<td>0.69</td>
<td>0.486</td>
</tr>
<tr>
<td>75-79</td>
<td>0.455</td>
<td>1.21</td>
<td>0.486</td>
</tr>
<tr>
<td>80-84</td>
<td>0.325</td>
<td>0.862</td>
<td>0.334</td>
</tr>
<tr>
<td>85-89</td>
<td>0.390</td>
<td>1.03</td>
<td>0.334</td>
</tr>
<tr>
<td><em>Total (n)</em></td>
<td>9.30</td>
<td>10.23</td>
<td>4.51</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hypertension detected and medicated and managed (n)</strong></td>
<td><strong>Hypertension detected and medicated and managed (n)</strong></td>
<td><strong>Attributable risk of stroke</strong></td>
<td><strong>Stroke prevented (n)</strong></td>
</tr>
<tr>
<td>40-44</td>
<td>0.651</td>
<td>0.028</td>
<td>0.488</td>
</tr>
<tr>
<td>45-49</td>
<td>0.390</td>
<td>0.041</td>
<td>0.488</td>
</tr>
<tr>
<td>50-54</td>
<td>0.911</td>
<td>0.190</td>
<td>0.488</td>
</tr>
<tr>
<td>55-59</td>
<td>0.651</td>
<td>0.251</td>
<td>0.488</td>
</tr>
<tr>
<td>60-64</td>
<td>0.455</td>
<td>0.307</td>
<td>0.532</td>
</tr>
<tr>
<td>65-69</td>
<td>0.651</td>
<td>0.769</td>
<td>0.532</td>
</tr>
<tr>
<td>70-74</td>
<td>0.911</td>
<td>1.40</td>
<td>0.486</td>
</tr>
<tr>
<td>75-79</td>
<td>1.04</td>
<td>1.60</td>
<td>0.486</td>
</tr>
<tr>
<td>80-84</td>
<td>1.11</td>
<td>1.70</td>
<td>0.334</td>
</tr>
<tr>
<td>85-89</td>
<td>1.04</td>
<td>1.60</td>
<td>0.334</td>
</tr>
<tr>
<td><em>Total (n)</em></td>
<td>7.81</td>
<td>7.898</td>
<td>3.52</td>
</tr>
</tbody>
</table>

**Figures are rounded**

**calculated by multiplying the final columns in the SystmOne and NHS Health Check estimates respectively in Table 12 by medication compliance rates estimated from NHS Health Check data (see Table 2)**

***refer to Table A2. Attributable risk is not given for ages 40-49. Figures were imputed from the 50-59 age band and are italicised.
1 estimated from SystmOne
2 estimated from NHS Health Check
**Diabetes:**
- Detection

Table 15 presents the results by age and gender for those patients who were screened at the HealthPods for diabetes using HbA1c were coded as being pre-diabetic (HbA1c between 42-48 mmol/mol) or suspected diabetic (HbA1c >48mmol/mol) as a result. Screening tests were conducted on 226 patients overall, 128 at the ‘real’ HealthPod and 98 at the ‘virtual’ HealthPod. Detection rates for pre-diabetics were 10.16% (13/128) at the ‘real’ HealthPod and 16.33% (16/98) at the ‘virtual’ HealthPod. Detection rates for suspected diabetics were 3.91% (5/128) at the ‘real’ HealthPod and 5.10% (5/98) at the ‘virtual’ HealthPod. The NHS Health Check data was used to estimate the number of patients diagnosed with diabetes from the suspected diabetic patients. Using these figures, the detection rates for those diagnosed with diabetes were 0.035% (0.045/128) at the ‘real’ HealthPod and 0.091% (0.089/98) at the ‘virtual’ HealthPod. The QOF recorded disease prevalence rate for diabetes for Wakefield CCG in 2015/16 was 7.15%; no distinction is made between Type 1 and Type 2 diabetes.

There is a suggestion that the majority of data for the “Virtual” Healthpod was anomalous due to the likelihood that the service users were more likely to be of south Asian ethnicity. Without ethnicity data having been collated, this cannot be proved or disproved.

**Table 15 Age and Gender of patients screened for diabetes and estimated number of diagnosed diabetics by HealthPod location (continued over)**

<table>
<thead>
<tr>
<th>Gender/Age Band</th>
<th>‘real’ HealthPod</th>
<th>‘virtual’ HealthPod</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HbA1c test (n)</td>
<td>Pre-diabetic (n)</td>
</tr>
<tr>
<td>Male</td>
<td>57</td>
<td>7</td>
</tr>
<tr>
<td>0-9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10-19</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>20-29</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>30-39</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>40-49</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>50-59</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>60-69</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>70-79</td>
<td>19</td>
<td>5</td>
</tr>
<tr>
<td>80-89</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>90-99</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*Diabetic (n)* refers to the estimated number of cases diagnosed with diabetes.
Table 15 Age and Gender of patients screened for diabetes and estimated number of diagnosed diabetics by HealthPod location (continued)

<table>
<thead>
<tr>
<th>Gender/ Age Band</th>
<th>‘real’ HealthPod</th>
<th>‘virtual’ HealthPod</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HbA1c test (n)</td>
<td>Pre-diabetic</td>
</tr>
<tr>
<td>Female 0-9</td>
<td>71</td>
<td>6</td>
</tr>
<tr>
<td>10-19</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>20-29</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>30-39</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>40-49</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>50-59</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>60-69</td>
<td>22</td>
<td>1</td>
</tr>
<tr>
<td>70-79</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>80-89</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>90-99</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>128</td>
<td>13</td>
</tr>
</tbody>
</table>

* Males = 2%, Females=0.9%, estimated from NHS Health Check data (see Table 2)

### Diabetes risk

Table 16 presents the results of the estimated number of patients in whom diabetes Type 2 maybe prevented or delayed due to the detection pre-diabetes and take up and compliance with lifestyle intervention. The estimated number of patients in whom diabetes is prevented or delayed was 4.97 in the ‘real’ HealthPod and 6.12 in the ‘virtual’ HealthPod.

