Independent evaluation of the North East Hampshire and Farnham Vanguard

Enhanced Recovery and Support at Home Service

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Disclaimer
The findings of this independent evaluation are those of the author and do not necessarily represent the views of the Enhanced Recovery and Support at Home Team.

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# Contents

Executive summary ........................................... 4

Introduction

1. Context and purpose of the report ...................... 6
2. The Enhanced Recovery and Support at Home Service 6

Quality of care

3. Patient and Staff Reported Outcomes .................. 10
4. Synthesised Patient Qualitative Findings .............. 14

The Team

5. Manager interviews ....................................... 20
6. Team evaluation .......................................... 24

Economic evaluation

7. Activity evaluation ....................................... 32
8. Economic evaluation ..................................... 34
9. Conclusions ............................................... 39
10. Active Ingredients ...................................... 41

Appendices  (separate document)
Executive Summary

This report describes the finding of an independent evaluation of The Enhanced Recovery and Support at Home (ERS@H) service, one of several new care models developed as part of the Happy, Healthy, at Home Vanguard programme. The service aims to facilitate timely discharge following an unplanned admission to hospital and a seamless transition to ongoing health and care, or, to avoid admission for those who can be supported to remain at home. The team intervenes for a time-limited period (typically up to 6 weeks post referral) and transitions the person if required to longer-term health or social care support. Implementation commenced in November 2016 with a phased increase in capacity during the past twelve months, during which time staff have been brought together from two separate provider organisations (Southern Health NHS Foundation Trust and Frimley Health NHS Foundation Trust) into one core team employed by a single organisation (Frimley Health NHS Foundation Trust).

The team has averaged 79 referrals per month and has an active caseload averaging 56 per month. The majority of referrals are made by the Integrated Referral and Information Service (Frimley Health NHS Foundation Trust). The analysis suggests that the majority of respondents are older (61% over 80 years old) and a significant percentage (54%) are taking six or more medications daily, indicative of multiple medical conditions.

The evaluation of the ERS@H service has identified significant evidence of a range of impacts indicative of the quality of care provided by the team. These included increased confidence to self-manage, addressing patients’ wish to be at home, addressing patients’ physical support needs at home to ensure safety, reduced post-admission anxiety, improved access to community support, and feeling informed and supported. Improvements were also seen in patient reported outcomes of ‘Requiring help from others,’ ‘I can look after my health,’ and ‘I was not anxious yesterday,’ further strengthening the evidence on quality of care, and in staff reported outcomes at both time points with high scores for ‘we treat people kindly,’ ‘we listen and explain’ and ‘we see people promptly’.

Effective teamwork is an essential part of the ERS@H model. A team evaluation using Normalisation Process Theory identified that team members believe that the model of care is worthwhile and valued its effect on their working practice. Staff Reported Outcomes corroborate this finding with high scores for ‘what I do in my job is worthwhile’ and a statistically significant improvement in ‘I was not anxious yesterday at work.’ However, at this stage in the development of the team, there is evidence of a lack of shared understanding of team roles which is impacting how staff carry out the work of the team and their experience of this work. These findings are supported by relatively low scores on some staff reported outcomes for work wellbeing and work organisation. There was also a reduction in scores for ‘I am involved in decisions that affect me’ compared with an earlier evaluation.

Interviews with three managers, who have been involved in the development of ERS@H, help to explain some of the challenges which are likely to have contributed to the findings from the team evaluation, in particular those associated with the integration of two culturally different teams into one organisation. The evaluation describes the commitment to overcoming these challenges and lessons learnt.

The activity and economic evaluation found that in the 11 months following referral to the ERS@H service, patients attend A&E and are admitted to hospital as emergencies less. In the first month this reduction is over 40%, and it reduces over time to around 12% 11 months later. This is good evidence of a positive impact on reducing emergency activity and equates to a potential commissioning value based on the current levels of caseload of £972,329. It is not possible to determine how much of this reduced activity is attributed to ERS@H because it is part of pathway of care that for most patients includes acute care and other primary, community and social care
services. The team report that they are operating at 78% capacity. If the team increased their current capacity to 95% in the coming year (representing “full capacity”, but with some slight headroom, modelling suggests a future potential commissioning value of £1,029,780.

Evidence from both the team evaluation and patient interviews identified a number of operational challenges that are presently affecting the staff and patient experience, in particular how the team is organised to collectively contribute to the work involved.

The evaluation identified five different active ingredients that are considered important to maintain and embed the model of care for maximum impact; fast action, time for discussion, taking the ‘whole’ into account, developing rapport to support change and working in a flexible way to support self-management.
1. **Context and purpose of the report**

1.1 The population served by Happy, Healthy, at Home Vanguard area is projected to increase by 2.6% in the next five years. The impact of this rise is particularly significant for the provision of health and social care services to those aged 75 years and older who may have acute and chronic needs associated with multiple long-term conditions.

1.2 Enhanced Recovery and Support at Home (ERS@H) is one of several new models of care that have been established by Happy, Healthy, at Home to respond to the changing needs of the population and to achieve the intended long term impacts set out in the programme logic model (Appendix 1):

- Patients are happy with the care they receive and feel confident to look after their condition in their home
- Patients are confident to manage their condition and are empowered to do so in their home
- Patients are facilitated to return home so that they no longer have to stay in hospital for longer than they need to
- There is a reduction in length of stay and avoidable admissions

1.3 This report brings together the evidence from a mixed methods evaluation design to address the extent to which this new care model has achieved these objectives. The majority of the qualitative fieldwork was undertaken over a three month period (July to September 2017).

1.4 The design of the evaluation is based on the logic model for the service (Appendix 1). This describes the links between the key activities (or inputs), outputs, outcomes and intended impacts of the service model. The logic model was developed by the service, with guidance from the evaluation team.

1.5 The model brings together multiple professionals from health and social care backgrounds to work in new roles in an integrated way. The extent to which this model has become embedded in clinical practice and integrated into the local health and care system are also key interests of this evaluation.

1.6 ERS@H is one component in a pathway of care that may be preceded by medical care and other input (nursing, Allied Health Professionals) on an acute ward and followed by another intervention (such as an Integrated Care Team). As such, the attribution of benefit may be distributed across multiple interventions. This evaluation seeks to understand, as far as possible, the distinct contribution made by ERS@H to the patient experience and outcomes.

1.7 This report begins by describing the care model of ERS@H and service activity, and then presents the key findings on quality of care, team working and an economic assessment of the impact. Conclusions are drawn regarding the extent to which this model of care has achieved its intended outcomes.
2. **The Enhanced Recovery and Support at Home Service**

2.1 The New Care Model of Enhanced Recovery and Support at Home Service (ERS@H) was developed in 2016. A phased implementation commenced in November 2016 during which time staff were brought together from two separate provider organisations (Southern Health NHS Foundation Trust and Frimley Health NHS Foundation Trust) into one core team employed by a single organisation (Frimley Health NHS Foundation Trust). These organisational changes, and the acknowledged implications for affected staff, were thought to be necessary to deliver the best quality of care, experience and efficiencies for the target population. The service wished to build on the established best practice of the two merged teams – Rapid Response Team (SHFT) and Frimley Outreach Rehabilitation Team (FHFT). An experienced operational lead was appointed in 2016 to manage this transition.

2.2 The service aims to facilitate timely discharge following an unplanned admission to hospital and a seamless transition to ongoing health and care, or, to avoid admission in those who can be supported to remain at home. The team intervenes for a time-limited period (typically up to 6 weeks post referral) and transitions the person if required to longer-term health or social care support. A review and monitoring plan is agreed on discharge from the service.

2.3 The groups of patients who are typically referred to ERS@H are:

- Those requiring supported discharge from hospital which may include rehabilitation at home and/or social support for a time-limited period (2 – 6 weeks) before transitioning to longer-term arrangements if required. This group constitutes approximately 70% of the caseload.
- Those experiencing a crisis whilst in the community but where an admission can be avoided by providing intervention at home, constituting approximately 25% of the caseload.
- A small cohort of patients requiring support with End of Life care in their own home (constituting approximately 5% of the caseload).

2.4 The following diagram aims to describe how the ERS@H service fits within the broader pathway of care provided in Frimley Park Hospital and in primary, community, social and voluntary care support for people in their homes:

2.5 An integrated approach to meet individuals’ health and social care needs is provided by a multi-disciplinary team. The service draws on the expertise of Nursing professionals, Allied Health Professionals and non-registered Rehabilitation Support Workers to deliver joined up care for the target groups of patients. Medical support is provided by primary care clinicians (GP or paramedic practitioner) and the service liaises with the locality Integrated Care Teams.
(ICTs) for ongoing case management, as required. ICTs may also refer patients back to ERS@H for support with admission avoidance. The core team is co-located at Fleet Community Hospital, staff work closely together and meet regularly to discuss patients and prepare a single support plan. Each patient has a named key worker. If partner agencies are required to deliver the plan, the case coordinator will liaise with them to agree the support that is required and how this will be provided.

2.6 The multidisciplinary team has core team members and an extended team, who participate as needed. The core team comprises:

- Physiotherapists
- Occupational therapists
- Registered nurses
- Rehabilitation support workers
- Administrators

The extended team includes:

- General Practitioners
- GP Fellows
- Community Geriatrician
- Specialist Nurses (diabetes, dementia, tissue viability and COPD)
- Pharmacy

2.7 The skill mix of the service is still evolving as the model of care becomes established, and additional roles, such as Associate Practitioners and rotational posts in Occupational Therapy, are being implemented.

2.8 The service works in alignment with the Integrated Care Teams in the localities of Aldershot, Farnborough, Fleet and Yateley. All ERS@H patients are referred on to these caseloads for the level of intervention that is required beyond the ERS@H intervention.

The service predominantly supports patients in the localities of Aldershot, Farnborough, Fleet and Yateley. For Farnham patients, their first point of contact is Virgin Care Rapid Response Team (RRT). ERS@H will support Farnham patients if the RRT does not have capacity.

