Draft 1 | Confidential

Northumbria Foundation Group

Evaluation of Acute Care Collaboration Vanguard Programme – Final Report

May 2017

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1 Introduction

1.1 Background

This report sets out findings from the second phase of the evaluation of the Northumbria Foundation Group Acute Care Collaboration (ACC) model by a team from Cordis Bright, PPL Consulting and Cobic. It contains an update on progress with the implementation of the Northumbria Group model since the baseline evaluation report was produced in February 2017.

This report should be read in conjunction with the baseline report, which sets out the background to the creation of NFG model, the policy context and the aims and objectives of the model. The baseline report was accompanied by an evaluation framework, which set out an agreed approach to completing the evaluation of project activity in 2016/17. As agreed, the second phase of the evaluation focused principally on satisfaction with services offered by the Group, together with emerging evidence of impact.

1.2 Evaluation methodology

The methodology for the local evaluation of the Northumbria Acute Care Collaboration is set out in detail in the baseline report and evaluation framework agreed in February 2017. To inform this update report the evaluation team:

- Reviewed data and documentation supplied by Northumbria Foundation Trust.
- Carried out semi structured telephone interviews with internal stakeholders and with members of the Group and recipients of services.

1.3 Limitations of the evaluation

It is important to note the limitations of this evaluation and the difficulty in drawing meaningful conclusions about the impact and effectiveness of the NFG model at this stage in its development. The main challenges in evaluating the project now are:

- The model is still in its early stages and progress in implementing some aspects of the group offer has been slower than planned. For example, the e-rostering system has only just gone live and it is far too early to see financial or other benefits.
- Some of the key stakeholders we hoped to interview have not been available. For example, we were not able to speak to anybody from North Cumbria University Hospitals Trust, which has been supported by Northumbria Foundation Trust for some years. At the time of writing we have not yet been able to have a detailed discussion with anyone involved

in the implementation of the telehealth aspects of the project, due to availability of key personnel to participate in the evaluation.

- It is impossible to attribute any change in key indicators, such as length of stay or patient satisfaction, to the work of the Acute Care Collaboration, given that many other initiatives are also aiming to affect these outcomes.
- We were not able to see detailed performance reports.
- The Northumbria Foundation Group was working on revising its strategy at the time when the second phase of the evaluation was happening. As the strategy has not yet been signed off within the Trust we were not able to have sight of it.

1.4 Overview of the report

The remainder of this report is structured as follows:

- Section two contains an overview of the policy context and the contribution the Northumbria Acute Care Collaboration is making towards the aims outlined in NHS Five Year Forward View.
- Section three contains a discussion of progress in implementing the Group model as planned.
- Section four considers evidence of impact and outcomes.
- Section five sets out next steps for an evaluation of the model, together with an updated evaluation framework.

2 The context for the programme

2.1 The NHS Five Year Forward View and New Care Models

In the baseline evaluation report (February 2017) we set out the policy context in which the Northumbria ACC was conceived and is operating. The ACC is one of five types of new care model vanguard being trialled in 50 sites in England as means of addressing the challenges set out in Five Year Forward View[1]. We noted that ACCs aim to link together hospital services to improve care quality and financial sustainability and that different types of ACCs are emerging in different parts of the country.

In Northumbria the ACC takes the form of a 'foundation group', through which the trust and its partners will support others. Northumbria Healthcare's experience gained in recent years working as 'buddy' with North Cumbria has been a platform to develop the model of replicability for a standard operating model across the Foundation Group. Alongside aiming to improve outcomes for patients in the longer term, the Northumbria Foundation Group will become more efficient and effective through sharing clinical knowledge and expertise, spreading innovation and best practice and reducing cost through sharing of back office services.

2.2 Sustainability and Transformation Plan

By January 2017 all 44 Sustainability and Transformation Plan footprints had published their plans to achieve financial balance by 2021. Northumbria Foundation Trust straddles the Northumberland, Tyne and Wear and North Durham (NTWND) STP footprint, which covers a total population of 1.7 million residents across three local health economies (Newcastle Gateshead, Northumberland and North Tyneside and South Tyneside, Sunderland and North Durham) and the West, North and East Cumbria footprint, which has a population of 327,000.

According to the draft NTWND STP document, the footprint has undergone significant structural change in recent years, including a merger of CCGs (reducing the number of CCGs from seven to five), the recent opening of the Northumbria Emergency hospital, resulting in the A&E departments at Hexham, Wansbeck and North Tyneside being downgraded, and Northumberland CCG being in the early stages of moving significant parts of its operations into a provider-led (Northumbria Healthcare) accountable care organisation developing out of one of the vanguards.