**Table 16. Estimated number of patients in whom diabetes may be prevented or delayed by gender and HealthPod location**

<table>
<thead>
<tr>
<th></th>
<th>Screened as Pre-diabetic</th>
<th>Take-up of lifestyle intervention*</th>
<th>Compliance with lifestyle intervention*</th>
<th>Diabetes prevented**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>‘Real’ HealthPod</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>13</td>
<td>11.05</td>
<td>9.95</td>
<td>4.97</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>5.95</td>
<td>5.36</td>
<td>2.68</td>
</tr>
<tr>
<td><strong>‘Virtual’ HealthPod</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>16</td>
<td>13.6</td>
<td>12.24</td>
<td>6.12</td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
<td>7.95</td>
<td>6.89</td>
<td>3.44</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>29</td>
<td>24.65</td>
<td>22.19</td>
<td>11.09</td>
</tr>
</tbody>
</table>

* 85% estimated from NHS Health Check data (see Table 2)
** 90% estimated from NHS Health Check data (see Table 2)
*** 50% estimated from NICE PH Guideline (see Table 2)
Summary of costs and outcomes:

Table 17 presents a summary of the costs and effects/outcomes of the analyses of the 'real' and 'virtual' HealthPods.

**Table 17. Summary of the costs and effects of the ‘real’ and ‘virtual’ HealthPods**

<table>
<thead>
<tr>
<th></th>
<th>‘Real’ HealthPod</th>
<th>‘Virtual’ HealthPod</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 1</td>
<td>Year 2</td>
</tr>
<tr>
<td>Annual cost (£)</td>
<td>133,852.42</td>
<td>121,638.82</td>
</tr>
<tr>
<td>Detection rates for AF*</td>
<td>1.87%</td>
<td>0.95%</td>
</tr>
<tr>
<td>Number and proportion of</td>
<td>3.38; 0.27% (3.38/1230</td>
<td>0.38; 0.09% (0.38/422</td>
</tr>
<tr>
<td>patients in whom a stroke</td>
<td>screened)</td>
<td>screened)</td>
</tr>
<tr>
<td>prevention from detection and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>management of AF*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost per stroke case prevented</td>
<td>£39,601.31</td>
<td>£35,987.82</td>
</tr>
<tr>
<td>Years 1 and 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detection rates for</td>
<td>7.84%; 7.69%</td>
<td>7.84%; 8.3%</td>
</tr>
<tr>
<td>hypertension**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number and proportion of</td>
<td>42.33; 3.19% (42.33/1325</td>
<td>8.03; 3.05% (8.03/263</td>
</tr>
<tr>
<td>patients in whom a stroke</td>
<td>screened)</td>
<td>screened)</td>
</tr>
<tr>
<td>prevention from detection and</td>
<td>41.02; 3.10% (41.02/1325</td>
<td></td>
</tr>
<tr>
<td>management of hypertension**</td>
<td>screened)</td>
<td></td>
</tr>
<tr>
<td>Cost per stroke case prevented</td>
<td>£3,162.12</td>
<td>£2,873.58</td>
</tr>
<tr>
<td>Years 1 and 2</td>
<td>£3,263.10</td>
<td>£2,965.35</td>
</tr>
<tr>
<td>Detection rates for diabetes</td>
<td>0.035%</td>
<td>0.091%</td>
</tr>
<tr>
<td>Detection rates for pre-</td>
<td>10.16%</td>
<td>16.33%</td>
</tr>
<tr>
<td>diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number and proportion of</td>
<td>4.97; 3.88% (4.97/128</td>
<td>6.12; 6.24% (6.12/98</td>
</tr>
<tr>
<td>patients in whom diabetes is</td>
<td>screened)</td>
<td>screened)</td>
</tr>
<tr>
<td>prevented or delayed through</td>
<td></td>
<td></td>
</tr>
<tr>
<td>detection and lifestyle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost per patient diabetes case</td>
<td>£26,932.08</td>
<td>£24,474.61</td>
</tr>
<tr>
<td>Years 1 and 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*restricted to age 50-99

**restricted to age range 40-89
Summary of Findings:

- The annual cost of the HealthPod was 4.5-5 times higher in the ‘Real’ HealthPod compared to the ‘Virtual’ HealthPod.

- The ‘Real’ HealthPod had contact with four times as many patients, although this would have been expected as it was running for longer and we are not comparing like with like with regards time of implementation.

- Detection rates for AF were nearly 2 times higher in the ‘Real’ HealthPod (1.87%) as compared to the ‘Virtual’ HealthPod (0.97%) and were similar to QUALITY Outcomes Framework (QOF) recorded figures for Wakefield (1.83%).

- The cost per stroke prevented from AF detection was around 0.5 times lower in the ‘Real’ HealthPod (£35,987) than the ‘Virtual’ HealthPod (£63,378).

- Detection rates for Hypertension were similar for both the ‘Real’ (7.69%) and ‘Virtual’ (8.3%) HealthPods but were a lot lower than those reported in the QOF for Wakefield (15.3%) (around 0.5 times lower).

- The cost per stroke prevented from hypertension detection was similar for the ‘Real’ and ‘Virtual’ HealthPods (~£3,000).

- Detection rates for suspected diabetes were 1.3 times higher and 1.6 times higher for pre-diabetes in the “virtual” HealthPod (5.10%, 16.333%) compared to the “real” HealthPod (3.91%, 10.16%). The detection rates for diabetes (suspected diabetes and pre-diabetes) was around 1.5 times higher in the “real” HealthPod and 2 times higher in the “virtual” HealthPod that the QOF reported detection rate (7.15%).

- The cost per diabetes case prevented was around 6 times higher in the ‘Real’ HealthPod (£24,474) compared to the ‘Virtual HealthPod (£3,935).

