EVALUATING STAY WELL@HOME

Report

for Cwm Taf SSWB Regional Partnership

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EXECUTIVE SUMMARY

This report provides an evidence-based evaluation of the Stay Well@Home programme in Rhondda Cynon Taf. This service was created in response to the Gold Command crisis in winter 2015/16. The Welsh Institute of Health and Social Care was commissioned by Stay Well@Home to evaluate their service, and using an evidence based analysis method, alongside qualitative interviews with key informants, WIHSC has provided a report which assesses Stay Well@Home's current data collection techniques and evaluative methods. This is in an effort to assess what Stay Well@Home is doing well, what areas it may need improving, and what areas of data collection it is missing when it comes to evaluating its own performance. This will then provide a foundation for Stay Well@Home to move into the future.

The report conducted a review of existing literature on integrated care. From there we constructed a gap analysis table, which identified a variety of performance measures used in the literature, and evaluated Stay Well@Home in relation to this evidence. We then used the indicators contained in the Stay Well@Home business case to further detail the criteria for performance measurement and from there were able to generate four key areas for recommendations going forward.

It is important to consider the context of Stay Well@Home, and its place in the prevention strategy outlined in the Social Services and Well-Being Act 2014. It is a positive move towards integrating health and community care, and in considering whether it assists with the vision of preventative services, one must consider what the regional picture would look like if Stay Well@Home were to be removed. The gap in prevention services along the prevention services and care pathway would not be addressed by current services and resources, and a new service would need to be set up, disrupting the continuity achieved by Stay Well@Home. This, along with Stay Well@Home's robust data collection methods and potential for cultural change and innovation in integrated care, highlights the value in the Stay Well@Home service.

CONCLUSIONS AND RECOMMENDATIONS

The report concludes that there are four areas for Stay Well@Home to consider in terms of making changes to the way the programme collects its data and understands its impact. These are discussed in more detail in Chapter 3 of the report and are focused on the following.

Patient Reported Outcome Measures (PROMs)

We have recommended the use of existing online PROMs (available at https://proms.nhs.wales/) so that Stay Well@Home can begin generating patient reported outcomes and therefore provide better data on the benefits to individuals of the service.

Culture Change

We recommend that Stay Well@Home beings to track culture change across its workforce. This will enable the value of Stay Well@Home as an integrated service to be understood from the perspective of staff. Whilst we were not able to find a specific tool to track culture change to recommend to Stay Well@Home, many of the integrated care programmes assessed in the

evidence review used qualitative methods to track such culture change. We have provided a transformation matrix (discussed in further detail below) which may also be useful in tracking these changes across Stay Well@Home.

Data Linking

We recommend that Stay Well@Home consider using data linking methods to track data on patients over different time periods. There were three options we considered:

a. Longitudinal data linkage over large sample size using existing database e.g. SAIL. This option is not recommended.

b. Individual outcomes could be collected over different time points, e.g. 3 time points across 12 months. We suggest that this is considered and adopted.

c. Integrating data systems across health and social care and between the key organisations delivering Stay Well@Home would be advantageous. We recommend that serious consideration is given to this.

Cost Implications

Finally, we consider the cost implications of Stay Well@Home. Many of the integrated care programmes assessed in the literature review posited that they could produce cost savings through integration of care. However, we were unable to find any evidence that integrated care programmes *do* produce cost savings. The true value of integrated care programmes such as Stay Well@Home is in outcomes for patients, cultural change and service transformation. Therefore, for cost we have recommended that Stay Well@Home continue in its current practices – it does not need to alter its stance on cost implications.

OVERALL

To summarise this report and its recommendations, our key message is that Stay Well@Home could better establish its true value by refocusing its own evaluative methods on areas such as Patient Reported Outcomes and workforce culture change. Though it will still need to focus on health service activity statistics (such as A&E admissions and length of stay) the real value in integrated care programmes such as Stay Well@Home is often to be found in the impact on patients and the culture change within staff perceptions that can occur as a result of the move towards a different way of working. We have made recommendations as described above on how we feel Stay Well@Home can make such improvements.

We see a number of challenges facing the region as it moves forward its desire to arrive at a comprehensive approach to prevention, namely to:

1. Ensure that there is continued understanding of, and commitment to, the fundamental principles enshrined in the SSWB Act at all levels across the agencies, and that knowledge about the different services in place to meet these principles is shared widely and embedded in practice so that their impact is maximised.

2. Ensure the local authorities' domiciliary care services are sufficiently robust and sustainable to respond to the inevitable pressures caused by a shift to a more community-based approach.

3. Consider how the community-based model can be applied across all adult user groups, not just older people.

4. Transfer the learning from the first phase of Stay Well@Home to the second phase and beyond.

5. Continue exploring ways of establishing core, sustainable joint funding for preventative initiatives like Stay Well@Home alongside future opportunities for grant funding.

6. Ensure that partnership working occurs at all levels across the organisations including, for example, reviewing the cost implications of Stay Well@Home.

7. Develop a holistic, and possibly longitudinal, means of evaluating the success and impact of Stay Well@Home and other preventative services which include, for example, measuring changes in organisational culture, well-being outcomes and enhancements in people's ability to exercise voice and control over their care.

8. Ensure that there are suitable resources available to implement the tools that are suggested in this report in order to further develop integrated working.

We recognise the difficulties some of these challenges present but feel that an early joint declared intent to meeting them would achieve the additional benefit of clarifying the region's commitment to the preventative approach and transforming ways of working.

TRANSFORMATION MATRIX

We have produced a transformation matrix for Stay Well@Home. This could act as a framework for a qualitative assessment to be made of progress from more transactional to more transformational forms of service delivery for Stay Well@Home. This relates to the cultural change element of the recommendations. The matrix addresses three key areas: service delivery; staff and value-based care. Within these areas, there are 12 different dimensions. These cells are then to be plotted against a scale of descriptors, which range from transactional approaches all the way to transformational approaches. The matrix is designed so that the Stay Well@Home team can determine which of the cells in the matrix best describes their progress to date against the 12 different dimensions within the three domains of service delivery, staff and value-based care. It is intended that progress could be compared over time from the more transactional to the more transformational forms of delivery.

The transformation matrix could be deployed variously with different audiences. There should, of course, be one composite matrix that is completed for Stay Well@Home as a whole, but this single matrix can be an amalgamation of a number of different matrices that have been completed by operational teams, managers, and others either in combination. It is crucial though that having established an approach, the same method is repeated the next time the matrix comes to be

completed to ensure comparability over time. It is useful also to reflect on the purpose for completing the matrix – whether it is for reporting, for evaluation, or for learning. These are not mutually exclusive of course, but it is worth being clear for those completing the matrix as to the purpose.

CHAPTER 1 – INTRODUCTION, METHODS AND CONTEXT

The Welsh Institute for Health and Social Care (WIHSC) was commissioned by the Stay Well@Home project group to conduct an evaluation of the Stay Well@Home Service. Stay Well at Home was created within the Cwm Taf Regional Partnership as a response to the vision for an integrated care model based on a Community@Home foundation and provision. It was also created in response to the winter of 2015/16, which saw a surge in A & E admissions in the region and resulted in Gold Command crisis management measures being introduced. The Stay Well@Home service obtained funding from the Integrated Care Fund (ICF) in July 2016.