2.9 Where required, and depending on available capacity, the team will bridge packages of care on behalf of social services. This may include providing elements of support for the community response team (Hampshire County Council).

2.10 The ERS@H team cares for patients over the age of 18, though the majority of the caseload is older people. Its patients are typically people with urgent, acute and/or complex care needs that need support to regain the confidence to self-manage at home. The primary source of referrals is the Integrated Referral and Information service (IRIS) run by Frimley Health NHS Foundation Trust who triage patients to the service for facilitated discharge. The ERS@H service also rotas a clinician on site who will identify suitable referrals and discuss with the medical team. The clinician on site covers all wards and the ‘front door,’ Emergency Department, Medical Assessment Unit and EDOU. The ‘GP on ward’ may also refer. Out-of-hospital referrals for admission avoidance may be received from the Integrated Care Teams, Paramedic Practitioners, GP, Ambulance Service, 111 service, Voluntary organisations or Adult Social Care. If a referral is not felt to be appropriate, the Shift Lead will advise the referrer and signpost as appropriate.

2.11 The service operates 7 days per week and 365 days per year, from 08:00 to 21:00 with target response times of 2 hours if a response is required to avoid an admission, and same day for rapid hospital discharges to agree steps required to meet predicted discharge date. The skill
mix is adjusted at weekends to reflect less demand for rehabilitation activities. Weekend rotas may also involve hospital based staff.

2.12 The service has collected the following activity information:

<table>
<thead>
<tr>
<th></th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Referrals</td>
<td>96</td>
<td>71</td>
<td>72</td>
<td>59</td>
<td>73</td>
<td>82</td>
<td>90</td>
<td>94</td>
</tr>
<tr>
<td>Caseload</td>
<td>51</td>
<td>55</td>
<td>44</td>
<td>39</td>
<td>52</td>
<td>74</td>
<td>53</td>
<td>77</td>
</tr>
<tr>
<td>Discharges</td>
<td>71</td>
<td>55</td>
<td>79</td>
<td>65</td>
<td>59</td>
<td>66</td>
<td>115</td>
<td>89</td>
</tr>
</tbody>
</table>

The average number of referrals is 79 per month and the average number on the caseload in 56.

![New referrals](image)

Referral numbers have been steadily rising since April 2017.

![Discharges](image)

![Caseload](image)

During July 2017, a review of the whole ERS@H caseload was undertaken resulting in a higher number of discharges during July, and a reduction in the caseload (across all localities).
3. Patient and Staff Reported Outcomes

3.1 Patient R-Outcomes

Information was collected for this review using the R-outcomes measures. These are a set of validated short generic patient reported outcome measures (PROMs) being used by Wessex AHSN as a way to evaluate innovations and new services. This review used four of the R-outcomes measures:

HowRu – Health Status

People record how they feel physically and mentally and how much they can do in terms of loss of function and independence. It asks how are you today? – meaning the past 24 hours. It has been validated against other measures including SF12 and EQ-5D.

Health Confidence Score

This score monitors people’s confidence in their ability to manage their own health and engage with health care providers. The first two questions address personal capability, while the second pair are informed by provider engagement. This measure is closely associated with the concepts of empowerment, perceived self efficacy, activation and engagement.

Personal Wellbeing

This is a short generic measure of happiness or subjective wellbeing and is closely based on the Office of National Statistics personal wellbeing questions used in the Annual Population Survey.

HowRwe – Patient experience

This is a patient reported experience measure of patients’ perception of their care. It includes both relational (clinical) aspects of their care, such as kindness, listening and explaining as well as systems (administrative) aspects such as promptness and organisation.
3.2 Patient Results

The following charts describe the demography of the 194 patients who recorded their R-Outcomes. It shows that:

- 85% are over 70, with 61% over 80 years
- 79% of patients take more than 3 prescribed medications daily, with 54% taking 6 or more medications daily
- Only 19% of patients report social services have been involved
- More women than men completed R-Outcomes surveys

The ERS@H service supported the collection of R-outcomes measures for 91 patients at first contact and 64 patients who had received their support.

The results are set out in the charts on the following page. The yellow bars represent how patients scored themselves when the service first made contact with them, and the green bars show the scores for patients who have been supported by ERS@H. The lines at the end of each bar signify the confidence intervals for each score. A T-Test P Value is shown in the vertical axis label. A P value of less than 0.05 demonstrates a where the difference in score is considered statistically significant.

All R-Outcomes results show mean scores on a 0-100 scale. If all respondents choose the best response, the score is 100. If they all selected the worst, the score is 0. What we are looking for is evidence of an improvement in reported scores from the two separate cohorts of patients and whether those improvements are statistically significant.
**Health Status**

Patients record a statistically significant improvement in **requiring help from others**. A post intervention score of 68 suggests that these patients still require a good amount of help. They record an improvement in **feeling low or worried**. Their experience of pain or discomfort is worse after intervention, although this difference is not statistically significant.

**Health Confidence**

None of the changes in this domain are statistically significant. However, a seven point improvement is recorded in **I can look after my health**.

**Personal Wellbeing**

All of the scores for personal wellbeing are low before and after, indicating that the patients supported by ERS@H struggle with their personal wellbeing. Patients do report improvements once they’ve been supported, but these are not statistically significant. The largest improvement was a 14 point improvement in **I was NOT anxious yesterday** which indicates an improvement in their short term wellbeing.

**Patient experience**

Patient experience scores are generally quite high to begin with and don’t change very much. It is interesting that there is a seven point fall in scores for how **services talk to each other**.
The two NHS staff survey friends and family questions were also recorded alongside the staff R-Outcomes measures. The results below show a notable change in scores over the 9 months between the two data collection points, which is encouraging.

3.3 Staff R-Outcomes

In addition to collecting patient reported R-Outcomes, staff R-Outcomes surveys were collected by the ERS@H team. This review used three R-outcomes measures; work wellbeing, job confidence and staff experience. The scoring scales described for patient R-outcomes applies to staff surveys too – scores are on a 0-100 scale, and higher scores are better.

The service collected data across two data collection periods – October 2016 and July 2017. A total of 35 responses were collected in October 2016, and 36 responses in July 2017. The results are set out in the following three charts. The yellow bars represent how staff scored themselves in October 2016, and the green bars show the scores for staff in July 2017.

Work Wellbeing

With the exception of what I do in my job is worthwhile, these scores are generally quite low. However, there is a statistically significant improvement in I was NOT anxious yesterday at work.

Some possible insights into these findings are provided by the team evaluation.

Job Confidence

Whilst not statistically significant, there is a reduction of eight points in the score for I am involved in decisions that affect me. Some possible insights into these findings are provided by the team evaluation.
Staff experience – how are we doing?

Staff experience scores are high at both time points for we treat people kindly, we listen and explain and we see people promptly. Scores for we are well organised and patients don’t have to repeat their story have changed little and remain relatively low. Whilst there is an improvement of nine points in services talk to each other, this remains a low score. It is interesting to note that patients reported a reduction in their experience of how services talk to each other.

4. Synthesised Patient Qualitative Findings

Two qualitative methods were employed to explore the Enhanced Recovery and Support at Home (ERS@H) service. Evidence from both patient interviews and case studies were brought together in a single synthesis. A methodological triangulation approach was used to enrich the overall findings and to enhance the understanding of the service.

The aims of the two components were:

i) 10 Patient/carer interviews – these sought to understand patients’/carers’ experiences of receiving support from the ERS@H team and what impact it had on them.

ii) 32 Case studies provided by staff – these sought to collect in-depth stories about situations, obstacles, action taken and impact of ERS@H work.

It was important to investigate contextual factors, processes, and perceived impacts to determine active ingredients of the ERS@H service. Factors were considered active ingredients if they were discussed as important and in the context of a described impact. Once active ingredients had been identified it was possible to present these as potential precursors of the various impacts identified. This is graphically represented in Figure 1.

See appendix 2 for a description of the synthesis approach.

4.1 Synthesis findings

A wide range of issues were identified in both qualitative components. These were combined into themes and are presented in the following table. No conflicting themes were identified which suggested both patients (interviews) and staff (case studies) viewed the service in a similar way. A total of 17 themes were identified from both data sources and these could be organised into 3 higher order themes. Findings indicated there were five ‘active ingredients’

to ERS@H work and each of these contributed to the first higher order theme ‘Pro-active highly tailored support’. Findings indicated there were 8 different types of impacts and these were grouped into the second higher order theme ‘Changes in outcomes’. The final higher order theme ‘Areas for improvement’ consisted of four areas that present opportunities for the service to develop further.

Table 1: Synthesised themes from patient interviews and case studies

<table>
<thead>
<tr>
<th>Higher order theme</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pro-active highly tailored support</td>
<td>1. Flexible working to support self-management</td>
</tr>
<tr>
<td></td>
<td>2. Rapport developed to support change</td>
</tr>
<tr>
<td></td>
<td>3. Takes the ‘whole’ into account</td>
</tr>
<tr>
<td></td>
<td>4. Has time for discussion</td>
</tr>
<tr>
<td></td>
<td>5. Fast action</td>
</tr>
<tr>
<td>Changes in outcomes</td>
<td>6. Generally satisfied with ERS@H support</td>
</tr>
<tr>
<td></td>
<td>7. Confidence to self-manage improved</td>
</tr>
<tr>
<td></td>
<td>8. Patients’ wish to be at home met</td>
</tr>
<tr>
<td></td>
<td>9. Family felt informed and supported</td>
</tr>
<tr>
<td></td>
<td>10. Physical support needs at home met to ensure safety</td>
</tr>
<tr>
<td></td>
<td>11. Post-admission anxiety reduced</td>
</tr>
<tr>
<td></td>
<td>12. Access to community support improved</td>
</tr>
<tr>
<td></td>
<td>13. Detection of need for appropriate hospital admission</td>
</tr>
<tr>
<td>Areas for improvement</td>
<td>14. Missed visits by team members were stressful for patients</td>
</tr>
<tr>
<td></td>
<td>15. Team arrival times could vary and be stressful for patients</td>
</tr>
<tr>
<td></td>
<td>16. More advanced notice of withdrawal of support was a patient preference</td>
</tr>
<tr>
<td></td>
<td>17. More continuity in team member visiting was a patient preference</td>
</tr>
</tbody>
</table>

Figure 1 represents the cumulative assessment of the ERS@H service. It presents participants’ themes as a synthesised dynamic framework of active ingredients, disruptive factors and impacts (see appendix 2: Framework propositions).
4.2 Demographics of those studied

The patients described in the 32 case studies and 10 patient/carer interviews were largely older aged 75+ (specific ages weren’t always provided in the case studies) and had a wide range of problems and reasons for receiving ERS@H support. For example, patients often required support to improve their independence after an acute episode, lived alone and were at risk of falls, had memory problems or were confused, needed help standing and dressing, or required support whilst agency care was being organised. Less often types of support included support for patients with palliative care needs, anxiety issues, depression issues, confusion about medication use, and to support carers/family. The demographic characteristics of an older age group and multiple conditions are similar to those represented in the R-Outcomes data.