In WNE Cumbria by 2020/21 an estimated additional £168m of funding could be required above expected allocations to keep pace with expected increases in demand and cost pressures. The STP identifies provider efficiencies, shared

[1] NHS (2014). Five Year Forward View.

organisational arrangements and services delivered outside of hospital as the principal means of closing the financial gap. The NTWND STP sets out plans to close a £641m gap between expected demand for health and social care services and funding available by 2021. Amongst the proposals which will contribute towards achieving this is acute services collaboration across clinical pathways and service models. The Northumbria ACC is leading the way in this respect. It is supporting the local health economy as a whole by keeping 'in house' services which might otherwise be delivered by external organisations and, at the same time, is generating income to support its own sustainability.

2.3 Five Year Forward View Next Steps

The document *Next Steps on the Five Year Forward View* was published on 31st March 2017. The 'next steps' document includes the following declaration of intent:

> Our aim is to use the next several years to make the biggest national move to integrated care of any major western country. Why? As the CQC puts it:
>
> "The NHS stands on a burning platform - the model of acute care that worked well when the NHS was established is no longer capable of delivering the care that today's population needs… transformational change is possible, even in the most challenging of circumstances - we have witnessed it, and seen the evidence that it delivers improved care. As the boundaries between organisations and sectors become increasingly porous, peer review and transparency will become ever more important."
>
> Prof Sir Mike Richards, Chief Inspector of Hospitals, *State of Care in Acute NHS Hospitals 2014 to 2016*, CQC

The move towards integration will take the form of Sustainability and Transformation Partnerships covering every area of England, and, for some geographies, the creation of integrated (or 'accountable') health systems. In the Northumberland, Tyne and Wear and North Durham footprint area other vanguards are already moving towards becoming accountable care organisations – a significant development which will have a major impact on the local health economy.

3 Implementation progress

3.1 Programme implementation

3.1.1 Overview

One of the evaluation questions posed by the Group was 'Has the programme been implemented as planned?' At the time when we wrote the baseline report in February 2017 there had already been some slippage in implementation. In that report we set out a detailed account of progress against the original plans. Given that some elements of the programme had not been implemented yet or were in their early stages, it was agreed that we would focus between February and May 2017 on exploring:

- Patient experience programmes
- Hip fracture work
- International partnerships
- The collaborative staff bank
- The E-rostering tool
- Telehealth, including the pilot COPD app, EPACCS and telehealth interventions for hypertension, smoking cessation and end of life care
- The patient information portal currently in development

In this section we look at the progress made with each element of the group model.

3.1.2 E-Rostering

Once it is fully operational, the E-rostering system is expected to bring significant financial benefits and a greater ability to attract and retain staff. Setting up the e-rostering system and assuring its functionality is a complex task. We understand that the following progress has been made:

- From 1st March 2017:
  - All requested bank shifts for 1st April 2017 onwards were entered into the Allocate system.
  - Training sessions were available.
  - Training manuals had been produced and added to the relevant webpages.
  - For the absence only input manager accounts were created and distributed.
- From 3rd April 2017:
  - All TAeR wards/departments (minus the pilot) were live with Health Roster; Employee Online and Payroll.
  - The Employee Online accounts had been set up.

Two further 'go live' phases are scheduled for 3rd July and 30th October 2017, with an additional 'go live' for medical staffing to go live at a later date, yet to be agreed.