This evaluation seeks to use an evidence based analysis, combined with qualitative interviews with key informants within the sector and region, to evaluate the Stay Well@Home service in the light of other integrated care services and the prevailing focus on integrated care across the UK. It uses evidence reviewing, gap analysis and qualitative interviews to analyse the Stay Well@Home service not only in light of existing evidence, but also of its own data collection methods, evaluation methods and benefits and impacts stated in the business case. By using this method of evaluation, this report aims to provide recommendations for future in-house evaluations of Stay Well@Home, practical ways of implementing these methods of data collection, and expand the understandings (based on the literature) of what integrated care services such as Stay Well@Home can realistically expect to achieve in terms of service provision, outcomes and data collection.

The report will outline the findings of the evaluation, which will be broken down into the following four sections:

- Literature review
- Gap analysis
- Reference to impacts and benefits in the business case
- Interviews

Following on from this, the last section provides detail regarding the recommendations of the report, which focus on the following four areas of Stay Well@Home: data linking; Patient Reported Health Outcomes (PROMs); cost implications; and culture change.

These areas will be analysed in detail, and compared against the literature and the business case proposed impacts and benefits. Our team of researchers will identify options and practicalities for implementing these recommendations, should the region decide to do so. These are not prescriptive recommendations; rather, they are drawn from the gap analysis, business case and literature review. It may be that at this point in time some of the recommendations will not be achievable, and may have to be considered for future iterations of the Stay Well@Home service. The report highlights which recommendations are considered essential to implement, and which are optional.

METHODS

The evaluation used a variety of research methods to collect information and form its recommendations. In many ways, the method of evaluation was a hybrid of the methods proposed in the original project evaluation tender, as well as a development on some of the proposed methods. The methods used in the evaluation are:

- Good practice literature review
- Gap analysis
- Assessment of outcomes to date against business plan
- Interviews with key informants

Good Practice Literature Review

This method sought to identify literature that reported on other integrated care projects that had similar aims or service models to Stay Well@Home: models that focused on using integrated care to reduce A & E admissions, length of stay, and readmission rates. Literature was identified via a variety of methods and sources (Boolean searching, think tanks such as Nuffield Trust and the Kings Fund, expert knowledge from the research team) and was then collected and collated into a table within which the quality of evidence, along with its fit to the Stay Well@Home service, was assessed. It is important to note here that the 'good practice' being researched was not service practice as much as it was data collection and evaluation practice: how were other integrated care services evaluating their own work, what metrics and measurements did they use, and how did this compare with Stay Well@Home?

Gap Analysis

The gap analysis took the metrics and methods of measurement and evaluation found in the literature review and separated them into a variety of categories. Those projects with high degrees of fit, and a high quality of evidence, were then placed into a table alongside Stay Well@Home and each metric and measurement was listed for each specific project. Stay Well@Home was given colour coded ratings for these categories – green meaning that the Stay Well@Home measurement is consistent with other services, amber meaning it could be improved, and red meaning it is missing or entirely inconsistent with the evidence.

Assessment of outcomes to date against business plan

Following on from the gap analysis, the evaluation looks at the ways in which Stay Well@Home is measuring outcomes and criteria against the project benefits and impacts set out in its business case. This part of the methods draws upon a variety of data sources, including – the business case benefits and impacts, the existing data collection resources and methods used by Stay Well@Home, and the good practice literature. These methods were synergized into a table, which identified the existence and robustness of the existing data collection methods against specific criteria set out in the business case. The feasibility and practical implications of collecting data against criteria that were not (or could not) be measured was then considered. This method and the data collected

through using it then informed the evaluation recommendations, presented in the conclusions section of the report.

Interviews with key informants

Two members of the research team, Heulwen Blackmore and Tony Garthwaite, conducted qualitative interviews with key informants within the region and across a variety of roles. This method was used to gauge their opinions on how Stay Well@Home has developed, how it may have instigated change across acute care and community care, and how Stay Well@Home is meeting the requirements and principles of the Social Services and Well-Being (Wales) Act 2014. This qualitative element enables us to marry the data analysis conducted in the previous methods with rich, narrative detail around the progress of Stay Well@Home.

CONTEXT – REFLECTIONS ON STAY WELL@HOME'S JOURNEY

Ahead of the substance of the report, we felt it was important to reflect on the distance travelled for Stay Well@Home.

Stay Well@Home is an important component of Cwm Taf's regional approach to preventing the escalation of need for care and support. The need for such an approach, supported by a range of effective preventative services, is a key principle of the Social Services and Well-Being (Wales) Act and has since been reinforced by the Parliamentary Review of Health and Social Care which cited prevention as one its quadruple aims to transform health and social care in Wales. Understanding Stay Well@Home's contribution to achieving this transformation in the region is fundamental in evaluating its relevance and worth.

Prevention has been frequently described as an elusive concept to define in the context of health and social care. For example, the Code of Practice on Part 2 of the SSWB Act did not provide a definition nor did guidance on implementing the 2014 Care Act in England[1] which acknowledged that "there is no one definition for what constitutes preventative activity and this can range from wide-scale whole-population measures aimed at promoting health, to more targeted, individual interventions aimed at improving skills or functioning for one person or a particular group or lessening the impact of caring on a carer's health and wellbeing." Some researchers[2] have commented that "prevention and independence will have a messy, contested and occasionally contradictory evidence base for some time."

There is, however, some common understanding that it is helpful to see prevention as a spectrum covering universal, secondary and tertiary levels, whereby activities and interventions take place along the care pathway and prior to people arriving at the front door of health and social care services. Cwm Taf's 2018 regional plan demonstrates commitment to the preventative approach and refers to achieving its aims by "building an integrated, co-ordinated approach to health and

[1] Department of Health and Social Care, 2018: *Care and Support Statutory Guidance*

[2] Research in Practice for Adults, 2015: *Reimagining Adult Social Care*

social care services (where they overlap) comprising 3 inter-related levels: Community, Universal and Prevention Services: Early Intervention and Reablement; and Specialist and Substitute."[3]

Effective prevention means having service responses in place along the care pathway and across the whole prevention spectrum. Stay Well@Home plays a specific role in this respect by intervening at a stage where people are entering the hospital environment via A&E, leading potentially to admission. It therefore clearly contributes to the prevention of unnecessary hospital admissions but its overall contribution to the prevention agenda needs to be considered more widely and measured alongside other interventions along the care pathway, the latter being outside the scope of this study. In practice, a holistic approach to prevention means having in place a good range and level of universal services and opportunities to intervene prior to referrals to Stay Well@Home, i.e. a robust community based approach that makes the most of the potential offered by all sources including the independent and third sectors. Our understanding is that the next phase of Stay Well@Home will play a significant role in achieving this.

It is useful to consider how the region would be placed to meet its aims if Stay Well@Home were to be removed from its range of services. There would be an obvious gap in preventative services along the prevention spectrum and care pathway which would need to be plugged via other means. These other means are not obviously available. Moreover, the potential effectiveness of the next phase of implementation of the care at home strategy would be diluted or even lost as the continuum of approach would be interrupted.

In this context, Stay Well@Home should be viewed much more than a stand-alone service. As stated earlier, it is an important component of the region's approach to prevention and also represents a different way of working across the agencies, thereby being a demonstrable part of another key principle and aim, namely the need for integrated health and social care. Whilst any evaluation of its effectiveness should clearly examine specific performance against defined targets, it should also take into account its position in achieving wider strategic aims and objectives, notably its contribution to achieving culture change within the agencies, meeting long-term aspirations of legislation and transforming the ways health and social care services are delivered.