The flexibility and responsiveness described can be considered a strength of the service. This undoubtedly ensured patients were supported when they might have otherwise been lost in the system or advanced straight to A&E, and/or supported quickly once identified in crisis.
4.3 Perceived impacts of the ERS@H service

Patient, carers and staff reported 8 different types of impact from their experience of the ERS@H service. The first being patients’ were generally satisfied with ERS@H support and reported their thanks to the team for their fast and tailored support during a difficult time. As an example, this patient said:

“They are all different and all have their own personalities, but all have put me at ease and do a fine job. I have no problems or complaints, I can’t thank them enough for their help.” (Patient interview)

The remaining seven reported impacts were more specific. It was widely felt that patients’ confidence to self-manage their situation had improved. Several case studies reported the ERS@H team encouraged patients to help themselves, slowly and with caution, and tried to help patients manage their anxiety of ‘not being able to do it’. In the patient interviews, there were also examples of confidence being improved and leading to independence, as described by this patient:

“As each day went by, I could do a little more. They helped me to see that I could do it. In the end, I only needed 3 weeks instead of 6 weeks that I was told it might take. I was determined to get better and [ERS@H staff member] helped me do it.” (Patient interview)

It was also clear patients’ wanted to be cared for at home and this wish to be at home was met by the team. Several case studies reported patients were happy support had been arranged to be at home and not in the hospital. Patients interviewed were very thankful for this and provided positive feedback, as described by this patient:

“There is nowhere like home, I’d rather be there than a hospital bed. I’m very glad they [ERS@H team member] were there to help me get home.” (Patient interview)

Many of the case studies and patients interviewed highlighted that patients’ physical support needs at home were met to ensure safety. Numerous examples were provided. For example, patients were often discharged with support devices like a stick, were assessed and supported to get upstairs at home, had personal care routines organised, had equipment such as special chairs and mattresses organised, and were asked about their medication routine to prevent misuse of medication. In addition, the team took time to record their assessments about safety issues so various professionals visiting the home would be aware of the situation.

The above examples were about safety in relation to potential accidents. Occasionally, ERS@H team members also acted to ensure safety arising from mental health needs, as described in this case study:

“On a visit to a patient’s home, the patient was very distressed and wanted to end his life. The patient was holding a box of medication in his hand and said he was going to take them all. I called a relative of his who told me this had happened on a few occasions and he had been depressed of late. I called 111 and the operator told me to call an ambulance, which I did. I waited and talked to the patient and calmed him down. He thanked me for staying with him. The patient was in hospital overnight and his medication changed. It was determined there was a better medication with fewer side-effects. I heard that the next day the patient felt much better.” (Case study)

Understandably, many older age patients leaving hospital after an acute episode were worried about coming home. It was apparent from both data sources that post-admission anxiety was reduced by the work of the ERS@H team. Patients often
reported being more relaxed and settled after ERS@H discussions about discharge and following initial visits. Team members worked to reduce anxiety by making patients feel they were safe to go home. This took time but often resulted in improved mood and a new found motivation, as described by this patient:

“I really didn’t want to go home, I didn’t think I was ready. She [ERS@H staff member] helped me see that I was and I could cope and would be happier there. I have a lot to thank her for.” (Patient interview)

Another important impact identified was **improved access to community support**. One example from a case study highlighted:

“After the patient was discharged, they were supported to access their regular community events and travel in a car as they had done so before.” (Case study)

Participants felt that **family were informed and supported** throughout the process of discharge and setting up support in the home, as described by this patient:

“They were very concerned about my husband, they knew all this would affect him too. He’s got arthritis and slow now. They spoke to him and asked if he’s ok with all this and if he can manage. He said yes and would call them if he needed help.” (Patient interview)

The final type of impact was related to **the detection of the need for an appropriate hospital admission**. Several case studies stated during visits by ERS@H team members, medical assistance was sought and it was decided the patient did need to go into hospital. Of course, this action should be welcomed and highlighted the ‘detection role’ team members were undertaking. As patients received care quicker than they might have, this aspect of their role may potentially help to avoid longer stays in hospital.

### 4.4 Active ingredients of ERS@H service

Five active ingredients of the work of the ERS@H team were identified. These all contributed to the broader concept of **pro-active highly tailored support**. This was the sum of the parts of the active ingredients; this appeared to be the central defining feature of the team.

The first active ingredient identified was **fast action** on behalf of the ERS@H team. It was clear from both data sources the team worked hard to respond quickly to avoid problems for both patients and hospital systems. One of the carers stated:

“It happened very quickly, my wife was discharged and that same day we were told a nurse practitioner would be with us that afternoon. Well, I’d hardly got back to the house and they were there. Later a carer arrived and asked what we required and took it from there. I was very impressed.” (Carer interview)

Despite working in a dynamic and fast moving environment, ERS@H staff made **time for discussion** with patients to understand their issues. Several case studies highlighted:

“I took time to listen to his [patient] story without interrupting. I spoke to him to try and lift his spirit and by listening to him with no judgements. I saw his mood improve and it was a real positive. When I left he was much happier than when I found him. A week later I rang to check on him and he was still in a positive frame of mind.” (Case study)
As well as making time for patients, they also ensured they took a holistic approach to care and the needs of the patients. Several patients said they took the ‘whole’ into account, as described by this patient:

“I think they saw the whole situation, including my home situation, and not just my health problems. That helped a lot.” (Patient interview)

An important active ingredient was the willingness and ability to develop rapport to support change. Many case studies and interviews referred to this issue and ERS@H staff were widely praised for doing this so quickly and easily, as demonstrated by this patient:

“I’d got to know her [ERS@H staff member] and a friend of mine was having a baby girl and I was knitting a jumper for her but didn’t have any buttons. On her way to see me she went to the shop, bought some buttons and brought them here. It was so kind of her, that really made me smile, I was really pleased.” (Patient interview)

The final active ingredient identified was the ability of the team to work in a flexible way to support self-management. Several case studies described how the team had increased the number of visits to supervise a particularly crucial element of care, e.g. supervising the assessment of ability to use the stairs. They also reported increasing GP awareness so action could be taken when required, e.g. knee pain discovered or signs of fluid retention. The message here being their role was not just about organising discharge support, but involvement in many aspects of care during this critical time with patients. This was also recognised in the interviews, as described by this patient:

“Sometimes I’ve arranged my GP appointments and they’ve said they’ll come earlier to help me get ready and get to the appointment without any problems.” (Patient interview)

4.5 Disruptive factors to the ERS@H service

Most patients were very satisfied with the support received. However, some patients reported four areas of improvement which may have affected the impacts. They may have acted as disruptive factors to the work of the ERS@H team. Addressing these factors may improve the frequency and depth of the impacts already identified. Firstly, patients reported that missed visits by ERS@H staff were stressful and secondly arrival times could vary from those planned. This was a particular problem if personal care support was required or their help was needed to get patients to other places. Thirdly, some patients witnessed a lack of continuity in personnel seen from the ERS@H team. This was stressful for some patients and they requested more continuity of support. This may be behind the reduction in how patients report whether services talk to each other in their R-Outcomes (2.1.3). Finally, patients often develop great rapport with their ERS@H team member and some patients reported a level of anxiety about the lack of notice of withdrawal of support from the team. It was a patient preference to have more advanced notice of withdrawal of support so the patient could fully prepare themselves for self-management in the home.

4.6 Conclusions of the patient qualitative evaluation

- Overall, the work of the ERS@H team was well received and positively discussed. A range of patient and carer impacts were identified from the case studies and interviews.
• Across the two different qualitative data sources, a number of active ingredients, disruptive factors and impacts were uncovered. These all contributed to understanding the work of the ERS@H service and how the team had contributed to the identified impacts.

• Identified impacts for patients were increased confidence to self-manage, patients’ wish to be at home met, patients’ physical support needs at home were met to ensure safety, reduced post-admission anxiety, improved access to community support, family/carers felt informed and supported, and the ERS@H team often detected the need for an appropriate hospital admission.

• Five different active ingredients were vital to enact ERS@H work on a day-to-day basis. By engaging in these five approaches, it was possible to effectively manage the discharge of patients to their homes and to their best of their ability avoid readmission and/or difficulties in the home environment. Each of the active ingredients in Figure 1 should be considered vital to maintaining the impacts identified. Changes in the application of the five active ingredients would likely change the impacts.

• A number of disruptive factors were apparent and it would be timely to address these to increase the impact of the care model. These were all process issues and could be overcome with attention. It is interesting to reflect on the fact that the ERS@H service is a dynamic team with activity (e.g. patient appointments) changing regularly. It may be difficult to balance the team goal of ‘tailored support’, which was reported as achieved, with the human resources requirements of a large diverse team (e.g. taking annual leave). This issue warrants further investigation.