- The figures for stroke can be compared to the average cost of care (acute and rehabilitation) per stroke patient which is currently estimated as £23,315 (National Audit Office, February 2010).

- These figures can also be compared to those estimated through the NHS Health Check programme. The HealthPod population aged between 40-74 was entered into the NHS Health Check Ready Reckoner tool (V.9 28th May 2014) (see Table A4). Using this tool it was estimated that from a population of 2313 the NHS Health Checks would cost £69,518 for the year and would identify:
  - 454 people with hypertension requiring antihypertensive drugs, of which 90 would be compliant with anti-hypertensive drugs;
  - 53 people with Type 2 diabetes of which 41 would take up lifestyle intervention and 37 would be compliant with lifestyle intervention; and
  - 32 people with Type 1 diabetes,
Discussion:

- Health economic analyses of different service provision are important alongside the patient outcomes and experience, especially in times of scarce resource.

- For prevention interventions, costs and benefits needed to be clearly articulated up front in order to capture outcomes which are in the longer term. Although these outcomes are in the future, they should be modelled in order to understand, if implemented, what the resource effect, positive and negative would have in the whole system in future years.

- It is important for future health economics analysis that costs should be adjusted for depreciation and discounted over the lifetime of the programme. Due to the limited data available linking the HealthPod Dashboard to primary care data, a number of assumptions have been employed in this analysis and data have been extrapolated from national data sets. None of the assumptions used in the analysis have been tested for reliability.

We are aware that the Healthpod has been decommissioned.
Summary of Recommendations:

Recommendations for Care Navigation

- Further investigation could be done around the reasons why people don't accept care navigation even though they might agree with it as a concept.
- Further investigation could be done around the reasons why care navigation doesn't happen consistently.
- It would be useful to understand why our data shows only a small reduction in the demand on GP time, when we are aware this contradicts the quantitative data findings.
- More information needs to be made available for patients about the reasons for and benefits of care navigation.
- All staff in the practice need to be aware of the practice of care navigation and how to engage with it effectively.
- Practices should consider how to offer confidentiality within the waiting room or at the reception desk if asking patients for details about their presenting issue.
- Care navigation training should be more than a perceived information session and should be made freely and easily available.
- Care Navigators' increase in responsibility and changes in day-to-day tasks should be reflected in their pay.

Recommendations for Physio First

- Booking systems and practices need to ensure that patients are directed clearly to the correct venue for their appointment.
- Consideration to be given to the role of the Physiotherapist and the ability to issue sick notes and undertake relevant prescribing.
- The service could be publicised more widely to patients, including the fact that it is an assessment appointment, not a Physiotherapy appointment.
- Consideration should be given to the fact that online booking options generally only offer GP appointments, which means diversion of patients to alternative professionals is then not possible.
- All staff need to be aware of the service and how to use it effectively, e.g. GP not referring to Physio First instead of the community Physiotherapy service.
- To ensure that the model is consistent and it is clear to all that Physio First appointments are for assessment rather than treatment.
- The model should be made more flexible and allow Physio assessment appointment even if GP contact has already been made.
It is understood that the service will be changed to a telephone Physio assessment and it will therefore be important to evaluate patient experience to compare with the face to face Physio assessment

**Recommendations for Pharmacy**
- The model at Outwood Park should be considered good practice, in particular that the pharmacist was well integrated into the practice, was seen as an equal and useful partner with the right qualifications, attended practice meetings and there was good two way communication.
- Qualifications required for pharmacists working in the scheme should be clear and standardised. Consideration could be given to pharmacists’ ability to provide fit notes if that is possible.
- Job descriptions should be standardised and could include specific pharmacy qualifications and possibly also nutrition training, Physiological measurements and interpretation/ action and the ability to take blood.
- Appointments should be a minimum of 15 minute and could be face to face, not by telephone.
- Consideration should be given to the fact that online booking options generally only offer GP appointments, which means diversion of patients to alternative professionals is then not possible.
- The patient information sheets that are provided could be made more attractive and user friendly e.g. nutrition.
- The service could be publicised more widely to patients.
- To investigate the potential to link in to NHS Health Checks.

**Recommendations for Extended Hours**
- This service should definitely be continued in some form, it is particularly good for people who work.
- Continue to ensure that NHS 111 refers appropriately, but don’t use this as the only route for referral.
- Publicise the service both to patients and to primary care staff.
- Ensure that it is resourced for the long term so that patients and staff have faith in it.
- Ensure that referrals to the service are appropriate and consistent across the district.

**Recommendations from Health Economics**
- A future analysis should involve the modelling of the costs and outcomes, using matched population data to model stroke and diabetes risk using the existing models available. In addition costs should be adjusted for depreciation and discounted over the lifetime of the programme, and sensitivity analysis should be performed around the variable parameters.
Future evaluations of this type of intervention that has implications across different health and social systems and time needs to have linked/shared records in order to robustly evaluate and understand patients journey and health resource utilisation.

NHS England should;

- In conjunction with local sites explore opportunities to tailor national MCP Vanguard programmes towards local context.
- Consult with regional Vanguards about their needs and requirements prior to implementation.
- Be aware that primary care practices wanted consultation on existing pressures, struggles and need for improvement relevant to their needs as a practice teams before being asked to implement new services and to consider this in line with the implementation requirements of Vanguards.
- Be aware that the pilot nature of interventions and associated budget limitations may lead to primary care teams' reluctance to advertise new services to patients.
- Be aware and accommodate the prevailing concept of GPs as family doctors and consider implications for training and future GP workforce.
- Consider the wider workforce education needs to accommodate and new ways of working across practice clinical and non-clinical staff.
- Make sure that the introduction of new services does not fragment health care.

Commissioners should;

- Be aware of primary care teams' specific pressures and needs for improvement and tailor interventions accordingly.
- Engage in ongoing communication with primary care teams who are implementing Vanguard services.
- Communication should be timely, collaboratively and based on a bottom-up mentality.
- Take into account that patients themselves play a key role in the implementation of organisational change. Vanguards are mainly aimed at staff, and could give more attention to patients'.
- Have clear expectations of health care and what is required.
- Possess a clear knowledge and awareness of Vanguards.