[3] *Cwm Taf Regional Plan* 2018

CHAPTER 2 – EVALUATION FINDINGS

GOOD PRACTICE LITERATURE REVIEW

The first part of the project was to identify literature and evidence that would give an idea as to the best practice for data collecting and evaluating integrated care services and programmes akin to Stay Well@Home. The following methods were used to conduct literature searches:

- Boolean searching of databases, including Pubmed, Cinahl, the Cochrane Library, Trip and Medline;
- Searching of relevant think tanks and evidence repositories e.g. Nuffield Trust, Kings Fund, Social Care Institute for Excellence;
- Searching of academic journals e.g. British Medical Journal, the Journal of Integrated Care; and
- Snowballing references from known interventions and literature, e.g. the Gwent Frailty Project.

Through these methods, a variety of literature was found and analysed in different ways. We considered:

- The degree of fit to the Stay Well@Home service
- The quality of the evidence presented
- The metrics used by the service or paper to measure and evaluate – quantitative, qualitative, outcome based, service based, etc.
- Location of the integrated care service in question

Literature Table

The table overleaf collects the literature under four categories:

- Higher quality of evidence, higher degree of fit
- Higher quality of evidence, lower degree of fit
- Lower quality of evidence, higher degree of fit
- Lower quality of evidence, lower degree of fit

When considering the quality of the evidence, we considered the type of publication (peer reviewed journal article, research report or evaluation, editorial or opinion piece) as well as the sample size and methods used. In terms of degree of fit, we were primarily concentrating on integrated care programmes as being the highest degree of fit, and within that we then looked at those services that focused on older people, health service activity (e.g. readmission rates) and location (primarily UK based, though not exclusively). The results are presented in the table below:

Higher quality of evidence, lower degree of fit	Higher quality of evidence, higher degree of fit
1. Mahmoud, A. (2016) "Scottish Patients at Risk of Readmission and Admission – SPARRA." 2. Kayleigh et al. (2018) "The Development of a Collaborative Framework for Commissioning Health and Social Care." 3. Local Government Association (2015) "Prevention: A Shared Commitment." 4. Dobrzanska, L. & Newell, R. (2005) "Readmissions: a primary care examination of reasons for readmission of older people and possible readmission risk factors." 5. Coleman, E. (2004) "Preparing Patients and Caregivers to Participate in Care Delivered Across Settings: The Care Transitions Intervention." 6. Brown, C.L. & Menec, V. (2018) "Health, Social, and Functional Characteristics of Older Adults With Continuing Care Needs: Implications for Integrated Care." 7. Humphries, R. (2015) "Integrated Health and Social Care in England – Progress and Prospects." 8. Hogan, KA, Burnett, S, Roberts, S. (2017) 'Help me get home safely: preventing medically unnecessary hospitalizations' (CANADA) 9. British Red Cross 'Prevention in Action: How Prevention and Integration are being understood and prioritised locally in England'.	1. Nuffield Trust (2013) "Evaluating integrated and community-based care." 2. Personal Social Services Research Unit (2009) 'The National Evaluation of Partnership for Old People Projects." 3. Cordis Bright (2015) "Gwent Frailty Programme Review." 4. Wallace, E., Smith, S.M., Fahey, T. and Roland, M. (2016) "Reducing emergency admissions through community based interventions." 5. "Southwark and Lambeth Integrated Care Report." (2016) 6. Thomas Round et al (2018) "An integrated care programme in London: qualitative evaluation". 7. Mayhew, L. (2008) "On the Effectiveness of Care Co-Ordination Services Aimed at Preventing Hospital Admissions and Emergency Attendees." 8. Curry N et al. (2013) "Integrated care pilot in North West London: a mixed methods evaluation." 9. The Kings Fund (2011) "Integrated Care" 10. National Audit Office (2017) "Health and Social Care Integration." 11. Marie Curie Nursing Unit for End of Life. 12. Holmas, T.H, Islam, M.K, and Kjerstad, E. (2012) "Interdependency between social care and hospital care: the case of hospital length of stay." 13. Rowe, J. et al (2016) in "The Ambulatory Integration of the Medical and Social (AIMS) model: A retrospective evaluation." (USA) 14. Glasby et al (2008) 'Older People and the Relationship Between Hospital Services and Intermediate Care: Results from a National Evaluation' 15. Aldeen A.Z et al (2014) "Geriatric emergency department innovations: preliminary data for the geriatric nurse liaison model" 16. Baker, A. et al (2012) 'Anticipatory care planning and integration: a primary care pilot study aimed at reducing unplanned hospitalisation' 17. Walvaren, C.V. et al (2010) 'Derivation and validation of an index to predict early death or unplanned readmission after discharge from hospital to the community' 18. Gravelle, H. (2008) 'Impact of case management (Evercare) on frail elderly patients: controlled before and after analysis of quantitative outcome data'. 19. Oliver, D. (2014) 'Making our health and care systems fit for an ageing population'. 20. NHS Confederation and Royal College of General Practitioners (2013). 'Making integrated out-of-hospital care a reality.' 21. NHS Benchmarking Network. (2015) "National Audit of Intermediate Care Summary Report."
Lower quality of evidence, lower degree of fit	**Lower quality of evidence, higher degree of fit**
1. Goddard, M. & Mason, A. (2017) "Integrated Care: A Pill for All Ills?" 2. Winfield, A. & Burns, E. (2016) "Let's all get home safely: a commentary on NICE and SCIE guidelines (NG27) transition between inpatient hospital settings and community or care home settings"	1. Themessl-Huber, M. et al (2007) "Frail older people's experiences and use of health and social care services"

Thirty-three pieces of literature and evidence were considered for the evaluation at this stage. Though there was a variety of literature on the impact of A & E admissions for elderly people, this was not always in the context of integrated care, and so this element of the literature search was refined to include those projects and papers that spoke to integrated care in some way.

Health Service Measurements and Quantitative Metrics

We were interested in projects and evaluations that used quantitative metrics, based on health service activity, to measure and evaluate integrated care programme. The reason we focused on these elements was because the Stay Well@Home programme cited a variety of statistics as evaluative metrics in its business case and in its own reporting. In Stay Well@Home's own 12-month evaluation report, the overarching measures of success are cited as being:

- % reduction in people admitted to a hospital bed from A&E (data available for age 61 - 74 and 75+)
- % increase in numbers admitted but returning home earlier (data available for 0,1-2, 3-4 and 5 days plus, split by age group)
- % reduction for those transferred to a community hospital" (Stay Well@Home interim report)

As indicated, these performance measures focus on quantitative, statistical metrics surrounding health service activity – length of stay, and entrance into community care. We therefore focused much of the evidence searching on projects that used the same or similar metrics to measure performance – length of stay, admission and re-admission rates to A & E, and delayed transfer of care statistics. Underneath the focus on these statistics was an understanding within many of the integrated care programme that by reducing these factors there would be a benefit to individual patients and potentially an impact on resources and finances within the health service.

The findings of the literature on these statistical measures were varied. Many of the integrated care programme and evaluations foregrounded quantitative measures on health service activity as a way of evaluating the effectiveness of their programme. There are multiple reasons for this – primarily, the reason for focusing on statistical measures such as this as a performance measure is that they are easily measurable and point to identifiable, 'hard' impacts that a service may be having. Of course, the issue of causality comes into play – if A & E admissions are reduced, how do we know that this is because of the integrated care programme alone? Quantitative measures rarely give us the 'why', but they can give us a picture of *what* is happening within a specific timeframe, demographic and service.