5. Qualitative findings – manager interviews

5.1 Introduction

A third qualitative method was employed to investigate the Enhanced Recovery and Support at Home (ERS@H) service. This involved interviewing key managers of the ERS@H service. This stood alone as a piece of evaluation and was not synthesised with the themes identified in the patient interview and case study synthesis.

5.2 Findings

A wide range of issues were identified. These are themed and presented in Table 2. These included contextual factors of the team, managers’ perceptions of team processes and attitudes, and perceptions of challenges and action taken to address those challenges. A total of 8 themes were identified and these were organised under one higher order theme which can be considered a unifying context for the themes. Lessons learnt were also reported and are described separately.
The overall narrative from the managers was one of challenges and action to address those challenges, all within the context of integrating two culturally different teams. This main story could be broken down into smaller stories about specific challenges; but an important take-away message was apparent right from the start: it was not easy to integrate two culturally different teams into a new entity. Whilst the majority of managers’ perceptions were challenges, they caveated them with the knowledge that:

“Bringing them [two teams] together was vital as the success of the team depends on the multi-disciplinary approach we offer.” (Manager 1)

This central idea appeared to drive much of the managers’ behaviour and patient feedback from other parts of this evaluation would support this central motivation.

During the early phase of setting up the service, there was considerable confusion about leadership and the role of different team leaders, as described by this manager:

“I had significant challenges to overcome, I had to establish myself as a leader across two organisations, where they had separate processes of recruitment, financial monitoring, and clinical policies and procedures. Also, to get the team to work together to maximise capacity to meet the needs of the population.” (Manager 1)

All the managers reported the need for a full-time leader with the head space to operationalise the integration of two teams with different backgrounds and working practices. In particular, they highlighted the need for strong emotional resilience in the face of certain conflict with either staff or the system when working to integrate. Ultimately, it was widely felt the managers did what they could with the resources and arrangements they had. But they indicated it was not organised to succeed at the start of the process and not enough time was given to predicting the challenges of integration.

An important organisational challenge that stood out was the need for clarity about financial risk sharing across two organisations. It was strongly felt this wasn’t operationalised in the best way to ensure success, as described by this manager:

“We agreed the financial risk about who would appoint which staff, but later there were decisions that changed this agreement and the organisations had different views on risk. So the recruitment of team members halted.” (Manager 3)
Another organisational challenge was the need to be under one organisational governance structure. At the beginning staff from the two teams were operating on different contractual arrangements, e.g. with different annual leave allocations. This created significant tension in the team, however, as this manager stated:

“Once we became one organisation, the dynamic of the team significantly changed for the better.” (Manager 2)

Furthermore, this manager stated:

“With one governance structure, many of the inter-organisational and logistic issues go away.” (Manager 1)

The early phase of setting up the team, coupled with the organisational challenges outlined above, led to a reasonable level of internal team struggles. Early changes in personnel played a part in initiating team struggles, as described by this manager:

“There was quite a lot of anxiety in the team in the beginning, and we did have some turnover of staff and that affected the team morale.” (Manager 1)

Early reasons for staffing anxieties were attributed to the differing contractual arrangements and bringing together two culturally different teams. Furthermore, the two teams perceived themselves as functioning effectively in their previous contexts and were required to integrate. Whilst this reorganisation was imposed on staff, managers took time to caveat the important reasons why - namely to provide a new service for their changing patient demographic.

Other team struggles centered upon the continuity of staff in the team. Managers acknowledged recruitment was difficult in the local system and there was a need to use agency staff.

“Recruiting to the team was problematic, we were recruiting from pots of staff elsewhere in the system and this created tensions.” (Manager 1)

The process of bringing two culturally different teams together created tensions on how to operate as a new team and a reasonable level of attitudinal challenges from staff. Bringing together the Rapid Response Team (Southern Health) and Frimley Outreach Rehabilitation Team, with their differing cultural practices, was highlighted by managers as a larger job than expected, as stated by this manager:

“We knew setting up the ERS@H service was needed to meet the needs of the local population but it took a long time to get the vision across to the team, despite trying really hard to engage with staff.” (Manager 3)

Managers reported the professional identity of some of their staff was significantly disrupted during the merging process. They described how some team members were used to being on a ward and having support on hand, but now they were being asked to work independently and in patients’ homes. This created anxiety and voiced major concerns from several staff. This would often translate into attitudinal challenges, in the form of challenging inter-personal behaviour and disruptive working practices. Managers’ ability to deal with this was also a challenge, as described by this manager:

“The line management structure in the two organisations was crucial in not being able to deal with this appropriately. Before we merged into one team, I had to report to someone outside of my organisation about a team member’s behaviour and hope their policies and procedures would be good enough to deal with the problem.” (Manager 1)
To address the organisational and inter-personal challenges, managers sought to create a new shared identity within the team. Merging teams under one organisation was undertaken and staff were consulted and encouraged to wear the same uniform, be physically co-located, share in the new vision for the team, agree on one annual leave policy, and help develop standard operating procedures for the team. This was operationalised via several away-days, was welcomed by staff, and perceived by managers as a major reason the team came together.

An interesting theme from managers was the vital need to engage in the minutiae of working practices to set up a new team, as described by this manager:

“The administration of IV antibiotics will have one policy in one organisation and another policy in another organisation. Depending on your microbiology and infection control departments, they will have plans to order certain things to do their work. Believe it or not, that can be a deal breaker because you can’t leave the staff on the shop floor wondering what do they order and what are they allowed to use.” (Manager 1)

Several actions were undertaken by managers to engage with the minutiae of working practices and this appeared to grow stronger over time.

“It took time but we engaged in the small details and you can reduce the anxiety of staff very well through this sort of work.” (Manager 3)

“We organised away-days for our large mixed team and asked them to bring their views and concerns. We stated we would treat everyone as equals at the away day to help build trust with the managers.” (Manager 1)

“The ethos of the team got a lot better after the away days and the staff had an opportunity to voice their concerns and bond with each other.” (Manager 2)

All the managers highlighted the need for earlier project management, as described by these managers:

“If we’d had a project manager right from the start, dedicated to the set up, we would have seen much faster progress with the difficult challenge of bringing two teams together from different organisations. It’s not really possible to do this quite of work alongside your day-job. Once we got a dedicated team leader to manage operational day-to-day activities in post, our internal processes improved dramatically.” (Manager 1)

“In the beginning, we were a team working on good will rather than formalised processes.” (Manager 2)

An important facilitating factor to bringing the team together was witnessing evidence of success. This sense of mastery and value for patients was highlighted by this manager:

“Once the team saw the benefits of the service for patients they felt better and things really started happening in a very positive way.” (Manager 1)

Managers highlighted their actions to take time to build relationships, be visible in the team, build trust and engage in lots of internal meetings to support staff and their concerns. Furthermore, managers reported perceptions by other health colleagues and used them to support concerned team members:
“It’s been interesting to witness our colleagues on the acute side of things recognise that we [community services] can manage patients being passed onto us. We’ve spent time building relationships with those colleagues and they now trust us to be safe with that patient and the patient won’t bounce back into hospital.” (Manager 2)

5.3 Lessons learnt

A number of lessons can be learnt from the themes identified and managers often discussed issues in a reflective manner to support future change work. Further to those, a number of short statements were made by managers to summarise the lessons learnt:

- Having a clear chain of command from the start
- Having a single organisation of HR processes and contractual arrangements
- Clear lines of governance and reporting
- Trust in team and management processes
- Don’t underestimate how long it will take to set up a new team (due to HR issues, clinical policies and procedures, operational management i.e. how many bodies on the ground, rostering, alignment of job descriptions and competencies)
- Don’t underestimate the challenge of bringing two culturally different teams together
- Need clarity about financial risk sharing across two organisations.
- Strong project management needed before starting the service
- Proper engagement (e.g. away days) with team members, not just consultation
- Emotional resilience needed by managers

6. The Team

6.1 Context and Purpose

The team evaluation sought to understand the experience of staff involved in developing and delivering ERS@H. This includes the enablers and barriers to embedding the service in a sustainable way and the extent to which members of the team feel that it is effective and productive. It also explored whether they felt that their contribution was valued and the extent to which team goals have been met.

6.2 Methods

Conceptual framework

The team evaluation used Normalisation Process Theory (NPT, a validated instrument that has been widely used to evaluate quality improvement interventions in health care. The starting point of NPT is to understand processes related to the embedding of a practice - what people actually do and how they work together. It provides an

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explanatory framework to better understand the routine embedding of healthcare interventions in their social contexts, in particular why some processes seem to lead to a practice becoming sustained over a long term while others do not (May and Finch, 2009, p539). Although May and Finch (2009a) make no claim of absolute predictive power, they argue that within certain limits the trajectory of a practice i.e. extent of sustainable long term embedding can be anticipated. This means that NPT can help ascertain the likelihood of the routine embedding of an intervention within certain limits.

The focus is on factors (beliefs and behaviours) that promote or inhibit (enablers and barriers) the implementation of an intervention, in this case the ERS@H. The factors are divided into four themes:

i. **Coherence**: the mobilisation of a practice – how it is conceptualised and held together in action

ii. **Cognitive participation**: participation in a practice – how members decide to engage and actually engage

iii. **Collective action**: enacting a practice – how the work is organised and activities structured and constrained

iv. **Reflexive monitoring**: the appraisal of a practice – how it is appraised and the effects of appraisal, i.e. how it is ‘understood’ and what changes the team make

The mixed methods (Plowright, 2015) conceptual framework was also informed by Force Field Analysis (Lewin, 1949; 1951) of enabling and restraining forces (drivers and barriers) in respect of the implementation process and Alexander (1985) team effectiveness as well as the NEHF Vanguard HHH ICT Logic Model.

**Scope and design, data collection and sampling**

Two researchers undertook non-participant observation of the weekly multi-disciplinary review meeting (n=25) and took notes. (See appendix 4). Two researchers attended the structured focus group (n=24) that took place immediately afterwards.

The lead researcher facilitated the structured focus group. The other researcher took notes. The focus group was also recorded.