GP practices should;

- Ensure that all staff are sufficiently aware of Vanguard services, what they are and how to implement them.
- Make sure that relevant information for both staff and patients is given in the most appropriate format in order to raise awareness and an understanding of Vanguard services as this increases level of buy-in and maximises utilisation.
Overall Conclusions

Combined planning, analysis and reporting from the qualitative researcher and Healthwatch Wakefield has allowed a richer and more robust evaluation.

We have observed that introducing change takes time and it is imperative to get all involved on board at the beginning of the process and they need to feel involved throughout and consulted where appropriate.

Feedback on a number of the interventions has been positive from patients, though there have been some mixed views from the staff involved, although staff were in a variety of states of engagement with the Vanguard programme at the time of the evaluation.

Detailed conclusions are available on page 76 and page 98 for the qualitative and health economic analysis respectively. However, many strands of the Vanguard were well received and starting to work in the practices.

It is important to have a process in place to baseline the starting point and measure change when targeting a specific intervention e.g. difficult to quantify the benefits of the HealthPod to the original target patient population.

It needs to be recognised that change takes time to embed and some may be aspirational and impacted by delays elsewhere in the system and needs to be considered in the round. There are lessons to be learnt from the evaluation itself and available data may drive what can actually be evaluated. Measuring implementation and performance needs to be considered at the design stage.
References and Appendices


http://www.normalizationprocess.org


NHS Health Check ready reckoner tool (V.9 28th May 2014)

NHS Digital (Oct 2016). QOF Recorded disease, prevalence and achievements CCG level.


Appendices:
A1. HealthPod costing template
A2. Attributable Risk of Stroke for Hypertension and Atrial Fibrillation by Age (taken from Wolf et al. 1991)
A3. NHS Health Check Ready Reckoner Underlying Data (Taken from Public Health England NHS Ready Reckoner tool (V.9 28th May 2014))
A4. NHS Ready Reckoner Results for South Yorkshire (user defined population).
5 Logic Model
6 Hypothesis Tree
7 Vanguard Area Map

Costing Spreadsheet. West Wakefield Health Pod (virtual/real)

<table>
<thead>
<tr>
<th>resource</th>
<th>quantity (min, max if range)</th>
<th>cost (£)</th>
<th>unit (variable or fixed) (per patient/per month/per year?)</th>
<th>virtual (v)/real (r)/or both?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>direct</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>costs associated with the inflatable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the inflatable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the pump</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cleaning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>risk assessment costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>room hire</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>electricity used?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>staff</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>primary care: GP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>primary care: nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>primary care: PA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>reception/record keeper/manager?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ambulance service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Johns?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>voluntary services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>council staff (to set up pod or do risk assessments etc)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>clinical costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>clinical equipment (please list what is used and associated additional costs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>tests conducted (list)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>investigations conducted (list)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>treatment costs (list)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>prescription costs (list)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cost of referral to primary care?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cost of referral to secondary care?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>other equipment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>computers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>promotion leaflets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>promotion twitter (staff time?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Indirect</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff travel costs to venue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>voluntary staff present</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anything else missing?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table A2. Attributable Risk of Stroke for Hypertension and Atrial Fibrillation by Age (taken from Wolf et al. 1991)

<table>
<thead>
<tr>
<th>Cardiovascular condition</th>
<th>Age Group</th>
<th>50-59</th>
<th>60-69</th>
<th>70-79</th>
<th>80-89</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension Attributable Risk (%)</td>
<td>48.8</td>
<td>53.2</td>
<td>48.6</td>
<td>33.4</td>
<td></td>
</tr>
<tr>
<td>Atrial Fibrillation Attributable Risk (%)</td>
<td>1.5</td>
<td>2.8</td>
<td>9.9</td>
<td>23.5</td>
<td></td>
</tr>
</tbody>
</table>

Table A3. NHS Health Check Ready Reckoner Underlying Data (Taken from Public Health England NHS Ready Reckoner tool (V.9 28th May 2014))

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>40-44</td>
<td>45-49</td>
</tr>
<tr>
<td>Require further investigations for hypertension</td>
<td>22.58</td>
<td>26.45</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>
Table A4. NHS Ready Reckoner Results for South Yorkshire (user defined population).

NHS Health Check Ready Reckoner for South Yorkshire (Met County)