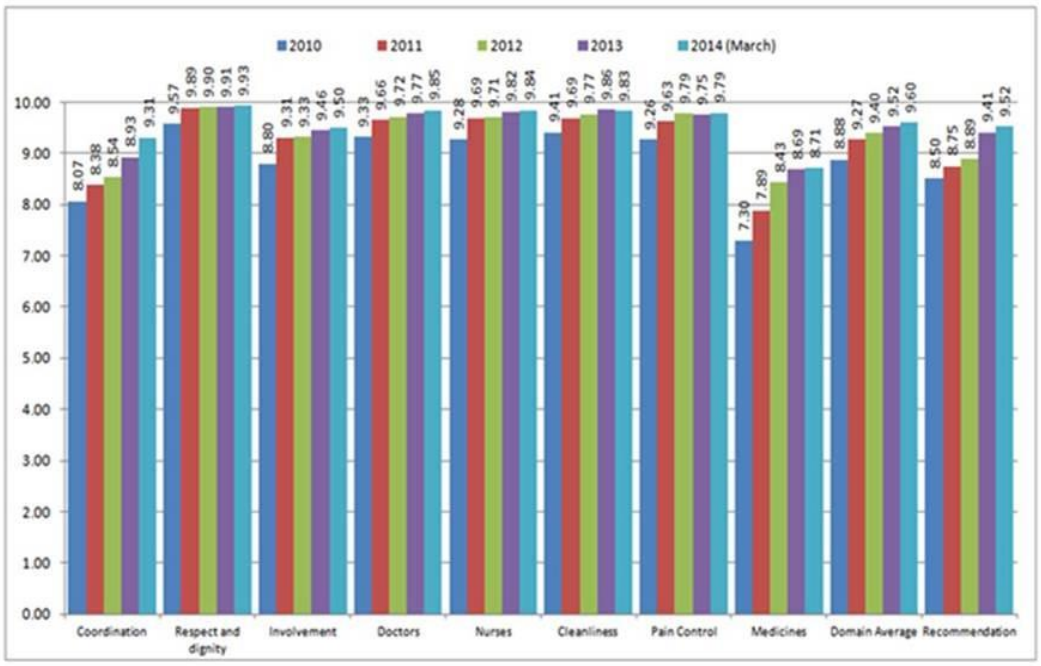
3.1.3 Patient experience

Northumbria Foundation Group is currently working with South Tees Hospitals NHS Foundation Trust to support the implementation of its patient experience measurement and improvement model. South Tees began real time and right time measurement of patient experience with effect from January 2017. NFG is also in the process of recruiting ten organisations with a planned launch in September 2017 for a 12-15 month programme of measuring patient experience with the aim to improve outcomes in the following core dimensions:-

- Co-ordination
- Respect and dignity
- Involvement
- Doctors
- Nurse
- Cleanliness
- Pain control
- Medicines

In Northumbria itself the model has demonstrated real time year on year improvements in patient experience, as figure 1 (supplied by the Trust) shows.

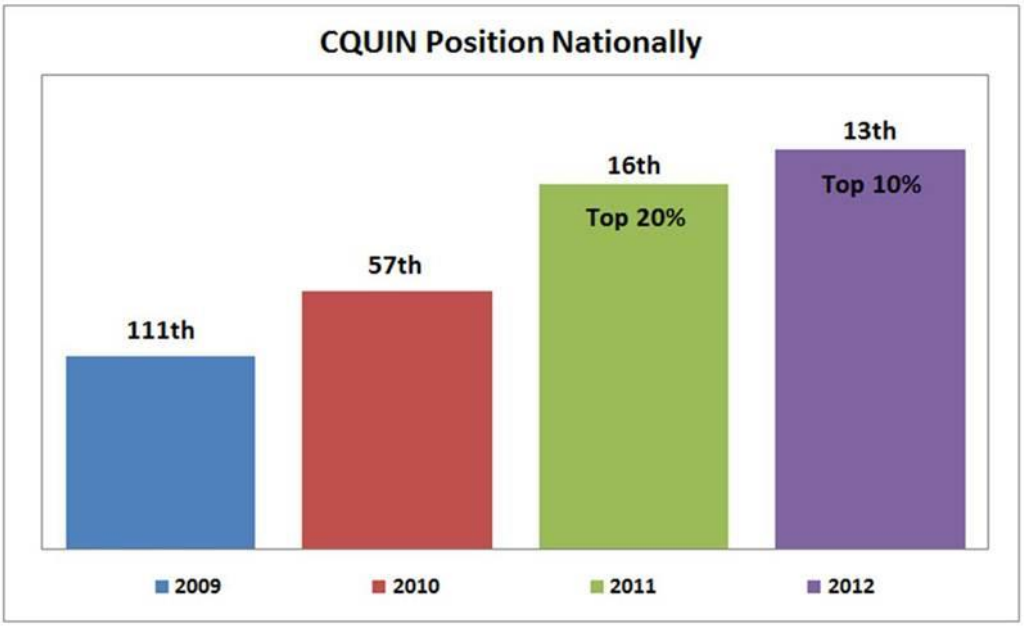
Figure 1: Northumbria Foundation Trust patient experience measures 2010 to 2014



Source: Northumbria Foundation Trust

The trust's performance in relation to Commissioning for Quality and Innovation (CQUIN) national goals has improved year on year, as figure 2 shows.

Figure 2: Change in Northumbria Foundation Trust CQUIN position



Source: Northumbria Foundation Trust

3.1.4 Standard operating models

The Hip QIP model is the most developed of the group standard operating models, through which the group aims to spread best practice and support others to achieve improved outcomes. The Northumbria Foundation Group is testing the Hip QIP model with five other sites.

An independent evaluation of this collaboration is being carried out by the Royal College of Physicians. The evaluation will largely be based on data collected routinely via the National Hip Fracture Database (NHFD). Data from organisations participating within the intervention will be compared against data from a similar number of trusts not participating.