At the beginning of the focus group participants undertook an anonymous 30 questions paper based survey based informed by the conceptual framework (n=23) (See appendix 5 and appendix 6). Participants (n=23) were asked to rate each of the 30 questions on a scale of 1-10 where 1=not at all agree and 10=completely agree. They could also use free text to provide more details in respect of their responses.

The results in the following tables distinguish between the team participants as:

- 14 were Rehabilitation Support Workers (RSWs)
- 9 were registered members of a healthcare professional bodies (e.g. nurse) (REGs)

And average scores can be interpreted as:

- <5.5 are negative
- 5.5 – 6.9 are slightly positive and require attention
- 7-8.9 are positive
- >9 are highly positive

**Appendix 3** provides more information on the study design.
6.3 Coherence - How the team is conceptualized and held together in action

<table>
<thead>
<tr>
<th>Coherence/sense-making</th>
<th>Average score all (n=23)</th>
<th>Difference higher/ lower score all (n=23)</th>
<th>Average score RSWs (n=14)</th>
<th>Difference higher/ lower score RSWs (n=14)</th>
<th>Average score REGs (n=9)</th>
<th>Difference higher/ lower score REGs (n=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ER@H distinct from previous ways of working</td>
<td>6.2</td>
<td>8pts</td>
<td>5.9</td>
<td>6pts</td>
<td>6.6</td>
<td>9pts</td>
</tr>
<tr>
<td>2. Team members have a shared understanding of the purpose of ER@H and of specific responsibilities required</td>
<td>5.5</td>
<td>9 pts</td>
<td>5.3</td>
<td>9 pts</td>
<td>5.7</td>
<td>8 pts</td>
</tr>
<tr>
<td>3. Team members understand how ER@H affects the nature of their work</td>
<td>5.9</td>
<td>7 pts</td>
<td>6.0</td>
<td>7 pts</td>
<td>5.8</td>
<td>5 pts</td>
</tr>
<tr>
<td>4. Team members can see potential value of ER@H for their work</td>
<td>6.6</td>
<td>7 pts</td>
<td>6.8</td>
<td>7 pts</td>
<td>6.3</td>
<td>6 pts</td>
</tr>
<tr>
<td>Overall averages</td>
<td>6.1</td>
<td>7.8 pts</td>
<td>6</td>
<td>7.3 pts</td>
<td>6.1</td>
<td>7.8 pts</td>
</tr>
</tbody>
</table>

Not all agree = 1, completely agree = 10

The survey results described in this table were less positive than the non-participant observation of the MDT and focus group – where the team demonstrated enthusiasm about the service.

The highest score was for RSW team members was seeing the potential value of the service (6.6) and for the REG team members it was that the ER@H was distinctive to previous ways of working highest. Both groups scored having a shared understanding of the purpose the service and the specific responsibilities required lowest. This indicates that they struggle to understand the boundaries between the various roles and responsibilities, which were being redefined and were no longer aligned with their former job descriptions.

During the RSW developmental meeting team members said that there was too much change and that it was difficult to keep up. The tension about the need to follow care plans which protect both patients and staff and to adjust to the needs of the patients during home visits was felt to have a potential negative impact on the autonomy of RSWs. In order to improve this, a system was being organised which allowed the RSWs to decide in what order they would do home visits. A working group was being set up to review job descriptions and develop these to reflect a recent change in the role of RSWs.

The RSWs would like to learn additional skills and the team leader reported that they were looking at how more responsibilities and autonomy could be delegated to them and their skills developed.

In the focus group, team members were very enthusiastic about the purpose of the ER@H service. They constructed ER@H as being innovative and proactive at providing a value added service to patients, so they could come back home sooner with the support from a number of health and social care professionals, including ER@H staff. An additional benefit was breaking down traditional barriers and moving to a more integrated approach which also enabled common learning and learning from each other.

However, there was a feeling of a lack of clarity about roles and about the fact that roles had recently changed. I understand my role. However, sometimes the boundaries as to what extent my role can be pro-active is unsure. Because now there are other functions like reporting to the key worker or occupational therapist, GP etc. Before I used to see a nurse band 6 or GP if needed [RSW].

There was a sense of fragmentation and of lack of cohesion, and of having to keep up with a number of changes in relation to how things were done while at the same time there was still confusion about how ER@H was different or distinct from previous ways of working. I recently joined the team and can see a number of different ways being pulled together [Occupational therapist] and There is no definite clarity with my job role [Associate practitioner].

Many RSWs wanted to gain more skills and hence more autonomy in order to better help the ER@H team, but opportunities for this were felt to be limited by the availability of upskilling and time pressures. I wish I had more time for study leave or shadowing clinicians to become more knowledgeable, so I can support patients better and also support clinicians better [RSW].
6.4 Cognitive engagement – how members engage with the team

<table>
<thead>
<tr>
<th>Cognitive engagement</th>
<th>Average score (n=23)</th>
<th>Difference higher/lower score (n=23)</th>
<th>Average score RSW (n=14)</th>
<th>Difference higher/lower score RSW (n=14)</th>
<th>Average score REGs (n=9)</th>
<th>Difference higher/lower score REGs score (n=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Key individuals drive ERS@H forward and get others involved</td>
<td>5.9</td>
<td>7pts</td>
<td>6.3</td>
<td>7pts</td>
<td>5.3</td>
<td>6pts</td>
</tr>
<tr>
<td>6. Team members are open and willing to work in new ways</td>
<td>4.9</td>
<td>7pts</td>
<td>5.2</td>
<td>9pts</td>
<td>4.1</td>
<td>5pts</td>
</tr>
<tr>
<td>7. Team members believe that contributing to ERS@H is a legitimate part of their work</td>
<td>6.5</td>
<td>8pts</td>
<td>7</td>
<td>7pts</td>
<td>5.8</td>
<td>7pts</td>
</tr>
<tr>
<td>8. Team members continue to support ERS@H</td>
<td>6.6</td>
<td>8pts</td>
<td>6.9</td>
<td>8pts</td>
<td>6.1</td>
<td>8pts</td>
</tr>
<tr>
<td>Overall averages</td>
<td>6.6</td>
<td>7.5pts</td>
<td>6.4</td>
<td>7.8pts</td>
<td>5.3</td>
<td>6.5pts</td>
</tr>
</tbody>
</table>

Not at all agree = 1, completely agree = 10

The flexible nature of ERS@H and willingness of RSWS to step in when and as required and their desire for upskilling to increase their responsiveness to the needs of patients are evidenced by a score of 7.0 which demonstrates their belief that contributing to ERS@H is a legitimate part of their work. The fact that the RSWS (n=14) agreed more [6.3] than did the registered staff (n=9) [5.3] that **key individuals drive ERS@H forward and get others involved** also seems to indicate that the RSWS have bought into ERS@H to a greater extent than the registered staff. A key individual who was highlighted as driving the ERS@H forward was the team leader. **Recent change in team leader is allowing the team to have more autonomy and input into the decision making process [Physiotherapist].**

The average score for coherence or sense making was 6.0 [6.4 for RSWS and 5.3 for registered staff], which is an overall slightly positive score. Although, the score is somewhat positive for RSWS and negative for registered staff, it would appear that RSWS demonstrate a higher degree of cognitive engagement with ERS@H than do the registered staff.

The RSWS forum facilitated by the team leader acknowledged a lack of registered staff to create work and case load for RSWS and to enable the latter to shadow clinical staff to in order to upgrade their own clinical competencies. **A holistic assessment is done so we know a lot about the patient and upskilling would enable us to be more flexible and better respond to their needs [RSW] and I would like the opportunity of having a bit of doing something different each week, [but] the study list is already fully booked and there are no opportunities [RSW].** The team leader indicated that Community Care Team was planning to put in place a rolling programme of training support for RSWS.

The focus group echoed the overall (n=23) low score and hence somewhat negative score [4.9] for **team members are open and willing to work in new ways.** The low score was due to the registered staff somewhat disagreeing with the statement [4.1] to which they gave the very lowest of all scores while the RSWS attributed a higher score [5.3], but still not a positive score since positive scores start at 5.6.

During the focus group discussion, more registered staff than RSWS underlined issues related to new ways of working. **There are a lot of unnecessary changes and these are always asked for in a short space of time [RSW] and A lot of things have changed when they already worked just fine [Nurse] and Members of the team are still stuck in the old ways of working [Associate practitioner].**

The team leader pointed out during the RSW forum that RSWS had brought up the issues of changes to allocations in the day and changes in working times. In view of the fact that they were losing protected time for one to one meetings and had to book visits instead, the RSWS had asked for dedicated time for the buddy system and triage support. The team leader asked for a list of additional tasks for information and said that any time away from clinical work (buddy, one to one meetings, study day) should be recorded on the daily planner to ensure time is protected.
6.5 Collective action – how the Team’s work is organised and activities structured

<table>
<thead>
<tr>
<th>Collective action</th>
<th>Average score (n=23)</th>
<th>Difference higher/lower score (n=23)</th>
<th>Average score (n=14) for RSWs</th>
<th>Difference higher/lower score (n=14)</th>
<th>Average score (n=9) for registered staff</th>
<th>Difference higher/lower score (n=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Team members can easily perform the required tasks</td>
<td>6.4</td>
<td>8 pts</td>
<td>6.6</td>
<td>6 pts</td>
<td>6.0</td>
<td>6 pts</td>
</tr>
<tr>
<td>10. The intervention not disrupt working relationships</td>
<td>6.0</td>
<td>6 pts</td>
<td>5.9</td>
<td>7 pts</td>
<td>6.1</td>
<td>5 pts</td>
</tr>
<tr>
<td>11. Team members trust ERS@H and trust each other</td>
<td>6.6</td>
<td>6 pts</td>
<td>6.7</td>
<td>6 pts</td>
<td>6.3</td>
<td>6 pts</td>
</tr>
<tr>
<td>12. Work is seen as appropriately allocated to staff who with required skills</td>
<td>5.6</td>
<td>9 pts</td>
<td>5.2</td>
<td>6 pts</td>
<td>5.1</td>
<td>9 pts</td>
</tr>
<tr>
<td>13. Sufficient training is provided to staff</td>
<td>5.3</td>
<td>9 pts</td>
<td>5.6</td>
<td>8 pts</td>
<td>4.9</td>
<td>7 pts</td>
</tr>
<tr>
<td>14. Sufficient resources are available to support ERS@H</td>
<td>6.0</td>
<td>7 pts</td>
<td>6.1</td>
<td>7 pts</td>
<td>6.4</td>
<td>6 pts</td>
</tr>
<tr>
<td>15. NHS/Vanguard programme management team adequately supports ERS@H</td>
<td>5.2</td>
<td>7 pts</td>
<td>5.0</td>
<td>7 pts</td>
<td>5.4</td>
<td>7 pts</td>
</tr>
<tr>
<td>Overall average</td>
<td>5.9</td>
<td>7.4 pts</td>
<td>6.0</td>
<td>6.7 pts</td>
<td>5.7</td>
<td>6.6 pts</td>
</tr>
</tbody>
</table>

The results of the survey (n=23) broadly mirrored the views of team members articulated in the RSW forum (n=25) and focus group (n=24).