<table>
<thead>
<tr>
<th>Condition/Intervention</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 40 to 74 years without CHD, CKD or diagnosed diabetes</td>
<td>2,313</td>
</tr>
<tr>
<td>People invited for Health Check</td>
<td>2,313</td>
</tr>
<tr>
<td>People who will attend</td>
<td>2,313</td>
</tr>
<tr>
<td>People who are obese</td>
<td>506</td>
</tr>
<tr>
<td>People who take up weight loss programme</td>
<td>430</td>
</tr>
<tr>
<td>Additional people complete weight loss programme due to NHS Health Check</td>
<td>137</td>
</tr>
<tr>
<td>Total cost of providing NHS Health Checks for one year</td>
<td>£69,518</td>
</tr>
<tr>
<td>People requiring statins</td>
<td>366</td>
</tr>
<tr>
<td>People prescribed statins due to NHS Health Check</td>
<td>183</td>
</tr>
<tr>
<td>Additional people compliant with statins due to NHS Health Check</td>
<td>128</td>
</tr>
<tr>
<td>People at high risk of diabetes</td>
<td>1,117</td>
</tr>
<tr>
<td>People with high glucose result</td>
<td>97</td>
</tr>
<tr>
<td>People diagnosed with IGR</td>
<td>53</td>
</tr>
<tr>
<td>Additional people complete IGR lifestyle intervention due to NHS Health Check</td>
<td>37</td>
</tr>
<tr>
<td>People with single high blood pressure measurement</td>
<td>810</td>
</tr>
<tr>
<td>People prescribed anti-hypertensive drugs due to NHS Health Check</td>
<td>454</td>
</tr>
<tr>
<td>Additional people compliant with anti-hypertensive drugs due to NHS Health Check</td>
<td>90</td>
</tr>
<tr>
<td>People with Chronic Kidney Disease</td>
<td>162</td>
</tr>
<tr>
<td>Additional people diagnosed with Chronic Kidney Disease due to NHS Health Check</td>
<td>39</td>
</tr>
<tr>
<td>People who are inactive</td>
<td>1,610</td>
</tr>
<tr>
<td>People who take up brief exercise intervention</td>
<td>1,240</td>
</tr>
<tr>
<td>Additional people increase physical activity due to NHS Health Check</td>
<td>2</td>
</tr>
<tr>
<td>People smoke based on national estimates</td>
<td>469</td>
</tr>
<tr>
<td>People referred to smoking cessation services</td>
<td>89</td>
</tr>
<tr>
<td>People who quit smoking due to NHS Health Check</td>
<td>89</td>
</tr>
<tr>
<td>People diagnosed with IGR due to NHS Health Check</td>
<td>48</td>
</tr>
<tr>
<td>People compliant with IGR lifestyle intervention due to NHS Health Check</td>
<td>41</td>
</tr>
<tr>
<td>People diagnosed with diabetes</td>
<td>32</td>
</tr>
<tr>
<td>People with diabetes due to NHS Health Check</td>
<td>19</td>
</tr>
<tr>
<td>People inactive</td>
<td>1,610</td>
</tr>
<tr>
<td>People who take up brief exercise intervention</td>
<td>1,240</td>
</tr>
<tr>
<td>Additional people increase physical activity due to NHS Health Check</td>
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<tr>
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</tr>
<tr>
<td>People referred to smoking cessation services</td>
<td>89</td>
</tr>
<tr>
<td>People who quit smoking due to NHS Health Check</td>
<td>89</td>
</tr>
<tr>
<td>People diagnosed with IGR due to NHS Health Check</td>
<td>48</td>
</tr>
<tr>
<td>People compliant with IGR lifestyle intervention due to NHS Health Check</td>
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</tr>
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<td>People diagnosed with diabetes</td>
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</tr>
<tr>
<td>People inactive</td>
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</tr>
<tr>
<td>People who take up brief exercise intervention</td>
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<td>People referred to smoking cessation services</td>
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<tr>
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</tr>
<tr>
<td>People diagnosed with IGR due to NHS Health Check</td>
<td>48</td>
</tr>
<tr>
<td>People compliant with IGR lifestyle intervention due to NHS Health Check</td>
<td>41</td>
</tr>
<tr>
<td>People diagnosed with diabetes</td>
<td>32</td>
</tr>
<tr>
<td>People with diabetes due to NHS Health Check</td>
<td>19</td>
</tr>
</tbody>
</table>
## Objective / Rationale

- The key objective is to provide faster access to Primary Care at a more convenient time, offering a wider choice of professional support directly within the Practice.
- The aim is to establish a unified model of extended primary care access across MCP Vanguards’ three GP networks to reduce the work carried out by GPs.
- The aim is for 152,000 patients to have access to urgent/routine appointments in the evening/weekends, close to their home.

### Inputs

<table>
<thead>
<tr>
<th>Financial</th>
</tr>
</thead>
<tbody>
<tr>
<td>£1,074,412 – Transformation Fund (£796,412)</td>
</tr>
<tr>
<td>Local Investment £278,000</td>
</tr>
</tbody>
</table>

### Non-Financial Enablers

- Extended provision to include weekend (Saturday morning) and evening provision.
- Proactive diagnosis and treatment interventions.
- Offering preventative care.

### Activities

- Extended provision to include weekend (Saturday morning) and evening provision.
- Proactive diagnosis and treatment interventions.
- Offering preventative care.
- Development of Central Hub service (Pharmacists and physio service).
- Developing modelling tool for staffing requirements.
- Policy suite for governance and assurance.
- SystmOne template development and 111 interface.

### Short Term Outcomes

- Quicker diagnostics.
- Extended hours FFT.
- Extended hours attendances (4,883 available appointments).
- Faster access to Primary Care.
- Wider choice of professional support within the Practice.
- Direct access to physiotherapists and pharmacists.

### Medium Term Outcome

- Reduction in GP time saved by Pharmacists (target 5,000 GP Hours).
- Reduction in GP Time saved by Physiotherapists (800 GP hours).
- Increased number of Physio First appointments (10,675).
- Increased GP capacity.
- Bigger Primary Care.
- 5.4% reduction in A&E attendances from West Wakefield.
- Extended hours FFT (95% ‘very or highly likely’ to recommend to family/friends in tests).

### Impacts

- Extended Primary care will improve clinical outcomes by offering preventative care, proactive diagnosis and treatment resulting in bigger primary care.
- Improved patient experience.
- Improved patient centred care.
- Improved clinical outcomes through preventative care.
- Improved safety and quality as a results of new care model.
- Improved access.
## Objective / Rationale:
Integration of pharmacists into all 17 practices across the MCP Vanguard. The aim is for these pharmacists to become prescribers thereby reducing the work carried out by GPs.

### Inputs
- **Financial**
  - £533,400 (133,350 per quarter of 2016/2017)
- **Non-Financial Enablers**
  - Resource from “pharmacy first” shifted to Pharmacists in General Practice.