Using assessment, with case mix adjustment when appropriate, the evaluation will aim to find out whether there has been any change in:

- mortality rates (both crude and case mix adjusted)
- best practice tariff attainment (a proxy measure for a good hip fracture programme providing high quality care)
- the proportion of patients getting their operation in a timely fashion
- the consideration of nutritional status
- prompt mobilisation of patients

A formative evaluation will also be undertaken whereby run charts and similar quality improvement feedback can be provided in rapid time to help Trusts assess locally whether the interventions have led to change.

Alongside outcomes collection, the team will carry out a process evaluation, which will help the project team to revise and modify the improvement plan should feedback indicate this is necessary. The key evaluation questions include:

- What has happened during the improvement programme?
- What could have been done better?
- Were the various activities successful?
- What has been learnt?

Ten to twelve in-depth interviews will be held in each of the sites with a mix of staff from the various project teams, ward teams, and Trust executives Interviews will take place in May and June 2017 and May and June 2018. The final report of the evaluation is expected in December 2018.

The baseline position, against which improvement will be measured, is set out in figure 3 overleaf.

Figure 3: Hip fracture baseline position

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17*
Number of patients	219	206	245	191	238	197	203	204	198	253	196	235	259
Percentage of patients that have x-ray within an hour of arrival in ED	-	-	-	-	-	-	-	-	-	-	-	-	29.34%
Percentage of patients having a nerve block in ED or ward prior to surgery	-	-	-	-	-	-	-	-	-	-	-	-	66.8%
Percentage of patients admitted to a ward within 4 hours	65.30%	63.11%	64.49%	68.59%	72.69%	73.60%	71.92%	65.69%	67.68%	60.08%	67.35%	58.72%	38.61%
Percentage of patients not admitted to an orthopaedic or orthogeriatric ward	0.91%	1.94%	6.53%	5.76%	2.10%	3.05%	3.45%	3.92%	2.02%	2.77%	2.55%	0.43%	3.09%
Percentage of patients assessed by an orthogeriatrician within 72 hours of admission	93.61%	95.63%	91.02%	94.24%	95.80%	93.40%	96.55%	94.12%	96.97%	91.70%	97.96%	90.21%	86.1%
Percentage of operated patients assessed by an orthogeriatrician pre-operatively	62.56%	68.45%	63.27%	62.83%	67.65%	66.50%	65.02%	65.20%	73.23%	71.15%	73.47%	63.83%	62.79%
Percentage of patients with documented evidence of full sets of observations	-	-	-	-	-	-	-	-	-	-	-	-	37.45%
Percentage of patients triggered EWS 1-4 with actions / decisions documented by appropriate responder	-	-	-	-	-	-	-	-	-	-	-	-	87.50%
Percentage of patients triggered EWS 5 or more, or 3 in one parameter, with actions / decisions documented by an appropriate responder	-	-	-	-	-	-	-	-	-	-	-	-	55.56%
Percentage of patients treated non-operatively	0.46%	0.97%	2.86%	1.05%	1.26%	2.54%	4.93%	3.43%	1.52%	1.58%	1.02%	0.85%	1.16%
Percentage of patients considered for critical care	-	-	-	-	-	-	-	-	-	-	-	-	9.65%
Percentage of patients operated within 36 hours of admission	78.54%	78.64%	76.73%	82.72%	76.89%	71.07%	78.82%	75.00%	72.22%	75.49%	85.20%	77.45%	83.72%
Percentage of operated patients with compliance with surgical care bundle in theatres	-	-	-	-	-	-	-	-	-	-	-	-	3.47%
Percentage of patients receiving vasopressor support intra-op	-	-	-	-	-	-	-	-	-	-	-	-	16.60%
Percentage of patients mobilised on the day of or after surgery	91.71%	80.88%	79.92%	79.47%	87.34%	79.38%	83.08%	89.00%	89.39%	86.40%	79.06%	82.05%	74.5%
Percentage of patients mobilised daily until discharge	-	-	-	-	-	-	-	-	-	-	-	-	23.55%
Percentage of patients who received an additional meal per day	-	-	-	-	-	-	-	-	-	-	-	-	-
Percentage of patients with hospital acquired pressure ulcers	2.74%	5.34%	3.27%	4.19%	0.84%	2.03%	2.96%	2.96%	4.04%	3.95%	3.59%	2.98%	1.16%
Percentage of patients from their own home discharged back there	37.21%	30.91%	37.02%	48.72%	39.34%	40.00%	44.94%	38.86%	34.57%	37.93%	38.93%	41.85%	28.71%
Mean acute LOS	15.052665	12.345173	13.325694	11.05844	12.528153	11.257075	12.813159	13.366008	11.315012	13.618182	12.738679	13.681012	10.4
Mean Trust LOS	22.395119	20.52093	20.977976	18.930235	21.30411	18.282075	19.645143	20.126008	20.873198	21.411286	20.152409	18.846234	13.6
Percentage emergency readmissions within 30 days	-	-	-	-	-	-	-	-	-	-	-	-	-
30 day mortality	7.31%	10.68%	4.90%	6.81%	7.56%	8.63%	6.90%	6.37%	6.06%	-	-	-	-

3.1.5 International partnerships

The Trust's international partnerships division has progressed significantly over the past year, forming valuable relationships with a number of overseas clients, offering significant opportunities for income generation, as well as with national and international partners, to collaborate on project delivery and build on our international offer.