The highest overall (n=23) score and highest score for RSWs (n=14) was Team members trust ERS@H and trust each other [6.6 for all and 6.7 for RSWs] closely followed by Team members can easily perform the required tasks [6.4 for all and 6.6 for RSWs]. The highest score for registered staff (n=9) was Sufficient resources are available to support ERS@H [6.4] closely followed by Team members trust ERS@H and trust each other [6.3]. These scores were only slightly positive as the ERS@H team members only somewhat agreed with these statements. See table 4.

The lowest overall (n=23) score was for NHS/Vanguard programme management team adequately supports ERS@H [5.2 for all and 5.0 for RSWs] closely followed by Sufficient training is provided to staff [5.3 for all and 4.9 for registered staff]. These scores were all slightly negative. The team did not feel they were adequately trained or supported. See table 4.

Overall, the team somewhat agreed that work was seen as appropriately allocated to staff who with the required skills [5.6] with RSWs agreeing [6.2] to a greater extent than the registered staff who in fact somewhat disagreed [5.1]. Overall the team somewhat agreed that Team members could easily perform the required tasks [6.4] with RSWs agreeing more [6.6] than the registered staff [6.0]. See table 4.

The overall score for collective action was 5.9 [6.0 for RSWs and 5.7 for registered staff]. The score is very almost the same than those of coherence [6.1] and cognitive engagement [6.0]. However, in both the RSWs forum and focus groups, RSWs felt that operational issues were often unclear and confusing. See table 4.

The team leader facilitated the RSW forum by working through a list of issues that had been highlighted during a recent development day. Keys concerns were: mileage; making changes re work on the day, communication and new processes and procedures, RIO and the White Board system; difficulties in logging in from home; time to get to know patients; and rostering issues. The team leader talked of establishing working groups to look into some of these issues and reminded the team about established processes i.e. using RIO to find out things and update the team.

The discussion demonstrated the structural constraints of the ERS@H consequent to the integration of community and secondary care staff who had different cultures. RSWs were unclear about basic operational issues which if unresolved would negatively impact on the ERS@H i.e. what to do about physiotherapists not picking up requests; how do we...
make sure that escalation works and whether all clinicians read notes made by RSWs.

Some of the issues were underlined during the focus group starting with the brainstorming and ranking exercise which took place after the individually completed NPT survey.

The brainstorming exercise enabled key barriers and drivers to be identified quickly that would complement the results of the survey and prompt a discussion to provide insights into the implementation of the ERS@H.

The brainstorming exercise underlined changes x13, communication x9, environment x8; team working x7, not feeling valued x5 as the barriers that were most frequently mentioned. The brainstorming exercise identified team x13, patient outcomes x8; support x5, flexibility x3 and job satisfaction x2 as the most frequently mentioned drivers. See appendix 10.

After the brainstorming exercise, the lead researcher briefly categorised the drivers and barriers and selected the most important category of barriers and drivers so that they could be ranked in descending order by team members, and these are set out in the table below.

<table>
<thead>
<tr>
<th>Barrier categories</th>
<th>Driver categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Changes 19</td>
<td>1. Patient outcomes 17</td>
</tr>
<tr>
<td>2. Environment 17</td>
<td>2. Flexibility 11</td>
</tr>
<tr>
<td>3. Communications 14</td>
<td>3. Learning from others 7</td>
</tr>
<tr>
<td>4. Team 11</td>
<td>4. Support 6</td>
</tr>
<tr>
<td>5. Lack of empathy 5</td>
<td>5. Individuals/team 6</td>
</tr>
<tr>
<td>7. Documentation 1</td>
<td>7. Feedback from patients 4</td>
</tr>
</tbody>
</table>

The analysis of barriers and drivers broadly mirrors the allocated votes to barrier and driver categories. The top barrier categories were identified as changes x19, environment x17, communications x14, and team x 11. The top driver categories were identified as patient outcomes x17, flexibility x11, learning from others x7 and support x6, followed by individuals/team x6. If the latter three categories are put together under team, this would make team the top category with 19 votes. See table 5.

During the focus group discussion team members explained how they had identified the drivers and barriers and how and why they had voted for barrier and driver categories. They underlined collectively they thought there was too much change ongoing and that they had limited time to implement changes and get used to the changes, but not sooner had they got used to the changes, that new changes would be introduced.

Some members did not understand why things that worked perfectly well had been changed and queried If it is not broken why change it? [Nurse]. Nonetheless, learning was conceived as an ongoing process within the team. It has been painful but cultures are beginning to change [Physiotherapist]. In particular, many team members felt that they could rely on the support of the team. A RSW gave an example of how a registered member of the team had helped with upskilling clinical skills by giving the RSW the needed support enabling the RSW to perform a procedure on a real patient for the very first time. It is different doing it for real compared to when I was doing it in training and I was supported in being able to have the confidence to do the procedure live for the first time.
6.6 Reflexive monitoring – how the Team receives and understands feedback and responds to this

<table>
<thead>
<tr>
<th>Reflexive monitoring</th>
<th>Average score (n=23)</th>
<th>Difference higher/lower score (n=23)</th>
<th>Difference higher/lower score RSW (n=14)</th>
<th>Difference higher/lower score REGs (n=9)</th>
<th>Overall average</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Team members can access information about ER@H are aware of the effects of ER@H</td>
<td>5.7</td>
<td>6pts</td>
<td>6.5</td>
<td>5pts</td>
<td>6.5 pts</td>
</tr>
<tr>
<td>17. Team members agree that ER@H is worthwhile</td>
<td>7.7</td>
<td>6pts</td>
<td>8.3</td>
<td>5pts</td>
<td>6.7</td>
</tr>
<tr>
<td>18. Team members value the effect of ER@H on their work</td>
<td>6.7</td>
<td>5pts</td>
<td>7.2</td>
<td>5pts</td>
<td>6.7 pts</td>
</tr>
<tr>
<td>19. Feedback about ER@H can be used to improve it in future</td>
<td>6.7</td>
<td>7pts</td>
<td>7.4</td>
<td>5pts</td>
<td>6.7</td>
</tr>
<tr>
<td>20. Team members can modify how they work with ER@H</td>
<td>5.7</td>
<td>5pts</td>
<td>6.1</td>
<td>4pts</td>
<td>5.1</td>
</tr>
<tr>
<td>Overall average</td>
<td>6.5</td>
<td>5.6 pts</td>
<td>7.1</td>
<td>5.0 pts</td>
<td>6.5 pts</td>
</tr>
</tbody>
</table>

The results of the survey are in line with the findings of the non-participant observation. Overall (n=23), ER@H has a greater level of reflexive monitoring [6.5] than of coherence [6.1], cognitive engagement [6.0] and collective action [5.9]. It is not unreasonable to speculate that this is due to the approach of the team leader and the role played by the RSWs weekly forum. The overall score given by RSWs for reflexive monitoring was 7.1 while the registered staff gave 5.7.

The highest overall score (n=23) in relation to reflexive monitoring was for Team members agree that ER@H is worthwhile with 7.7 [8.3 for RSWs and 6.7 for registered staff]. Out of the 20 NoMAD statements, this was the highest or top score, whether overall or for RSWs or registered staff. See table 6. See appendices 4-6. Team members value the effect of ER@H on their work [6.7] ranked second overall highest score for all (n=23) with 6.7 and third highest overall score for RSWs [7.2]. Feedback about ER@H can be used to improve it in future [6.7] ranked third highest score for all and second overall highest scores for RSWs [7.4]. See table 6. See appendices 4-6.