### Activities
- Training Pharmacists to become prescribers
- Two sessions of pharmacy time per GP surgery
- Post discharge medicine reconciliation
  - Medication reviews
  - Minor ailments advice
  - Interface with community and hospital pharmacists and CCG MO team
  - Management of repeat prescribing process
  - Implement MRHA guidance
  - Safety alerts and changes in indications and availability
  - Medicines advice to whole team

### Short Term Outcomes
- Empowered staff with new knowledge and prescribing qualification
- Pharmacists in 17 practices across the MCP Vanguard
  - Optimised medication
  - Reduced prescribing errors, side effects and poly-pharmacy
  - Increased time saved for repeat prescriptions through pharmacist direct
  - Improved medicine management

### Medium Term Outcome
- Wider choice of professional support directly within the Practice
- Reduced GP time (5,000 GP Hours saved therefore halving the original figure)
- Pharmacist FFT survey – 95% satisfaction
- Stable and committed local workforce
- Reduced medication errors

### Impacts
Extended Primary care will improve clinical outcomes by offering preventative care, proactive diagnosis and treatment resulting in bigger primary care

- Improved patient experience
- Improved patient centred care
- Improved clinical outcomes through preventative care
- Improved safety and quality as a results of new care model
- Improved access
Appendix 5 – Logic Model - Workstream 1.2: Physio First

**Objective / Rationale:**
Development of first line physiotherapy – direct 15 minute assessment and advice appointment with musculoskeletal expert, without seeing the GP first. The aim is to reduce GP time through physiotherapists in practices and the hub.

<table>
<thead>
<tr>
<th>INPUTS</th>
<th>ACTIVITIES</th>
<th>SHORT TERM OUTCOMES</th>
<th>MEDIUM TERM OUTCOME</th>
<th>IMPACTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>Development of Physio First service</td>
<td>Increased analysis and evaluation of data inputted into Systm One</td>
<td>Reduction in GP time by physiotherapists (800 GP hours saved)</td>
<td>Clinical outcomes will be improved through prevention, proactive diagnosis and in increased range of interventions.</td>
</tr>
<tr>
<td></td>
<td>• Model development</td>
<td>Physio First service in all 17 GP practices in West Wakefield</td>
<td>Increased number of Physio First appointments (10,675)</td>
<td>Improved access</td>
</tr>
<tr>
<td></td>
<td>• Development of Systm One data collection template</td>
<td>• Physio First service in all 17 GP practices in West Wakefield</td>
<td>Improved choice</td>
<td>Improved safety and quality</td>
</tr>
<tr>
<td></td>
<td>• Development and integration with GP workflow</td>
<td>• Rapid access to the right expert advice</td>
<td>Increase in GP time spent on patients with complex health needs</td>
<td>Improved patient experience</td>
</tr>
<tr>
<td></td>
<td>Physiotherapist</td>
<td>• Increased recommended actions by physio (Prescription, referral or investigations)</td>
<td>Improved stable and committed local workforce</td>
<td>Cost savings on GP time</td>
</tr>
<tr>
<td></td>
<td>• 15 minute triage assessments</td>
<td>• Reduced GP time on minor musculoskeletal complaints</td>
<td>Physio First FFT survey – 95% satisfaction.</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 5 – Logic Model - Workstream 2.2: HealthPod / Pop up Primary Care (Disruptive Prevention)

#### Objective / Rationale:

The aim is to target hard to reach segments of the population that typically do not attend GP surgeries in order for earlier identification of long term conditions.

<table>
<thead>
<tr>
<th>INPUTS</th>
<th>ACTIVITIES</th>
<th>SHORT TERM OUTCOMES</th>
<th>MEDIUM TERM OUTCOME</th>
<th>IMPACTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>Health Pod Services</td>
<td>• Improved behaviour in schools to reduce future ill health</td>
<td>• 3,500 interactions with the population through Health Pod</td>
<td>Reduced A&amp;E attendances</td>
</tr>
<tr>
<td></td>
<td>• Procurement of a specially equipped vehicle</td>
<td>• Increased navigation of available resources</td>
<td>• 95% &quot;very or highly likely&quot; to recommend in family/friends tests</td>
<td>Improved patient experience</td>
</tr>
<tr>
<td></td>
<td>• Oral health advice to schools</td>
<td>• Increased provision of appropriate local interventions</td>
<td>• 350 high risk people referred for further follow up to primary care services.</td>
<td>Improved clinical outcomes through preventative care</td>
</tr>
<tr>
<td></td>
<td>• Health trainers at business locations</td>
<td>• Increased detection of hypertension (in middle aged men)</td>
<td></td>
<td>Improved access</td>
</tr>
<tr>
<td></td>
<td>• At local events for high risk individuals:</td>
<td>• Increased detection of AF (eg in middle aged men)</td>
<td></td>
<td>Disruptive prevention will improve clinical outcomes by offering early intervention to high risk individuals who do not normally access services and school children to change behaviours in a primary school setting to reduce the risk of future ill-health.</td>
</tr>
<tr>
<td></td>
<td>o AF screening</td>
<td>• Increased detection of diabetes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Hypertension screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Diabetes screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop marketing campaign</td>
<td>• Increased awareness of the Health Pod</td>
<td>• Earlier identification of long term conditions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Twitter account</td>
<td>• Increased knowledge about the Health Pod from different segments of the population (eg middle aged men)</td>
<td>• Improved self-care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Tracking app</td>
<td>• Increased capacity of the Health Pod</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Commissioning of second Health Pod</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

*Non-Financial Enablers*

- Partnership with Wakefield District Council

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*Inputs*

- £199,128 in 2016/17 (£49,782 per quarter)
# Appendix 5 – Logic Model - Workstream 3: Care Navigation

**Objective / Rationale:**

Develop an “Apple Store” experience – removing the need for a reception person/desk, but rather to have a range of helpful people and digital resources to signpost patients to appropriate care. The aim is to reduce GP time enabling cost savings.