The Trust is in discussions with private organisations such as Global Business & Investment (GB&I) to acquire expertise on the UAE market and project management; Aspen Medical to acquire human resources and capacity and other NHS trusts to broaden the clinical offering, for example. This work has culminated in the development of NHS International; a proposed company, managed by Northumbria Healthcare NHS, to source, filter and distribute opportunities to this network. NHS International will manage all the infrastructure and income involved in delivering on international projects. This will be a ground-breaking concept, offering international buyers a direct route to work with the NHS and therefore, offers Northumbria a potentially very lucrative and progressive dimension to its international work.

Key markets currently include China, India, UAE Brazil and the trust has live, high value, opportunities in each of these areas:

China

- Rongquaio Group, Fuzhou, China: a real estate property developer looking to invest over £100million in building a cancer specialist hospital. Following a high level delegation visit from Rongquaio Group to Northumbria earlier this year, they have affirmed their interest in selecting Northumbria as an international partner to deliver. This project would be undertaken in collaboration with NHS Christies, to deliver cancer clinical specialist expertise and offer the desired UK cancer care brand sought by the client. Northumbria and Christies are in the process of discussions with the client and a feasibility study to progress this opportunity is to be submitted for consideration.

- Xiangya Hospital, Hunan, China: discussions are on-going with Xiangya Hospital, following the signing of an MOU in January 2017. Xiangya have requested a training programme for two doctors and four nurses to develop skills and expertise around integrated care. A proposal has been developed and the project currently offers potential income of £72,000 for the first stage of this work. Should further cohorts follow, this could offer year on year income of £72,000 or more, depending on uptake.

India

- Mayar India Ltd, a corporate group, is seeking an international clinical partner to outfit healthcare facilities. An MOU has been signed with Mayar and Northumbria is working with GB&I to formulate a proposal. Income value is not currently known.

UAE

- Al Khaily Hospital is to be a multi-specialty facility in Abu Dhabi, offering various services. The development of the facility is led by investment from leading hospitals group 'HSK', who are seeking an international partner to design, build and operate the new hospital. Northumbria has been shortlisted as a potential partner in this project and is working with GB&I to formulate a proposal and move to the next stage of discussions.

Brazil

- UniMed Brazil, a leading medical work cooperative and health insurance provider in Brazil, has invited Northumbria in to discussions to develop integrated care in the country. Project ideas and the client's proposal are yet to be developed.

3.1.6 Telehealth

Implementation of the COPD app has been delayed due to technical issues. At the time of writing we have not been able to interview a member of the team working on this, due to difficulty in making space in busy people's diaries. We have an interview scheduled for the end of June.

3.1.7 Collaborative regional bank

The regional evaluation team is looking at the implementation and impact of the collaborative regional bank.

3.2 Enablers and barriers to implementation

At the outset of this evaluation the team was asked to consider the question 'what are the key enablers and barriers to implementation of the hospital chain group?' Although it is too early to be able to identify outcomes that are clearly attributable to the Northumbria collaboration, some barriers and enablers to the establishment of a model have emerged.

Enablers

The key enablers are: entrepreneurial leadership, with people in senior positions who make the case for doing things differently and lead on seeking out opportunities to do so; a vision of what can be achieved, and the expertise and proven track record of local success which makes the offer to other trusts a credible one. Funding from the New Care Models programme has enabled the Trust to invest in technology-based solutions – for example E-rostering and the COPD app - which will help the Trust and others to achieve financial efficiencies and improved patient and staff experience. The funding has also enabled the Trust to backfill the roles of senior staff who are leading the delivery of services to Group members; this is a crucial aspect of the feasibility of the model in the longer term.

Barriers

Key barriers to implementation have been:

- Getting the balance right between focusing on the internal operations of the Trust and marketing and implementing the Foundation Group offer.
- Delays in launching some elements of the model – in particular the COPD app – due to technical issues arising and needing to be solved
- The Group can only develop at the pace at which partners wish to take up elements of the model. From the outset the Trust recognised that some partners would be likely to purchase support services but would not be want to progress to a closer collaboration.