The literature reviewed offers a variety of findings on these kinds of health service measurements in respect of integrated care. One of the key pieces of evidence used in this evaluation has been the Nuffield Trust's 'Evaluating Integrated and Community Based Care' report from 2013. This comprehensive report evaluated integrated care programmes over 30 different sites, and focuses on claims that integrated care programmes can produce cost savings or have an impact on admissions rates and other health service measures. The researchers found little in the way of evidence in the programmes they evaluated to support these notions. They state that:

"The service models evaluated to date generally appear not to be associated with reductions in emergency hospital admissions (Purdy, 2010; Purdy and others, 2012). This has also been the conclusion of others with respect to community models of care for frail older people (for example D'Souza and Guptha, 2013)" (Nuffield Trust, 2013)

The Nuffield Evaluation notes three major problems that contribute to this inability to achieve these quantitative service indicators. They are:

- *"Faults in problem theory: the programme is built upon a faulty understanding of the social processes that give rise to the problem to which the social programme is ostensibly addressed.*
- *Faults in programme theory: the programme is built upon a faulty understanding of how to translate problem theory into specific programme.*
- *Faults in programme implementation: there are faults in the organisations, resources levels and/or activities that are used to deliver the programme to its intended beneficiaries." (Nuffield Trust, 2013)*

However, there were other integrated care programme found in the literature that did present successful reductions in some of these quantitative health measures. One of these was the Southwark and Lambeth Integrated Care Programme. They noted that:

"During the period of SLIC (2012–2016), despite the population of Lambeth and Southwark aged 65 years and over growing by 5%, hospital admissions and bed days were stabilised and residential and nursing home placements were reduced." (Southwark and Lambeth Integrated Care Programme report, 2016)

Southwark and Lambeth were able to provide evidence of integrated care having an impact on quantitative health service measures, specifically a stabilization of bed days and a decrease in residential and nursing home placements. However, they were not able to demonstrate a reduction in A & E admissions or re-admissions, length of stay or costs.

Overall, the findings from the evidence were that integrated care programmes frequently assumed they could impact these quantitative service metrics at their inception and in their funding proposals. However, the overwhelming evidence was that it was difficult for integrated care programme to significantly reduce certain measures, such as A & E admissions, or cost. However, many of the reports and evaluations cited here note that this does not mean these programme were not successful. Rather, the evidence clearly states that reframing the parameters for success in respect of integrated care was necessary. Much of the impact from these programmes came from a change in culture across integrated care or impact on the experiences of patients and beneficiaries. These elements will be explored in the next section.

Parameters for Success in Integrated Care Programmes

As noted above, the sense from the evidence collected is that it can be difficult for integrated care programmes to obtain impact across quantitative health service indicators. Many integrated care programmes highlight metrics around emergency admissions, hospital use and cost as these are seen to be reliable and presentable indications of impact. However, the evidence suggests that perhaps the best way to implement and evaluate integrated care programmes, particularly those in their infancy, is to use different parameters for success. These parameters would focus on culture change across hospital and community care settings, and patient experiences of health and care treatment and settings. The Nuffield Evaluation suggests that:

> *"While an avoidable emergency admission is clearly undesirable for patients (and taxpayers) there are also many other legitimate outcome indicators that might be used. These include changes in clinical markers of health (such as control of HbA1c in people with diabetes), patient-reported health status or care experiences, and staff perceptions. These markers of success may be achieved earlier than the desired change in hospital use" (Nuffield Trust, 2013).*

These other legitimate outcome indicators may be better indicators of progress and success for integrated care programmes, particularly as they may be evidenced sooner than the harder metrics mentioned earlier.

Similarly, the Southwark and Lambeth Integrated Care programme highlighted staff perceptions and care experiences as part of the successes of the programme in their report. They list the following areas as successes in their report:

- *"Vision: partners in the care system united to achieve a common goal of integrating care across health and social care."*
- *"Relationships – enhanced trust and communication between partners led to improved relationships between partners." (Southwark and Lambeth Integrated Care programme, 2016)*

As we can see, these successes tie in to the areas of staff perception and culture change highlighted by the Nuffield Evaluation and in the evidence in general. We see a similar change in emphasis from the Round et al article, which qualitatively evaluated an integrated care programme in London. They state that:

> *"The integrated care project had not delivered expected radical reductions in hospital or nursing home utilization. In response, the scheme was reformulated to focus on feasible service integration. Other benefits emerged, particularly system transformation." (Round et al, 2018)*

Here again, we see a journey from the initial focus on reductions in hospital utilisation to a focus on service integration and system transformation. It would appear from the literature that many of the integrated care programmes featured in the evidence had a similar journey and came to similar realisations: the benefits of integrated care programmes may not be in their capacity to impact health service activity measures, and hospital utilizations, but rather in creating culture change, changing staff perceptions and improving patient experiences.

As a caveat, it should be noted here that we did not find evidence of randomized control trial (RCT) studies on integrated care programmes. A study of this kind may give longitudinal information on patient experiences across a variety of settings, and may give granular detail on the potential (if any) for integrated care programmes to provide cost savings. It may be that the sheer complexity and expense involved in conducting an RCT study of this kind have contributed to a lack of this type of evidence on integrated care.

From this stage of the project, the literature was analysed and a variety of evaluation measurements were derived from across the literature. These were then collated into a table for the Gap Analysis, which is presented in the next findings section.

GAP ANALYSIS

The gap analysis funnels the literature and evidence collected in the literature review down into the evidence that fits most directly with Stay Well@Home. This analysis then highlights the variety of ways that integrated care programme and evaluations have been measuring programme performance. They are separated into four distinct areas:

- Health Service Activity
- Descriptive Sources
- Finance
- Patient Reported

These metrics cover quantitative measures, qualitative methods, data-linkage and patient reported outcomes and experiences. We then developed a table covering this gap analysis and positioned Stay Well@Home within the table to give an indication as to how it compares to these other programmes in terms of its performance measures and recording techniques. It has also been given a colour-coded rating: green means this measure is consistent with other programme, amber means it could potentially be improved, and red means it is missing or entirely inconsistent with the evidence. The table is presented overleaf.

As indicated in the gap analysis, there is a range of areas where Stay Well@Home is measuring the criteria in a consistent way with the integrated care services assessed in the literature. There are four identified gaps in Stay Well@Home's data collection methods:

1. Health Service Activity

In the area of Health Service Activity, which primarily focuses on quantitative measurements, we can see that Stay Well@Home has been coded green for:

- Measurements of Length of Stay/Bed Days/Delayed Transfer of Care
- Readmissions reductions
- A & E admissions reductions

Name of Project/Evaluation	Health Service Activity					Descriptive Sources		Finance	Patient Reported	
	Length of Stay	Readmissions reduction	Reduction in planned admissions/ outpatient attendances	Case control matching/ Data linking	A&E Admissions reductions	Qualitative Evidence/ Surveys	Culture change	Cost Savings	Patient Reported Experience Measure (PREMs)	Patient Reported Outcomes Measures (PROMs)
1. Nuffield Trust (2013)	✓	✓	✓	✓	✓	✓	✓	✓	✓	
2. Cordis Bright (2015)	✓	✓				✓	✓	✓	✓	
3. Wallace, E.,et al. (2016)					✓					
4. Southwark/Lambeth Integrated Care (2016)	✓	✓					✓		✓	
5. Thomas Round et al (2018)						✓	✓		✓	
6. Mayhew, L. (2008)	✓	✓			✓					
7. Curry N et al. (2013)						✓	✓			
8. The Kings Fund (2011)	✓	✓			✓					
9. National Audit Office (2017)	✓	✓	✓		✓			✓		
10. Oliver, D. et al (2014)	✓				✓					
11. Gravell, H. (2008)	✓	✓			✓					
12. Rowe, J. et al (2016)		✓			✓					
13. Aldeen A.Z (2014)		✓	✓		✓					
14. Holmas, T.H et al. (2012)	✓			✓						
15. NHS Benchmarking Network. (2015)						✓			✓	
16. NHS Confederation and RCGP (2013).						✓				
17. Glasby et al (2008)										
18. PSSRU (2009)						✓			✓	
19. Themessl-Huber, M. et al. (2007)							✓			✓
20. Baker, A. et al (2012)				✓	✓					
21. Walvaren, C.V. et al (2010)	✓	✓				✓				
STAY WELL@HOME	✓	✓	N/A		✓	✓		✓	✓	

However, in the category of Health Service Activity, there is one criterion for which Stay Well@Home has scored red, namely data linking.