## Inputs

**Financial**

- £236,276 (£59,069 per quarter)

**Non-Financial Enablers**

- Partnership across 17 General Practices
- MCP team

## Activities

- **Care Navigation**
  - Phone
  - Email
  - Chat
  - Web

- **“Apple Store”**
  - Internet enabled “kiosks” in each practice
  - Care Navigation website
  - Service directory (search and find database)

- **Care Navigation phone app**

- **Developing a team of Care Navigators**

- **Training package for existing members of staff**

## Short Term Outcomes

- **Reduction in the number of patients accessing GPs**
- **Signposting patients to appropriate points of care**
- **Tablet utilisation**

- **Reduction in need for a receptionist**
- **Reduction in queueing at GP receptions**
- **17 practices with kiosks installed**

- **Faster access to the right care (physios and pharmacists)**

- **Increase in trained people**
- **Empowered staff with new knowledge of how the wider health and social care system works**
- **Empowered staff with new knowledge of different care options available to Patients**

## Medium Term Outcome

- **Empower patients to determine the most appropriate and accessible solution to their needs**
- **Improved self-care through signposting to VCS services**
- **Increased number of Care Navigation interactions (24,000)**
- **Improved web application page hits (20,000 sessions)**
- **Care Navigation app downloads (1,500)**
- **Improved number of social prescribing interventions (408)**
- **Increased social well-being scores (60% increase in well-being)**

## Impacts

- Costs savings from a reduction in GP time (880 hours)
- Improved patient experience
- Improved safety and quality of care
- Improved community based solutions for high risk and moderate risk patients
- Improved “medical model” of care to “health, well-being and community” care model
- Improved career experience
- Increased staff capacity
**Appendix 5 – Logic Model - Workstream 4.1: Community Anchors and Micro-commissioning**

**Objective / Rationale:**
Development of engagement resources (personal and projects) from within Community Anchors to develop a more community-centred approach to health and wellbeing; in order to improve the “medical model” of care to a more “health, wellbeing and community” model of care.

<table>
<thead>
<tr>
<th>INPUTS</th>
<th>ACTIVITIES</th>
<th>SHORT TERM OUTCOMES</th>
<th>MEDIUM TERM OUTCOMES</th>
<th>IMPACTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>Recruitment and development of community anchors:</td>
<td>• More engaged relationships with patients</td>
<td>• Increased involvement of anchors in co-production, service design, delivery, evaluation and improvement</td>
<td>Improved patient experience</td>
</tr>
<tr>
<td>• £150,004 for 2016/17 (£37,501 per quarter)</td>
<td>• Diverse spectrum of provision</td>
<td>• More engaged relationships with carers and citizens</td>
<td>• Improved person centred approach</td>
<td>Improved community cased solutions for high risk and moderate risk patients</td>
</tr>
<tr>
<td>Non-Financial Enablers</td>
<td>• Micro commissioning to small VCS service providers to support the third sector</td>
<td>• Increased partnerships (from social prescribing and care navigation)</td>
<td>• Sustainable engagement with the community</td>
<td>Improved “medical model” of care to “health, wellbeing and community” care model</td>
</tr>
<tr>
<td>• Co-operation of community anchors</td>
<td>• Improved patient support in the community</td>
<td>• Increased number of Care Navigation interactions (24,000)</td>
<td>• Care Navigation app downloads (1,500)</td>
<td>Improved safety and quality of care</td>
</tr>
<tr>
<td></td>
<td>• Increase capacity and support for third sector to respond to increased workload</td>
<td>• Cost savings from a reduction in GP time (880 hours)</td>
<td>• Improved number of social prescribing interventions (408)</td>
<td>Improved career experience</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increased social well-being scores (60% increase in wellbeing)</td>
<td>• Increased social well-being</td>
<td>Increased staff capacity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>scores</td>
<td></td>
</tr>
</tbody>
</table>
**Objective / Rationale:**

Development of engagement resources (personal and projects) from within Community Anchors to develop a more community centred approach to health and wellbeing; in order to improve the “medical model” of care to a more “health, wellbeing and community” model of care.

### Financial
- £0

### Non-Financial Enablers
- In kind contributions from resources developed by West Wakefield in 2015/16

### Co-operation of community individuals

<table>
<thead>
<tr>
<th>Resource Development</th>
<th>Financial Cost</th>
<th>Non-Financial Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment and development of Health Champions</td>
<td>£0</td>
<td>Improved health inequalities, Improved patient experience</td>
</tr>
<tr>
<td>Training for Volunteers</td>
<td></td>
<td>Improved “medical model” of care to “health, wellbeing and community” care model</td>
</tr>
<tr>
<td>Increased number of volunteers within GP practices</td>
<td></td>
<td>Improved career experience</td>
</tr>
<tr>
<td>Improved patient support</td>
<td>Improved resource and capacity for GP practices</td>
<td>Increased staff capacity</td>
</tr>
<tr>
<td>Improved individual skill-set for Champions (confidence and personal reward)</td>
<td>Faster access to the most appropriate support for the needs of patients</td>
<td></td>
</tr>
<tr>
<td>Improved resource and capacity for GP practices</td>
<td>Increased number of Champions per practice (20 for each practice)</td>
<td></td>
</tr>
</tbody>
</table>
### Objective / Rationale:
- To deliver more co-ordinated, proactive care through monitoring and integrating sources of information to guide focused work by MDT in order to improve clinical outcomes.
- The aim is to provide a central channel for the wider health and social care systems across Wakefield, that will be situated within a Response Centre.