Focus group discussion mirrored the results of the survey. Team members, and in particular RSWS underlined that ER@H was the only service that doesn’t say ‘no’, and we adapt at any time/in any way for the patient and We deal with patients no-one else with pick up, so in order to prevent a long inpatient stay we take them on. RSWs described how rewarding it was to see patients appreciate what the ER@H does and to see patients getting better when they are kept at home rather than in the hospital. We are an asset to the NHS, they make us feel we are important.
6.7 Non-NPT questions

<table>
<thead>
<tr>
<th>Non NPT questions</th>
<th>Average score (n=23)</th>
<th>Difference higher/ lower score RSWs (n=14)</th>
<th>Average score higher/ lower score RSWs (n=14)</th>
<th>Average score REGs (n=8)</th>
<th>Difference higher/ REGs score (n=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER@H communicates effectively with other providers</td>
<td>5.6</td>
<td>8pts</td>
<td>5.3</td>
<td>8pts</td>
<td>6.1</td>
</tr>
<tr>
<td>ER@H has achieved shared learning by working with partners</td>
<td>4.6</td>
<td>8pts</td>
<td>4.1</td>
<td>8pts</td>
<td>5.3</td>
</tr>
<tr>
<td>I feel valued as a member of ER@H</td>
<td>4.2</td>
<td>6pts</td>
<td>4.4</td>
<td>8pts</td>
<td>4.0</td>
</tr>
<tr>
<td>ER@H has achieved a cultural shift in organisational integration</td>
<td>4.2</td>
<td>8pts</td>
<td>4.1</td>
<td>7pts</td>
<td>4.2</td>
</tr>
<tr>
<td>ER@H has successfully upskilled staff in generic roles</td>
<td>4.0</td>
<td>7pts</td>
<td>3.5</td>
<td>7pts</td>
<td>6.1</td>
</tr>
<tr>
<td>Members external to ER@H are aware of/ have an understanding of the range of services offered by ER@H</td>
<td>3.5</td>
<td>6pts</td>
<td>3.3</td>
<td>6pts</td>
<td>3.9</td>
</tr>
<tr>
<td>Overall average</td>
<td>4.4</td>
<td>6.1 pts</td>
<td>4.1</td>
<td>7.3pts</td>
<td>4.5</td>
</tr>
</tbody>
</table>

*Not at all agree – 1, completely agree – 10*

The findings indicate that overall team members somewhat disagree that ER@H has achieved:
- Shared learning by working with partner agencies
- A cultural shift in organisational integration
- That members external to the team are aware of or understand the range of services they offer

Neither RWS or REG staff felt valued as members of the ER@H team.

6.8 Conclusions of team evaluation

Together the team is working towards delivering its goals of bringing together staff from a wide range of health and social care backgrounds and organisations to provide holistic care, support to patients after they are discharged from hospital and admission avoidance. Four fifths of NPT NoMAD statements [16 out of 20] were rated positively i.e. above 5.5. However the team members only somewhat agreed with 16 statements. The highest rating overall was 7.7 and 8.3 for RSWs and 6.7 for registered staff that ER@H is worthwhile. See appendices 7, 8 and 9. The average rating was around 6 with on average 7 points difference between the highest and lowest individual score for statements.

Neither RSWs nor registered staff said they felt valued as members of the ER@H team. However, they nonetheless agree that ER@H is worthwhile and very beneficial for patients, which was strongly underlined during the focus group.
Overview of responses to NPT questions and NPT four domains

This figure shows that sense-making or coherence, cognitive engagement or participation and collective action have the potential for improvement and that reflexive monitoring is scored more highly than the other three NPT domains.

The responses that are closer to the centre indicate that team members may struggle with sense making and having a shared understanding of their role and that this may prevent them from buying into it or being able to enact ERS@H it in a way that works for them. In the case of ERS@H despite difficulties with sense-making, participation and action and in particular operational barriers, team members have a belief in the worthwhileness of ERS@H and its effect on their working practice that has persisted regardless (May et al, 2015).

For more details on the ranking of the responses to the NPT questions see appendices 4-9.

7. Activity Evaluation

7.1 Changing the pattern of health care received by its patients and reducing their use of emergency secondary care, is an important aim of the ERS@H service. To evaluate whether there has been an impact, the Commissioning Support Unit (CSU) has analysed the records of the patients referred to the service. Using the date of referral to ERS@H as the pivot point, the CSU looked at the A&E attendances and emergency admission activity for patients one year before and after their referral date to the service, in 30 day windows. Because the service began in November 2016 and the numbers of patients supported have built up over time, the numbers of patients included in this analysis reduces over time. For example, there are 711 patients activity when looking at ± 30 days of referral, and this falls to 57 patients in the ± 360 day window. This is shown in the graph below.

7.2 Using the activity analysis completed by the CSU, a rate of activity per person per day has been calculated over each 30 day window. The following chart compares the rates of A&E
attendance and emergency admission for the patients over the 12 months before and after referral to the ERS@H service.

7.3 The key observations from this activity analysis are that:

- Patients gradually use more hospital services in the year before admission to ERS@H, and use services significantly more in the 3 months before their referral to ERS@H.
- Following support from ERS@H, patients quickly use hospital services less, and continue to use services less over the following year.

7.4 The following graph is another way of showing the change in activity levels following support from ERS@H. It shows the percentage change in activity for each 30 day window over the first year. So for example, in the first 30 days following referral to ERS@H there is a 42% reduction in the rate of A&E attendances – and over the next 11 months A&E activity is still less than before, but by a diminishing amount, but in the 12th month it is slightly higher.

7.5 The activity evaluation has shown evidence that following referral to ERS@H, there is a reduction in emergency secondary care activity, and this diminishes over the following year. What we don’t know is how much of this reduced activity can be attributed solely to ERS@H, because it is part of pathway of care that for most patients began in Frimley Park Hospital and ended with them being supported at home by their local Integrated Care Team and primary, community and social care services. The next section seeks to understand what the economic value of this change in activity could be.
8. Economic evaluation

8.1 The economic evaluation takes the evidence of reductions in activity and calculates potential financial savings using average (median) tariff costs for A&E and emergency admissions. These savings are modelled to identify the potential to avoid costs, or the potential commissioning value of a service, based upon a projected annual caseload of 668 patients. This is based on an average monthly caseload of 56 patients from January to August 2017.

8.2 Step 1 – evidence of reduced activity

We know from the activity evaluation described above that there is a measurable reduction in patient’s use of A&E and emergency admissions following referral to ERS@H. It is possible to identify the potential commissioning value of this reduced activity, by seeking to calculate the tariff based value of the grey shaded areas in the graphs below. This is different to actual costs saved or avoided.

8.3 Step 2 – model potential value for annual activity levels

The analysis in step 1 has identified the difference in rate of service usage before and after referral to ERS@H for the patients who have used the service over the past year. This enables us to calculate a potential commissioner value for these different rates of activity before and after referral (the grey shaded area above).

<table>
<thead>
<tr>
<th></th>
<th>Cost before (1 year)</th>
<th>Cost after (1 year)</th>
<th>Potential commissioning value over 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>£220,213</td>
<td>£169,711</td>
<td>£50,503</td>
</tr>
<tr>
<td>Emergency admissions</td>
<td>£3,202,716</td>
<td>£2,280,890</td>
<td>£921,826</td>
</tr>
<tr>
<td>Total</td>
<td>£3,422,930</td>
<td>£2,450,601</td>
<td>£972,329</td>
</tr>
</tbody>
</table>

We have identified that there is an annual potential commissioning value of £972,329 that could be saved for the caseload of 668 patients. It is not possible to attribute this whole value, or part of this value, to the ERS@H service as there are three key steps in the care pathway for patients who use ERS@H - a person’s treatment and care in Frimley Park Hospital, their care by the ERS@H service, and their ongoing care in the community by the Integrated Care Teams and primary care.

It is not possible to disaggregate the impact of each service and attribute this commissioning value to parts of the pathway. What we do know is that across all three parts of the care pathway there is a reduction in the number of A&E attendances and emergency admissions over the period of time analysed – particularly in the first three
months of following referral to ERS@H, but also with lasting benefits across the following year.

The resource impact as a result of a reduction in A&E attendances and emergency admissions is only one benefit of the ERS@H, and is the only dataset presented here. We also know that a successful discharge will have other benefits to the health and care system and will for example, reduce costs in social care, primary care and/or the residential/care home sector, meaning that the potential commissioning value presented here is only part of the financial return this team can deliver. We have not been able to quantify these other potential benefits within this report.

8.4 Step 3 – model potential value of an increased annual caseload

Step 2 modeled the potential economic value of the current levels of referral and caseload. The ERS@H service has reported that the service is currently operating at 78% capacity. This means that it is possible to model what the potential commissioning value of the service might be if the service was running at 95% capacity – 95% has been used to represent “full capacity” as the team would always like to operate with some headroom for unknown pressures and demands. Under this scenario, the annual caseload would increase from 668 to 814. Increasing capacity to this level would represent a fully staffed team – this includes recruiting two administrators for the team. These posts are currently being filled by two Rehab Support Workers.

As guided by the HMRC Green Book, an adjustment should be made for (over) optimism bias when considering the potential benefits of a future project – a rate of 10% has been used. A time preference has also been added to the future potential commissioning value of ERS@H using a discount rate of 3.5% (as recommended HMRC Green Book) on the assumption that the increase to the caseload will be implemented during the coming year.

<table>
<thead>
<tr>
<th></th>
<th>Cost before (1 year)</th>
<th>Cost after (1 year, with service at 100% capacity)</th>
<th>Potential commissioning value over 1 (future) year</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>£268,209</td>
<td>£206,699</td>
<td>£55,359</td>
</tr>
<tr>
<td>Emergency admissions</td>
<td>£3,900,744</td>
<td>£2,778,007</td>
<td>£1,010,463</td>
</tr>
<tr>
<td>Gross Total</td>
<td>£4,168,953</td>
<td>£2,984,706</td>
<td>£1,065,822</td>
</tr>
<tr>
<td>Net total, including discounting</td>
<td></td>
<td></td>
<td>£1,029,780</td>
</tr>
</tbody>
</table>

Modelling suggests a future (one year from now) potential commissioning value of £1,029,780 based on a caseload of 814 people. As noted in Step 2, it is not possible to attribute this part or all of this value to the ERS@H service or disaggregate this value to differing parts of the care pathway.

8.5 Vanguard Funding

The Happy, Healthy, at Home Vanguard Programme provided £350,000 funding to this service to contribute to the delivery of integrated care by the ERS@H service.
8.6 **Resource and costs of providing the ERS@H service**

The annual costs of operating the service are £1,192,72. This is split between staff costs of £1,136,446, and non-staff costs of £56,275 (representing 5% of the total budget).