This method of data collection, which allows for services to collect data on individuals longitudinally, did not feature significantly in the literature assessed for this evaluation. This may be due to the complexity of collecting such data, as well as the potential expense involved in designing or using systems that can achieve this aim. There is also the issue around collecting data on individuals over a variety of different services, in different sectors: this could encompass acute and secondary settings, primary settings, social services and community care. However, to see the long-term effects of integrated care programmes, linked data methods would be necessary to assess longitudinal impacts. Indeed, the Nuffield Trust, in their evaluation of integrated care programmes,[4] recommends the use of linked data sets in order to properly evaluate integrated care services:

> *"Exploit the potential of linked data sets, including greater use of GP data to develop cohort-based techniques for tracking the care of individuals with long-term conditions that include analysis of the quality of care, as well as estimated cost and service use."*

2. Descriptive Sources

In terms of this category of the gap analysis, Stay Well@Home has been given one green code, for Qualitative Evidence/Surveys (as Stay Well@Home does conduct service satisfaction surveys with those who use the service) and one red code, for culture change. This is a difficult criterion to track; however, it may be important to see the ways in which integrated care services affect the culture across the sectors involved.

The importance of culture change in integrated care programmes is highlighted by this quote from the Southwark and Lambeth Integrated Care Programme[5]:

> *"To succeed required more than just 'joining up' services: the partnership knew it would need to bring about a fundamental culture change, radically redesigning models of care and commissioning approaches, and breaking down silos." (Southwark and Lambeth Integrated Care, 2016)*

However, this report also notes the difficulties in measuring this nebulous, subjective quality: "*While SLIC brought about positive change, it was not an easy process and mistakes were made, including a lack of engagement and no systematic measurement." (Southwark and Lambeth Integrated Care, 2016)*

The report did not identify one key model for measuring culture change. Rather, it would appear that measuring workforce culture change involves using adaptive qualitative methods, such as

[4] Nuffield Trust (2013) *Evaluating Integrated and Community Based Care,* available online https://www.nuffieldtrust.org.uk/files/2017-01/evaluating-integrated-community-care-web-final.pdf

[5] Southwark and Lambeth Integrated Care (2016) 'Integrating Care in Southwark and Lambeth: What we did and how we did it' available online https://www.kingshealthpartners.org/assets/000/000/690/FINAL_Full_End_of_SLIC_Report_original.pdf

interviews and/or surveys, to gain a sense of the workforce perceptions of integrated care over a variety of time points.

3. Patient Reported

Here, Stay Well@Home scores a red, as it does not use PROMs in its service so far. However, it is important to note that only one piece of literature included in the gap analysis measured patient reported statistics, and even then, did not use PROMs, but rather qualitative surveys assessing health-related quality of life. However, PROMs could be a useful measure to gain access to the patient perspective on Stay Well@Home, and the recommendation section goes into further detail on the existing PROM tools available that Stay Well@Home could consider using.

4. Finance

Stay Well@Home is given an amber rating in relation to cost savings. This is a contentious and ambiguous category. The literature illustrated that many integrated care programmes posited that they would achieve cost savings through integrated care. In this sense, Stay Well@Home *was* consistent with much of the literature, as it attempts to measure cost savings through bed days saved (though, importantly, it does not include cost savings as a criterion in its business case).

The overwhelming sense from the literature, however, was that there is no evidence to support the notion that integrated care programmes provide cost savings. Though many services akin to Stay Well@Home often acquire funding or support via the notion of potential cost savings, the clear message from the research was that once evaluated, cost savings were not found. This was evident in the Gwent Frailty project, the Southwark and Lambeth Integrated Care Service, and the projects evaluated by the Nuffield Trust and Kings Fund.

Therefore, the amber rating highlights the fact that though consistent with the literature in attempting to measure cost savings, Stay Well@Home faces the same dilemma as the other integrated care projects evidenced in this report; that is, attempting to measure costs savings may be necessary, but suggesting that integrated care programmes can produce cost savings may be erroneous. Cost implications are discussed in more detail in the recommendations section of the report.

ASSESSMENT OF OUTCOMES TO DATE AGAINST BUSINESS PLAN

This final section of the findings uses the Project Benefits and Impact table included in Stay Well@Home's business case as a way of considering the kinds of benefits and impacts that Stay Well@Home are measuring, in comparison with the existing literature detailed in this document.

The table overleaf shows three means of assessing this:

- Do other projects measure this?
- Feasibility of Stay Well@Home measuring this?
- How can Stay Well@Home measure this?

Criteria from the Stay Well@Home Business Case	Do other projects measure this?	Feasibility of SW@H measuring this?	If so, how can SW@H evidence this?
To provide benefits to the individual			
1. To improve the experience of people using both health and social care services	✓ Qualitatively / Time-bound	Feasible	PROMs/PREMs/ Surveys or Qualitative methods
2. People and their carers are better supported to live independently and avoid reliance on long term community service (LINKED TO 15 + 18 + 21)	✓ Poor baselines / Not longitudinal	Challenging	Linked data methods using existing databases e.g. SAIL
3. People receive the right service at the right time in the right place	✓ Qualitative / partial	Challenging	Triangulated qualitative methods
4. People avoid being admitted or readmitted to hospital and return to their home where their needs can be met in the community	✓✓ Quantitative	Feasible	Use existing SW@H data collection methods
5. People are supported to return safely home from hospital earlier to reduce lengthy hospital stays and the risk of further complications and deterioration (e.g., hospital acquired infections and falls). Prevent likelihood of reduced mobility and dependence (LINK TO 11 & 14)	✓✓ Quantitative	Feasible	Use existing SW@H data collection methods
6. People will experience less repeat assessments and be supported by joined up services	✓ Social care data / qualitative	Feasible	Use existing assessment measures
7. People are not admitted to residential/nursing care straight from an acute hospital following a period of ill health. (LINK TO 16)	NOT FOUND		
Benefits to the University Health Board			
8. Percentage reduction in unscheduled hospital admissions per day/month	✓ Quantitative	Feasible	Use existing SW@H data collection methods
9. Percentage reduction in the number of people who re-present to A&E within 30 days	✓✓ Quantitative	Feasible	Use existing SW@H data collection methods
10. Percentage increase in the number of people who avoided admission or are discharged within 24 hours of first attended	✓✓ Quantitative	Feasible	Use existing SW@H data collection methods
11. Improved flow through to hospital settings (LINK TO 5 AND 14)	✓✓ Quantitative	Feasible	Use existing SW@H data collection methods
12. Reduction in transfer to community hospitals	NOT FOUND		