3.3 Delivery plan 2017/18

Figure 1Figure 4 below summarises the Northumbria Acute Care Collaboration delivery plan for 2017/18. The detailed plan includes the following overarching areas of activity:

- A range of best practice clinical and non-clinical models supported into organisations through collaboration
- Targeted design and implementation support for systems and providers developing new large scale models of care aligned to the 5YFV
- Evidence based strategies to enable providers to manage/reduce flow into acute settings
- Expanding range of technology to enable better use of resource and upstream triage away from acute settings
- Investing to provide industrial scale diagnostics/scanning capacity for a wide geographical area
- Centralised bank function and models to support operational workforce issues
- A plan to provide structured routes for private funding into NHS providers
- Effective and efficient packages of support for NHS organisations to address financial issues
- Expanding range of back office functions encompassing a greater number of organisations
- Programmes to support quality improvement and new models of care (MCPs and PACs) through direct training and train the trainer approach

Key to the delivery plan

	Design Stage
	Development phase
	Operational
	Concept Stage

Figure 4: Northumbria Foundation Group Summary Delivery Plan 2017/18

	2017/18		Apr-17	May-17	Jun-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Clinical and Operational Sustainability	**Costs**	**Savings**																				
Standard Operating Models	**£000's**	**£000's**	**Range of best practice clinical and non clinical models supported into organisations through collaboration**																			
Cumbria		408																				
Anaemia	100																					
Medicines optimisation	100	100																				
HIP QIP	250																					
Sepsis	101																					
Patient Experience	20	65																				
Expanding range of clinical/non clinical SoMs	360																					
Other/various (including PMO support)	180																					
New Models support to wider system			**Targetted design and implementation support for systems and providers developing new large scale models of care aligned to the 5YFV**																			
Primary and Acute Care Systems support	80																					
Mutil-specialty Community Provider support	80																					
Supporting Frailty in care homes	50																					
International business activty	100	500																				
ACO	50																					
PMO support	100																					
Adminission Avoidance Strategies			**Evidence based strategies to enable providers to manage/reduce flow into acute settings**																			
Frailty Pathway																						
Lower level trauma																						
Stratification approaches	80																					
Range of models to support LTC mgt	90																					
Technology/Devices			**Expanding range of technology to enable better use of resource and upstream triage away from acute settings**																			
COPD App																						
Range of technologies to support LTC mgt	50																					
Joint equipment library	150																					
Telemonitoring	250	200																				
Patient Portal	855																					
Equipment/diagnostic Hubs			**Investing to provide industrial scale diagnostics/scanning capacity for a wide geographical area**																			
Consolidation																						
Workforce solutions			**Centralised bank function and models to support operational workforce issues**																			
Collaborative bank	100	150																				
Recruitment support																						
E-Rostering																						
Financial Sustainability																						
Funding Solutions			**Plan to provide structured routes for private funding into NHS providers**																			
Routes for capital and business development	30																					
VAT and TAX Efficiency																						
Financial Turnaround Support			**Create effective and efficient packages of support for NHS organisations to address financial issues**																			
Diagnostics and implementation	80																					
Commercial Products			**Range of products to generate savings across organisations through consolidation and mutually beneficial commercial products**																			
Income Generation Schemes	20																					
Shared Organisational Arrangements			**Expanding range of back office functions encompassing greater number of organisations**																			
Procurement	40																					
Payroll Services	30																					
ERP Solution																						
Communications	25	126																				
IT and informatics	25																					
Leadership and Governance																						
Strategy Development Support																						
Well Led Governance Reviews																						
Organisational Training & Development			**Programs to support quality improvement and new models of care through direct training and train the trainer approach**																			
Year of Care	10																					
DAFNE (Diabetes)																						
Developing Clinical Leadership	25																					
Safety and QI	20																					
	3451	**1549**																				

4 Impact and outcomes

4.1 Overview

The original value proposition underpinning the ACC project sets out the following objectives:

- **Clinical outcomes** will be improved through creation of tools and practices that make up a group standard operating model
- **Patient experience** will be improved through spreading best practices of care and staffing across group members
- **Quality of services** will be ensured across the group by sharing staff, online patient information, and benchmarks
- **Resource sustainability** will be realised through savings from reduction in clinical and back office functions and more income will be generated from contracted services

At this early stage it has not been possible to measure clinical outcomes, patient experience or resource sustainability arising directly from the ACC. As agreed at the baseline stage, this phase of the evaluation has focused on finding out how partners view the services and support they are receiving from the Northumbria Group. In that section we look at partners' perceptions on patient experience work and payroll and fleet services. Findings are based on interviews with a sample of partners from other trusts.

4.2 Patient experience

Northumbria has been working with South Tees to implement a system to measure real and right time patient feedback. Northumbria has supported South Tees to design and set up an approach based on the Northumbria programme. The South Tees programme was launched in December 2016. This is.