The table below provides a summary of how the ERS@H service is made up, and the assumed costs of staffing – the total figure will not tally with the above figure as the specific pay point of each individual staff member is unknown, and the mid-point of each Agenda for Change pay scale has been assumed. Other assumptions include:

- For one whole time equivalent member of staff (WTE), there are 42 working weeks a year after annual leave, training, sickness etc. and one WTE member of staff works 37.5 hours per week
- A 25% uplift of salaries has been included to account for National Insurance, Pension, and on costs to the organisation
### Table 3: Service costs

<table>
<thead>
<tr>
<th>Role</th>
<th>WTE</th>
<th>AfC Band</th>
<th>Total staff costs (using AfC mid point, +25% on-costs)</th>
<th>% time spent available for patient care*</th>
<th>Hours available for patient care (per year)</th>
<th>Number of permanent posts (WTE)</th>
<th>Number (WTE) New Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Lead</td>
<td>1</td>
<td>8a</td>
<td>£54,311</td>
<td>0%</td>
<td>0</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>1</td>
<td>7</td>
<td>£45,765</td>
<td>60%</td>
<td>945</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>3</td>
<td>6</td>
<td>£114,979</td>
<td>70%</td>
<td>3308</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>1</td>
<td>7</td>
<td>£45,765</td>
<td>60%</td>
<td>945</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>2</td>
<td>6</td>
<td>£76,653</td>
<td>70%</td>
<td>2205</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>2</td>
<td>5</td>
<td>£63,878</td>
<td>80%</td>
<td>2520</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>1</td>
<td>7</td>
<td>£45,765</td>
<td>60%</td>
<td>945</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>2</td>
<td>6</td>
<td>£76,653</td>
<td>70%</td>
<td>2205</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>2</td>
<td>5</td>
<td>£63,878</td>
<td>80%</td>
<td>2520</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Associate Practitioners</td>
<td>2</td>
<td>4</td>
<td>£53,158</td>
<td>85%</td>
<td>2678</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Rehab Support Workers</td>
<td>26</td>
<td>3</td>
<td>£595,823</td>
<td>90%</td>
<td>36855</td>
<td>26</td>
<td>1</td>
</tr>
<tr>
<td>Administrator</td>
<td>2</td>
<td>3</td>
<td>£45,833</td>
<td>0%</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>45</strong></td>
<td></td>
<td><strong>£1,282,457</strong></td>
<td><strong>55,125</strong></td>
<td><strong>38</strong></td>
<td><strong>14.5</strong></td>
<td></td>
</tr>
</tbody>
</table>

* - Time spent for delivering patient care is defined as face-to-face, travel and documentation/admin associated with the delivery of care to a patient. Non-clinical time is for managerial responsibility, training, team meetings etc.
8.7 Commentary on economics and attribution

The key activity and economic evaluation findings are:

- That in the 11 months following referral to the ERS@H service, patients attend A&E and are admitted to hospital as emergencies less. In the first month this reduction is over 40%, and it reduces over time to around 12% 11 months later. This is good evidence of a positive impact on reducing emergency activity.

- The potential commissioning value of this reduced activity based on the current levels of caseload is £972,329.

- If the team increased their capacity by 17% in the coming one year and caseload, modelling suggests this value may potentially increase to £1,029,780.

The staff costs of providing the service have been calculated as £1.3 million (this is slightly different to the actual value provided by the service due to the assumed banding mid-point of all staff for the calculation). There are important contextual factors to take into account when considering these key financial values:

- We know that the ERS@H service is part of a pathway of care and support, as shown in the following high level diagram:

- It has not been possible to disaggregate the impact of each service and attribute this commissioning value to parts of the pathway. What we do know is that across all three parts of the care pathway there is a reduction in the number of A&E attendances and emergency admissions over the period of time analysed – particularly in the first three months of following referral to ERS@H, but also with lasting benefits across the following year.

- The resource impact as a result of a reduction in A&E attendances and emergency admissions is only one benefit of the ERS@H service, and the only dataset presented here. We also know that a successful discharge will have other benefits to the health and care system and will for example, reduce costs in social care or primary care.

The economic evaluation of individual new care models have focused on identifying the potential commissioning value of reduced activity using tariff costs. The intention in Q4 is for the evaluation team and the CCG to work bring all of the activity and economic evidence together to consider what the system impact has been. This will also aim to identify potential cost savings in providing care services.
9. Conclusions

9.1 The evaluation of the ERS@H service has identified significant evidence of a range of impacts indicative of the quality of care provided by the team. This has been drawn from patient reported outcomes, case studies and patient interviews. Impacts included increased confidence to self-manage, addressing patients’ wish to be at home met, addressing patients’ physical support needs at home to ensure safety, reduced post-admission anxiety, improved access to community support, and feeling informed and supported. Improvements were also seen in patient reported outcomes of ‘Requiring help from others,’ ‘I can look after my health,’ and ‘I was not anxious yesterday,’ further strengthening the evidence on quality of care, and in staff reported outcomes at both time points with high scores for ‘we treat people kindly’, ‘we listen and explain’ and ‘we see people promptly’.

9.2 Effective teamwork is an essential part of the ERS@H model. A team evaluation using Normalisation Process Theory identified that team members believe that the model of care is worthwhile and valued its effect on their working practice. Staff reported outcomes corroborate this finding with high scores for ‘what I do in my job is worthwhile’ and a statistically significant improvement in ‘I was not anxious yesterday at work.’ However, at this stage in the development of the team, there is evidence of a lack of shared understanding of team roles which is impacting how staff carry out the work of the team and their experience of this work. These findings are supported by relatively low scores on some staff reported outcomes for work wellbeing and work organisation. There was also a reduction in scores for ‘I am involved in decisions that affect me’ compared with an earlier evaluation. The findings suggest ways in which the team can address these issues and it is clear that there is a commitment to do so.

9.3 Interviews with three managers, who have been involved in the development of ERS@H, help to explain some of the challenges which are likely to have contributed to the findings from the team evaluation, in particular those associated with the integration of two culturally different teams into one organisation. “Bringing them [two teams] together was vital as the success of the team depends on the multidisciplinary approach we offer.” (Manager 1). The evaluation identified eight key challenges; confusion about leadership, the need for clarity about financial risk sharing across two organisations, the need for one governance structure, internal team struggles, attitudinal challenges, the need to engage in the minutiae of working practices, earlier project management needed and the importance of witnessing success.

9.4 The activity and economic evaluation found that in the 11 months following referral to the ERS@H service, patients attend A&E and are admitted to hospital as emergencies less. In the first month this reduction is over 40%, and it reduces over time to around 12% 11 months later. This is good evidence of a positive impact on reducing emergency activity and equates to a potential commissioning value of £972,329 over a year for a caseload of 668 patients. However, it is not possible to determine how much of this reduced activity is attributed to ERS@H because it is part of pathway of care that for most patients includes acute care and other primary, community and social care services. The service has reported that it is operating at 78% capacity (668 patients) – modelling has been undertaken to consider what the potential commissioning value of the service might be if the service was running at
95% capacity (814 patients). This scenario suggests a potential commissioning value of £1,029,780 if the increase in caseload was implemented in the coming year.

9.5 Evidence from both the team evaluation and patient interviews identified a number of operational challenges that are presently affecting the staff and patient experience, in particular how the team is organised to collectively contribute to the work involved. The report makes recommendations of areas that the team may wish to address.

9.6 The evaluation identified five different active ingredients that are considered important to maintain and embed the model of care for maximum impact; fast action, time for discussion, taking the ‘whole’ into account, developing rapport to support change and working in a flexible way to support self-management.

9.7 Taken together, the findings from this mixed methods evaluation contribute a substantial evidence base of the extent to which ERS@H is achieving the intended impacts identified in the logic model:
   i) Patients are happy with the care they receive and feel confident to look after their condition in the home
   ii) Patients are confident to manage their condition and are empowered to do so in the home
   iii) Patients are facilitated to return home so that they no longer have to stay in hospital for longer than they need to
   iv) There is a reduction in avoidable admissions

9.8 However, it is also clear that further development of team working is required to fully realise the benefits of the service. There appear to be some inherent tensions in a model where flexibility and responsiveness to respond to the changing needs of (often) frail patients is both a strength of the service (person-centred, capacity enhancing through generic roles) and a significant operational challenge, impacting the ability of the team to have a coherent sense of their roles and to work collectively. The challenges of working in an environment of constant change emerge clearly from the team observation and may correspond to some low scores for work wellbeing and job confidence particularly the reduction in scores for I am involved in decisions that affect me. A team commitment to addressing these issues and improving ways of working is evident.
10. **Active Ingredients**

10.1 The evaluation findings have been shared and discussed with the team leaders to identify the active ingredients that characterize the work done by the ERS@H team. Five active ingredients are listed below, all of which contribute to the broader concept of **pro-active highly tailored support**, the central defining feature of the team. Five active ingredients of the work done by the ERS@H team were identified, listed below:

**A. Fast Action**

The team have worked hard to respond quickly to avoid problems for both patients and hospital systems.

**B. Make time for discussion**

Despite working in a dynamic and fast moving environment, ERS@H staff have made time for discussion with patients to understand their issues.

**C: Take the ‘whole’ into account**

The team have ensured that they take a holistic approach to care and the needs of the patients.

**D: Develop rapport to support change**

An important active ingredient was the willingness and ability to develop rapport to support change. Many case studies and interviews referred to this issue and ERS@H staff were widely praised for doing this so quickly and easily.

**E: Work in a flexible way to support self-management**

Several case studies described how the team had increased the number of visits to supervise a particularly crucial element of care, e.g. supervising the assessment of ability to use the stairs. They also reported increasing GP awareness so action could be taken when required, e.g. knee pain discovered or signs of fluid retention. The message here being their role was not just about organising discharge support, but involvement in many aspects of care during this critical time with patients.

10.2 Should another locality or area seek to implement ERS@H, the following learning points may inform the set up and management of the service:

- Clarifying leadership roles
- Clarifying financial risk sharing across organisations (if more than one involved)
- Having one provider organisation with one governance structure
- Awareness of the potential for internal team struggles and attitudinal challenges (if merging existing teams)
- Vital need to engage in the minutiae of working practices
- Project management of the set-up from early on
- Sharing evidence of success and making this visible to the team