Criteria from the Stay Well@Home Business Case	Do other projects measure this?	Feasibility of SW@H measuring this?	If so, how can SW@H evidence this?
Benefits to the Local Authority			
13. Reduction in individual dependency on long term services (LINK TO 25)	X Not longitudinal / lack of linked data	Challenging	Linked data methods using existing databases e.g. SAIL
14. Improved flow through hospital to community settings (LINK TO 5 AND 11)	✓✓ Quantitative / qualitative	Feasible	Use existing SW@H data collection methods
15. Most efficient use of Social Work Resource (right place, right time) (LINK TO 3, 18 AND 21)	✓ Co-location / culture change	Feasible	Qualitative methods
16. People are not admitted to residential/nursing home from acute hospital (LINK TO 7)	NOT FOUND		
17. Reduced occasions for crisis management relating to Gold Command (LINK TO 24)	NOT FOUND		
Benefits to Both Organisations			
18. Provides a foundation for the future development of a single point of access for health & social care services. (LINK TO 3, 15, 20)	✓ Qualitative / partial	Feasible	Qualitative methods
19. New roles/ opportunities to meet the Welsh Government vision for the integration of health, social care and third sector services. (LINK TO 23)	✓ Welsh evidence from ICF / other studies	Feasible	Qualitative methods
20. To increase the capacity and resilience of community response services	✓	Feasible	Qualitative methods
21. The resources required supporting individuals in both hospital and community settings are allocated at the appropriate time to maximise the efficiency and efficacy of the resource. (LINK TO 3, 15 AND 18)	✓	Challenging	Triangulated qualitative methods
22. The longer-term outcome of the percentage increase in the number of people going home with support rather than moving to a nursing/residential care from a hospital setting.	X Not longitudinal	Challenging	Linked data methods using existing databases e.g. SAIL
23. To improve the interfaces and reduce the gaps between health, social care and third sector services (LINK TO 19)	✓ Qualitative / culture change	Feasible	Qualitative methods
24. Better system management during periods of high demand and escalation (LINK TO 17)	NOT FOUND		
25. Reduce dependence on long term care (LINK TO 13)	X Not longitudinal / lack of linked data	Challenging	Linked data methods

The colour coding system continues in this table, with those rows coloured dark green being highly consistent and robust existing measurements, those coloured light green being slightly less robust, and those coloured red missing or inconsistent. This is also complemented by the ticks included in the boxes: those boxes with two ticks means that this evidence is robust, those with one tick mean this evidence is slightly less robust, and those with an X means this evidence is missing from the literature collected so far. Brief summary explanations have been included in many of the boxes as to the kinds of evidence collected, or why certain kinds of evidence might be missing. Those boxes that say 'NOT FOUND' mean that we have not seen this measured in the evidence collected.

The table above suggests that Stay Well@Home is correctly measuring many of the criteria set out in its business case, particularly those quantitative, statistical elements that centre on health service activity. For the rows marked red, we can see that these match up with the gap analysis from the previous section: these criteria would need to be measured via data linking, culture change or PROMs. These findings allow us to further hone in on the gaps in Stay Well@Home's data collection and evaluation methods, and present recommendations as to which gaps in the data collection could be filled, along with practical suggestions as to how this may be achieved.

INTERVIEWS WITH KEY INFORMANTS

A small but significantly important number of key informants were interviewed as part of the project. The aim of the interviews was to take high-level soundings from them about how far Stay Well@Home was in line with the principles of the SS&WB (Wales) Act 2014.

The interviews focused on key principles of the Act, which are integral to supporting people to stay well at home. These are well-being, prevention and early intervention, voice and control, co-production and integration and partnership working. Each area is described briefly below, highlighting the key messages that emerged.

Well-being

The concept of well-being was developed as part of the policy and legislation for the SSWBA and takes on a broader meaning, acknowledging the wider well-being of people and the contributions played by social services, but going well beyond that to the contributions played by the wider public sector, the third sector and people themselves and their families, carers, friends and communities.

The interviews highlighted the fact that Stay Well@Home is enabling people to stay at home where previously they would have been admitted to hospital from A&E, which is a positive outcome for frail, elderly people. There is believed to be a shared understanding of well-being but there is further to go in embedding the wider concept of well-being across the whole of Cwm Taf. Culture change was identified as key to success, with a level of change identified, but an acknowledgement that this required ongoing investment.

Prevention and early intervention

Prevention and early intervention is central to meeting the objectives of the Act, focusing on getting things right first time, working together much more effectively, cutting out wasteful practices and listening to people themselves, building on their strengths and assets. Getting in early and getting it

right first time is regarded as being better for people and services and was the thinking behind this significant approach.

The interviewees identified prevention and early intervention as fundamental to the Stay Well@Home work, and noted that it is preventing the escalation of need. Phase 2 will be critical to ensure there is a whole system approach to early intervention and prevention, ensuring that there are appropriate levels of support in primary care and within community resources.

In terms of sustainability, additional investment was identified as being needed in the community, where resources are stretched at present. Primary care will need to play a significant role for NHS A&E staff and others to feel more confident about people staying well at home. There is significant pressure on domiciliary care and unpaid carers at present which Stay Well@Home phase 2 should address to ensure sustainability.

The links to the @Home service are important. Capacity & consistency issues were identified, i.e. the challenge of changing staff within a hospital setting where there are agency arrangements in place. This is being tackled by working proactively to ensure all staff are clear about the desired outcomes of Stay Well@Home. A level of confidence has been built which provides a platform for extending this approach out into the community.

Voice and control

Voice and control is a key tenet of the SSWBA, including the "what matters" conversation. The focus is on putting the individual child or adult at the centre of his or her own care and support. They should be enabled to have control to reach the outcomes that help them achieve well-being across all aspects of their lives.

From the limited interviews we conducted, we identified a commitment to putting people at the centre and an understanding of the "what matters" conversation.

Co-production

The Act introduces the concept of co-production in respect of care and support. In the context of Stay Well@Home, this is about working together with people who need care and support, carers and across agencies to identify how needs will be met, working from an asset based position. We found some evidence of a commitment to co-production and were provided with case studies evidencing the co-productive approach. It was acknowledged that co=production will need time to be embedded as an approach across all services.

Integration and partnership working

The SSWBA has brought a fresh impetus to collaborative working through its statutory obligations for co-operation. It puts in place requirements for regional collaboration, and a legislative framework to enforce this if required amongst local authorities and between local authorities and health boards.

Stay Well@Home is firmly based on a multi-agency approach. Progress on effective partnership working was identified, as was a commitment to proactively seeking solutions where issues arose.

Having joint ward rounds and regular meetings facilitated effective communication and enhanced joint working. Specific pieces of work such as the medicines management and trusted assessor were cited as examples where challenges were worked through in partnership with positive outcomes. Evidence points to a higher level of maturity of the already existing partnership working, building confidence between partners. Further potential for shared resources was identified. There is potential for further integration between teams, consultants, primary care, therapies and the individual.

Summary

From the interviews, we found evidence that:

- Stay Well@Home is meeting the principles of the SS&WB (Wales) Act 2014.
- Managers and staff of the Stay Well@Home initiative are committed to adopting new ways of working and there is evidence that confidence about this approach has been built. Continuing development is needed in respect of education and learning for staff. This will help to contribute to the culture change needed to make sure that people are not inappropriately admitted to or overstay in hospital.
- The Stay Well@Home work has built a further level of maturity into the already existing partnership working within Cwm Taf.
- There is some uncertainty about the long-term sustainability of Stay Well@Home, especially given that it is funded via ICF and that funding is time limited without certainty about future years. Commitment to Phase 2 would assist in demonstrating further belief in SW@H as a sustainable service model.
- Knowledge and information about Stay Well@Home needs to be shared and understood more widely amongst professionals. There are challenges given changing staff, and effective communication was highlighted as being crucial. Working together across boundaries supports shared understanding.
- There needs to be a clearer understanding and demonstrable belief by senior leaders of the value of a well-being and preventative approach. This means creating long-term service responses that do not necessarily result in immediate benefits, and links to the need to measure the success of Stay Well@Home and other preventative initiatives on a broad spectrum of criteria, both quantitative and qualitative. We refer to this in the Reflections section earlier in this report.