The current focus is on establishing a baseline which can be used to see where there are scores that are moving and what is driving that. According to the person leading the work in South Tees*: '[patient experience is] particularly important for South Tees as we see patient feedback as one of the earliest warning signal of things going off track…the benefit is in being able to see where the best and worst areas are and then tailoring a programme of intervention to support improvements'*.

South Tees is using the same scoring methodology as Northumbria. Annie Laverty, patient experience lead from Northumbria, has provided advice on how to work with the information being received and how to intervene. South Tees report: *'So far the experience has been that the interventions can be small, for example putting in soft close bin lids, or bigger, such as training programmes. South Tees has developed customer service training for staff – different levels to support the different levels of intervention required – from bitesize (e.g. unconscious bias) to more in-depth (translating values to ways of working)'*.

For South Tees, benefits of working with Northumbria have been *'getting the opportunity to talk to another NHS organisation facing similar challenges, and who are doing something simple well and relatively inexpensively… the changes were relatively easy to implement and set up so that South Tees was able to run with it quickly on our own'.*

South Tees report that they are very satisfied with the service from Northumbria, adding: '*It has been really well received and is one of the nicest pieces of work being done'.*

When asked about possible improvements to the support offered by Northumbria, clarity over future support was mentioned, as well as a wish for ongoing learning and improving practice, for example patient experience teams linking up. Finally, the South Tees lead suggested that if patient experience support is a commercial venture, *'it would be good to define the offer more clearly and clarify how it will work in practice'*.

4.3 Payroll and fleet

Five interviews were carried out with representatives from other trusts who have received a fleet management or payroll service from Northumbria. All of those interviewed are highly satisfied with the service and are able to identify qualitative benefits, although not financial savings.

Benefits mentioned by interviewees who receive a payroll service were:

> *NFT provide a cost-effective, stable payroll service… the clear service structure provides confidence in a well-run, safe and secure operation.*
>
> *Leadership is a massive strength. They are knowledgeable in complex areas and engaged with national policy and NHS-wide issues. This keeps the service modern and up-to-date.*
>
> *There is a user panel held on a frequent basis to discuss issues and express concerns.*
>
> *NFG remain affordable and provide a high-quality service, backed by real professional expertise providing support in a timely, responsive, engaging manner.*
>
> *They were really, really, helpful during the implementation – around 800 staff were paid with only 1 or 2 errors, which were sorted out within days, which is an excellent performance.*
>
> *There are multiple examples of positive partnership behaviour.*
>
> *Northumbria provides additional help when resources/teams are 'really up against it' (e.g. providing temporary resources for emergency maternity cover).*

They provide experts in the field to attend workshops and roadshows.

Nobody suggested any improvements to the payroll service.

Customers are also highly satisfied with the fleet service, highlighting its efficiency and flexibility in getting issues resolved. A small number of improvements to the service were suggested:

Having a secure portal for communications could be a potential improvement opportunity.

Fleet solutions could improve their processes to allow more time for us to complete their own processes – for example, paperwork can at times come through with only a day to go before a policy expires. As this is an additional non-priority, role finance has to perform and creates pressure, especially at month end, it can be difficult to return paperwork within deadlines. A portal might be able to sort this problem.

A potential improvement could be to offer an insurance policy for some common issues that create a lot of admin to sort out – e.g. loss, default on termination fees, parking tickets or excess payments. This would relieve a lot of the administration involved in chasing people for payments, or the trust writing off the cost. The down side is that it might raise everybody's premium overall.

5 Proposed next steps

5.1 Introduction

As noted in the introduction to this report, there are a number of limitations to this evaluation, and it has not been possible at this stage in the implementation of the ACC project to evaluate the impact of the work. As the various strands of the project become more established it should be possible to collect data to inform measurement of impact in 2017/18.

5.2 Completing the 2016/17 evaluation

We have still to speak to a member of the telehealth team and would like to update the evaluation report once we have done that.

We suggest holding a 'sense testing' workshop as soon as convenient to gather the relevant people together. The purpose of this would be to fill in any additional gaps in the 2016/17 evaluation and to agree an approach to embedding evaluation into the ACC project in 2017/18.

5.3 Draft evaluation framework and metrics for evaluation in 2017/18

We thought it might be helpful to include in this report an outline evaluation framework for 2017/18, with suggested metrics and approaches to collecting data. We suggest that this might be a starting point for the Trust to consider how it would like to evaluate the work going forwards. A draft evaluation framework is included at Figure 5.