<table>
<thead>
<tr>
<th>INPUTS</th>
<th>ACTIVITIES</th>
<th>SHORT TERM OUTCOMES</th>
<th>MEDIUM TERM OUTCOMES</th>
<th>IMPACTS</th>
</tr>
</thead>
</table>
| Financial | **Information Hub:**
  - Design and build the information hub
  - GP system notifications and population data
  - Ambulance service
| **Response Centre:**
  - Design and build the response centre
Incoming referrals digitally and by phone | **All MDT staff with shared record access**  
**5,000 patient records shared across clinical teams**  
**Increased number of direct contacts with MDT Fusion cell team (10,400 contacts)**  
**Increased number of patients reviewed on day of discharge by hub-based pharmacy (400 visits)** | **Increased number of patient contacts with community consultants (624 complex patients)**  
**Admissions avoidance – reduced admissions for over 75 years old from West Wakefield (640 fewer admissions)**  
**Support at Home / Early supported discharge – reduced length of stay for over 75 years old from West Wakefield (1,132 fewer bed days)**  
**95% Patient Satisfaction on MDT FFT Survey** | Increase in earlier identification of clinical and social risks allowing prompt interventions.  
Reduced deterioration of health and wellbeing  
Improved patient experience  
Reduced secondary care admissions  
Reduced length of stay  
Improved self-management |
| Non-Financial Enablers | **Information Hub:**
  - Design and build the information hub
  - GP system notifications and population data
  - Ambulance service | **Increase in calls received by Response Centre (5,000 calls)**  
**Increased number of ECP / Paramedic responses to same-day demand (1,040 responses)** | | |

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**Appendix 5 – Logic Model - Workstream 5: Information Hub and Response Centre**

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NHS OFFICIAL SENSITIVE: COMMERCIAL
Appendix 6 – Original Value Generation Hypothesis Tree

Through expanded primary care, proactive teamwork and new technology we will deliver health and social care at scale to the GP registered lists of Vanguard

Clinical Outcomes will be improved by prevention, proactive diagnosis and increased range of interventions

Patient experience will be improved through digitalisation, personalisation, rapid access and community development

Safety and Quality will improve as a result of the new care model as will, through access, care co-ordination and information

Resource requirement of £4.22M is reasonable and required workforce can be put in place

Resource sustainability will be driven through more in-community treatment, reducing the burden on GPs and A&E

Extended Primary Care will improve clinical outcomes by offering preventative care, proactive diagnosis and treatment interventions – Bigger Primary Care.

The Information Hub and Response Centre and integrated team will target patients most at risk to improve clinical outcomes reduce admissions and length of stay, prolonging independent living and self-care.

Digital Initiatives will improve clinical outcomes by increasing the opportunity for self-care, self-navigation and improved flow of information between professionals to support improved care co-ordination. Personalised technology will be deployed, via the Hub, to support independent living for longer.

Disruptive Prevention will improve clinical outcomes by offering early intervention to high risk individuals who would not normally be driven through more community treatment, self-care, MDTs, care navigation, prevention resulting in:

- Increase staff capacity
- Improved carer experience
- Reduction in GP workload
- Improved patient satisfaction
- Reduction in attendance (£0.63M)
- Reduction in walk-in centre attendance (£0.63M)
- Reduction in A&E (£1.53M)
- Reduction in Referral (£1.575M)
- Reduction in elective care (£1.575M)
- Reduction in referral (£0.156M)
- Reduction in discretionary funding (£0.745M)
- Non-recurring cost (£0.156M)
- Future impacts (£0.978M)

Disruptive Prevention will drive £13.22 of gross savings by 2020 through:

- Reduction in GP workload
- Improved patient satisfaction
- Improved carer experience
- Increase staff capacity

Non-cashable – up to £6.5M GP time resource potentially re-deployable if FULL realisation of 50% GP time saved.

Extended Primary Care will deliver rapid access to a local clinical team with access to the full care record.

The Response Centre will allow earlier identification of clinical and social risks allowing prompt interventions and reduction of deterioration in health and wellbeing

Shared care record and interoperability across the system will ensure better flow of information allowing dynamic assessment of health and social needs

Delivering Pop-up Primary care and extended outreach into schools and communities improves case finding and unidentified illness that may end in non-elective care

Better navigation will support faster access to the right point of care, improving quality by increasing access to the most appropriate professional

£278K of funding from Local Health Authority will be secured in 2016/17

Current clinical staff can be shifter and/or re-trained to support effective delivery of this model.

£4.22M of Vanguard Funding in 2016/17 and £14.74M in total funding through to 2020 is reasonable and accurately reflects financial needs of site supporting;

- Extended Primary Care (£1.575M)
- Information Hub and Response Centre (£0.745M)
- Digital Initiatives (£0.156M)
- Disruptive Prevention (£0.578M)
- Care Navigation (£0.578M)

Resource requirement of £4.22M is reasonable and required workforce can be put in place

Proposal will drive £13.22 of gross savings by 2020 through;

- Reduction in Referral (£1.53M)
- Reduction in A&E attendances (£1.30M)
- Reduction in walk-in centre attendance (£0.63M)

- Reduction in referral (£0.156M)
- Reduction in discretionary funding (£0.745M)
- Non-recurring cost (£0.156M)
- Future impacts (£0.978M)
Appendix 7 – Map to show area of Vanguard

NHS Wakefield - New Network Configuration

<table>
<thead>
<tr>
<th>Network</th>
<th>List Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 United Health Wakefield Alliance 1</td>
<td>41226</td>
</tr>
<tr>
<td>2 United Health Wakefield Alliance 2</td>
<td>106036</td>
</tr>
<tr>
<td>3 Network Three</td>
<td>41665</td>
</tr>
<tr>
<td>4 Five Towns</td>
<td>537289</td>
</tr>
<tr>
<td>5 Trinity Health Group</td>
<td>360309</td>
</tr>
<tr>
<td>6 West Wakefield</td>
<td>532388</td>
</tr>
</tbody>
</table>

MAP ID | Practice Name
--- |-------------
16 | Stanley Health Centre
17 | Outwood Park Medical Centre
18 | New Southgate Surgery
19 | Homestead Medical Centre
20 | Averthorpe Surgery
28 | King Street Health Centre
29 | Warrengate Medical Centre
30 | Eastmoor Health Centre
31 | Almshore Surgery
32 | Grove Surgery
33 | Maybush Medical Centre
34 | Crofton and Shaktson Health Centre
35 | Church Street Surgery
36 | Prospect Road Surgery
37 | Lupset Health Centre
38 | Orchard Croft Medical Centre
39 | Middlestoke Medical Centre
40 | Chapelthorpe Medical Centre

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