CHAPTER 3 – CONCLUSIONS AND RECOMMENDATIONS

This final section of the report focuses on the gaps in Stay Well@Home's data collection processes highlighted by the gap analysis and business case comparison. These gaps encompass four categories:

- Patient Reported Outcome Measures
- Culture change
- Data linking
- Cost implications

We have produced a table of recommendations for these four categories below. It outlines the strength of the area of recommendation, the strength of the recommendation (essential or optional) and the reason for it as well as the feasibility for implementation. We then go through each category individually, giving a specific example from the literature (where possible) as to how this has been measured by others. We then suggest a practical way that this gap could be addressed by Stay Well@Home and for the amber category (cost savings/cost implications), a possible rethinking of the prioritisation of this category in light of the evidence.

PATIENT REPORTED OUTCOME MEASURES

PROMs are not currently being collected by SW@H. We recommend their use, as they would enable data to be collected on criteria 1, 3 and 21 of the business case. These are:

- 1. To improve the experience of people using both health and social care services
- 2. People receive the right service at the right time in the right place
- 21. The resources required supporting individuals in both hospital and community settings are allocated at the appropriate time to maximise the efficiency and efficacy of the resource.

Examples from the literature

There were no examples in the integrated care literature of PROMS's being used. However, Themessl-Huber, M. et al (2007) do measure issues around health-related quality of life. They conducted semi-structured interviews to explore older people's views and experiences of services in different geographical areas, and of unscheduled hospital admissions. They note the importance of collecting this kind of data, stating that:

"It emerges that older people are the best qualified experts to give a holistic and longitudinal view of their health status and their health and social care experiences."

Potential for Stay Well@Home Implementation

Outcome measures are considered to be an essential component of any evaluation of quality, safety or effectiveness in both Health and Social Care. Recent legislation in Wales has produced a large number of potential Outcome Measures for the Stay Well@Home project. The Social Services and

Area	Type of recommendation	Explanation for the recommendation
Patient Report Outcome Measures	Essential	We strongly recommend that Stay Well@Home implement Patient Reported Outcome Measures to gather data from service users. We consider outcome measures to be an essential component of any evaluation of quality, safety or effectiveness in both health and social care. There are existing PROM tools available to services (such as the EQ5D) and we recommend as a starting point the PROMS Wales website (https://proms.nhs.wales/) which has existing PROM tools for services to utilise
Workforce culture change	Essential	We strongly recommend that Stay Well@Home measure workforce culture change, to reflect the changes in staff perceptions of integrated care. Qualitative methods, such as interviews or open-text surveys, could be used to measure this area, although there is no pre-existing 'template' from our review of the literature that could be implemented.
Data linking	Optional	Data linking is an optional recommendation for Stay Well@Home. We outline three potential options for implementation: a. Longitudinal data linkage over large sample size using existing database e.g. SAIL. This option is not recommended. b. Individual outcomes over different time points, e.g. 3 time points across 12 months. We suggest that this is adopted. c. Integrating data systems across health and social care and between the key organisations delivering Stay Well@Home. We recommend that serious consideration is given to this.
Cost implications	Maintain current practice – no need to make any changes to the *status quo*	In regard to measuring cost implications of Stay Well@Home, we recommend that SW@H continues its current practices and makes no changes in respect of how it currently collects data on cost implication for four reasons: a. Feasibility challenges associated with the complexity of the required methodology; b. There is no evidence that services like this deliver cost savings from the literature; c. Some of these concerns are mitigated by adopting a robust approach to PROMs; and d. Extant financial analyses are being undertaken by the health board.

Well-Being Act introduced outcome measures for populations not individuals. The National Health Service has 105 outcome measures in its Framework, many of which relate to the outcomes, experiences and feedback from individuals using NHS services.

The recommendations and tools agreed by the International Consortium on Health Outcomes Measurement are mentioned as the preferred source of outcome measures in *'A Healthier Wales"*, the recent Health and Social Care Strategy for Wales. The International Consortium for Health Outcomes Measurement has published a paper detailing their recommendations[6]. The Stay Well@Home team may wish to use these recommendations in their Outcome evaluations. These are summarised below. The recommended Health-Related Quality of Life Measure (HRQL) is the SF-36.

Outcome Measures for Older People were reviewed for NHS England in 2004[7]. Their findings can inform the Stay Well@Home team in their decision-making. The Welsh NHS now has an online outcomes questionnaire which is the EQ-5D in a menu-driven form. In terms of implementation, this PROMs Wales website (https://proms.nhs.wales/) would be a good starting point for Stay Well@Home. They have an existing PROMs survey set up that patients can log-in to and fill out. This resource could potentially assist with implementing PROMs for Stay Well@Home.

CULTURE CHANGE

This category speaks to the necessity of culture change in integrated care programme such as SW@H. Innovation and integration of health and social care services, as well as specific clinical practices and diagnosis, are changing in the face of integrated care priorities and projects.

Examples from the literature

Southwark and Lambeth Integrated Care Report. (2016) There are a number of examples of measuring culture change across the literature listed in this evaluation, however, Southwark and Lambeth was a particularly strong one. They describe this in their project aims: *"To succeed required more than just 'joining up' services: the partnership knew it would need to bring about a fundamental culture change, radically redesigning models of care and commissioning approaches, and breaking down silos."*

Potential for Stay Well@Home Implementation

To collect data on culture change across SW@H, qualitative methods would need to be used with staff across a variety of areas of SW@H. There would ideally be a reflective component to this, with long-term staff reflecting on the culture prior to SW@H, during SW@H and the present moment.

DATA LINKING

Data linking is not currently being conducted by SW@H. We recommend its use as it enables the collection of longitudinal data, which will enable the criteria in the business case that need

[6] https://bmcgeriatr.biomedcentral.com/track/pdf/10.1186/s12877-017-0701-3

[7] http://phi.uhce.ox.ac.uk/pdf/phig_older_people_report.pdf

longitudinal data and data linking processes to be collected. However, this is only an optional recommendation due to the feasibility issues surrounding this process.

Examples from the literature

Holmas et al. (2012) linked data from the Norwegian Patient Register with Local Authority variables. They then used the Quantile Regression technique to analyse the impact of social services on Length of Stay Data over two years (2007-2009). This enabled them to collect longitudinal data on this cohort.

The Nuffield Evaluation of Integrated Care (2013) recommends the use of data linking techniques when implementing integrated care programme. They recommend that integrated care programme: "*Exploit the potential of linked data sets, including greater use of GP data to develop cohort-based techniques for tracking the care of individuals with long-term conditions that include analysis of the quality of care, as well as estimated cost and service use."*

Potential for Stay Well@Home Implementation

There are three options for Stay Well@Home to use when it comes to data linking. Those are:

a. Large scale, longitudinal data linking across regional and national populations using existing NHS databases e.g. SAIL
b. Individual outcome measurements across different time points in a 12-month period, within Stay Well@Home and associated services
c. Integrating data systems across health and social care.

Of course, some of these are more feasible than others, and this kind of data linking would help to establish the ways in which Stay Well@Home impacts patients over a range of time points and services.