Figure 5: Proposed evaluation framework 2017/18

Activities	Indicators of progress	Proposed evidence gathering methods and tools	Timescale
Objective 1: Clinical outcomes will be improved through creation of tools and practices that make up a group standard operating model			
Development of a **hospital group**, including governance and membership model supporting multi-layered approach *(this activity contributes to the achievement of all four key outcomes).*	• Group membership arrangements agreed and formalised • Shared understanding amongst internal and external stakeholders of what the model is and the benefits it can bring • Other organisations take up services/group membership at different tiers • Members have a positive view of involvement with the Group • Members report positive outcomes as a result of involvement with NFG (for example, improved patient outcomes, financial savings, learning, culture change)	• Review of documentation • Interviews with a sample of key stakeholders • Review of project documentation detailing take up • Qualitative interviews with group members • Qualitative interviews with group members	• September 2017 • October 2017 • November 2017 • February 2018 • February 2018
Development of **telehealth** services, including remote haematology; COPD app; Year of Care training approach and other patient centric technology.	• Take up of telehealth services • Satisfaction with telehealth services • % increase in patients self-managing long term condition • % reduction in hospital emergency/unplanned admissions	• Review of project documentation • Survey of telehealth users • Use of Patient Activation Measure? • Data study focusing on a sample of people with LTCs who have a piece of equipment	• Quarterly • January 2018 • We will need to selected a baseline period and dates for repeat admin • January 2018

Activities	Indicators of progress	Proposed evidence gathering methods and tools	Timescale
		or take part in teleconsultations	
Roll out of a standard approach to **rostering** to ensure appropriate skill mix and control of agency spend.	• Rostering system in place and used by group members • Group members report satisfaction with the rostering system • Reduction in agency spend for group members using standard rostering	• Review of project documentation • Qualitative interviews with group members • Reported change in spend to be obtained through interviews	• August 2017 • March 2018
Objective 2: Patient experience will be improved through spreading best practices of care and staffing across group members			
Development of **standard operating models** which can be replicated and shared with other NHS organisations *(also contributes to improving clinical outcomes).*	• Numbers of organisations adopting standard operating models • Hip QIP: % mortality rates reduced – specifically tested with 6 organisations • Hip QIP - % reduction in length of stay for hip fracture surgery (targeted evaluation as LOS is difficult to attribute due to other varying factors) • Anaemia and surgical site infection: collaborative of 20 organisations to determine % reduction in readmission and LoS	• Review of project documentation • Separate evaluation of the Hip QIP initiative • Evaluation by participating organisations	• February 2017 • Jan 2017 to Jan 2019 • September 2017 to December 2019.
Delivery of **shared clinical services** to	• Members taking up shared services	• Review of project	• February 2018

Activities	Indicators of progress	Proposed evidence gathering methods and tools	Timescale
members of the group.	experience cost savings and/or improved efficiency	documentation • Interviews with members	• March 2018
Roll out of **patient experience** measurement and improvement models to other organisations.	• Number of organisations adopting models • Improvement in patient experience • Patient Experience – local and national surveys to demonstrate % improvement in care received (Quality)	• Review of project documentation and interview with workstream lead • Secondary analysis of any patient experience surveys carried out by group members (covering, for example, access to services; quality of information; friends and family test; PROMs)	• September 2017 • March/April 2018
Objective 3: Quality of services will be ensured across the group by sharing staff, online patient information, and benchmarks			
Development of a **patient information portal** and **contact centre.**	• Number of patients and healthcare professionals using the portal • Reduction in physical GP consultations • Reduction in patient and clinician travel time	• Review of project records • GP records	• Quarterly • Quarterly
Establishment of a **Collaborative Regional Bank** to enable members across the region to access temporary staff more efficiently and cost-effectively.	• Reduction in % shifts allocated to agency staff locally and regionally • Reduction in % agency spend locally and regionally • Group members satisfied with the	• Review of rostering data covering January to December 2017 • Review of payroll and finance data • Interviews with group members	• Review data quarterly • Review data quarterly • June and

Activities	Indicators of progress	Proposed evidence gathering methods and tools	Timescale
	operation of the bank	using the bank	December 2017
Objective 4: Resource sustainability will be realised through savings from reduction in clinical and back office functions and more income will be generated from contracted services			
Development of **international partnerships**: create an international business to develop education, IT and best practice support/roll-out as chargeable services.	• Number of partnership agreements in place • Number of partnership marketing actions undertaken • Partnerships in prospect • Income from partnerships	• Qualitative interviews with stakeholders involved in developing international partnerships • Review of project documentation	• March 2018 • Quarterly
Shared services: provide shared back office, procurement and payroll services to group members on a fee paying basis (N.B. this activity comprises tier one of the Northumbria Foundation Group model but has no direct investment through vanguard funding).	• Take up of shared services • Income from shared services • Reduction in Northumbria FT back office costs • Reduction in group member back office costs • Group member satisfaction with services	• Review of project documentation • Review of Group finance reports • Review of NFT finance reports • Interviews with group members • Interviews with group members	• Quarterly • Quarterly • March 2018

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