COST IMPLICATIONS

Many projects in the literature posited that integrated care would have implications for costs in some form or another for the health service. Many measured changes in costs across their projects; however, few if any were able to show a cost saving attributable to the implementation of integrated care. As noted in the table above, we are recommending that Stay Well@Home continue with the current model for measuring costs. However, to understand this recommendation, it is necessary to provide further explanation on issues of cost in integrated care, and why we feel Stay Well@Home does not need to make any changes in this area – but rather, reprioritise parameters for impact and success.

Feasibility Challenge

Firstly, the job of constructing an appropriate data collection method to accurately measure the cost implications provided by an integrated care programme like Stay Well@Home would be extremely expensive and complex. Stay Well@Home has previously been using the 'bed days saved' calculation to calculate the cost savings related to the project. However, this calculation does not

accurately represent reductions in costs. The release of existing staff time or existing bed-days (system capacity) creates very important improvements in the use made of existing (and expensive) resources. Either because the cost has been avoided (people are not admitted to hospital at all) or the cost has been minimised (the length of stay is as short as it possibly can be). It also has the secondary (and health economic) benefit of ensuring that other people waiting to utilise the resource tied up in the bed can access it as speedily as possible ensuring that their quality of life can potentially be improved more immediately. But this does not mean that it is a cost saving *per se*.

To accurately measure cost implications, therefore, would involve a complex experimental or controlled study, which could look at the ways in which the future benefits of integrated care programmes, e.g. the benefits felt in well-being, or capacity increase, might translate into cost savings when compared with another similar group. This kind of study would be expensive, complex and have to take place over a significant timeframe.

No Existing Evidence of Reductions in Costs

As already noted, there is no evidence from the literature analysed that integrated care programmes *can* produce cost savings although they can produce other key benefits and outcomes. Therefore, as well as the relatively unfeasible nature of running a study to evidence whether costs are actually saved or not (as described above), the evidence of other studies is that no such cost savings have hitherto been found.

The Nuffield Trust (2013) provides an interesting perspective concerning integrated care programmes and cost savings:

> *"The importance of reducing avoidable hospital costs means that it attracts a high degree of policy attention and profile. Indeed, a target of reducing admissions is often a prerequisite for funding and support for pilots. As a consequence, we have observed that these targets may be included in business cases even though they are not plausible. In some cases, those related to hospital costs might be related to the primary aims of the people developing and running the pilots, who may be more interested in health improvements or in the long-term strategy for transforming care. The result is that pilots comprise interventions that are more likely to influence outcomes other than admissions (at least in the short term), but are evaluated primarily in terms of impacts on admissions. It is generally easier to evaluate the impact of interventions on hospital use than other outcomes, as data are readily available."*

Mitigation by PROMs

A robust approach to measuring Patient Reported Outcome Measures will, to a degree, mitigate for the inability to evidence changes in costs attributable to Stay Well@Home. This is because PROMs will measure the impact of Stay Well@Home on patients and resources, potentially at different time points, and will also highlight the health and well-being impacts on patients that Stay Well@Home is contributing to.

Extant Financial Analysis

As noted in the resources and documents supplied by Stay Well@Home to WIHSC, the Director of Finance for Cwm Taf University Health Board has been reviewing the cost implications of the service.

Therefore, taking the overall four elements above as a whole, it becomes clear why we recommend strongly that Stay Well@Home continue with their current practices around cost. The only caveat to that is to state that perhaps a reprioritisation of cost (as necessary to measure, but not necessarily a key indicator of impact) may be helpful for Stay Well@Home in its future iterations.

SUMMARY

To summarise this report and its recommendations, our key message is that Stay Well@Home could better establish its true value by refocusing its own evaluative methods on areas such as Patient Reported Outcomes and workforce culture change. Though it will still need to focus on health service activity statistics (such as A&E admissions and length of stay) the real value in integrated care programmes such as Stay Well@Home is often to be found in the impact on patients and the culture change within staff perceptions that can occur as a result of the move towards a different way of working. We have made recommendations as described above on how we feel Stay Well@Home can make such improvements.

As stated earlier, Stay Well@Home contributes to the regions approach to prevention, as well as contributing to the strategic aims and objectives of the region and the SSWBA. Our view is that there is evidence that Stay Well@Home is playing a role in this regard and, along with other preventative services being developed along the care pathway, is likely to be an important ingredient of the region's plans for some time. As these other services come on stream, Stay Well@Home is likely to need to be modified to achieve the seamless approaches to care and support demanded by the Parliamentary Review but it appears to be, as some senior managers described it, clearly the "right thing to do", particularly in respect of enhancing people's well-being, giving them more voice and control over how their needs are met, and ensuring people work together to achieve the right outcomes for people.

We see a number of challenges facing the region as it moves forward its desire to arrive at a comprehensive approach to prevention, namely to:

1. Ensure that there is continued understanding of, and commitment to, the fundamental principles enshrined in the SSWB Act at all levels across the agencies, and that knowledge about the different services in place to meet these principles is shared widely and embedded in practice so that their impact is maximised.

2. Ensure the local authorities' domiciliary care services are sufficiently robust and sustainable to respond to the inevitable pressures caused by a shift to a more community-based approach.

3. Consider how the community-based model can be applied across all adult user groups, not just older people.

4. Transfer the learning from the first phase of Stay Well@Home to the second phase and beyond.

5. Continue exploring ways of establishing core, sustainable joint funding for preventative initiatives like Stay Well@Home alongside future opportunities for grant funding.

6. Ensure that partnership working occurs at all levels across the organisations including, for example, reviewing the cost implications of Stay Well@Home.

7. Develop a holistic, and possibly longitudinal, means of evaluating the success and impact of Stay Well@Home and other preventative services which include, for example, measuring changes in organisational culture, well-being outcomes and enhancements in people's ability to exercise voice and control over their care.

8. Ensure that there are suitable resources available to implement the tools that are suggested in this report in order to further develop integrated working.

We recognise the difficulties some of these challenges present but feel that an early joint declared intent to meeting them would achieve the additional benefit of clarifying the region's commitment to the preventative approach and transforming ways of working.

MOVING TOWARDS TRANSFORMATION

In closing, we provide a transformation matrix below which could act as a framework for a qualitative assessment to be made of progress from more transactional to more transformational forms of service delivery for Stay Well@Home. The matrix is designed so that the Stay Well@Home team can determine which of the cells in the matrix best describes their progress to date against the 12 different dimensions within the three domains of service delivery, staff and value-based care. It is intended that progress could be compared over time from the more transactional to the more transformational forms of delivery.

Whilst not wishing to be overly prescriptive about the way in which the matrix should be used and the frequency with which it is to be completed (at least annually we would suggest), it is important to note that it can be deployed variously with different audiences. There should, of course, be one composite matrix that is completed for Stay Well@Home as a whole, but this single matrix can be an amalgamation of a number of different matrices that have been completed by operational teams, managers, and others either in combination or completing it alone. It is crucial though that having established an approach, the same method is repeated the next time the matrix comes to be completed to ensure comparability over time. It is useful also to reflect on the purpose for completing the matrix – whether it is for reporting, for evaluation, or for learning. These are not mutually exclusive of course, but it is worth being clear for those completing the matrix as to the purpose.

STAY WELL AT HOME - TRANSFORMATION MATRIX

Domain	Descriptors – for each of the 12 dimensions below, which cell below best describes current progress? More transactional ⟷ More transformational				
1. SERVICE DELIVERY					
1.1 - Geographical location of service	In specialist secondary care centre	In DGH setting	In community hospital	In other community setting	No fixed setting
1.2 - Location of key worker	In specialist secondary care, available for referral	In secondary care, immediate access	In community hospital clinic	In General Practice setting	In community neighbourhood setting or at home
1.3 - Referrals	Referrals only from clinical staff	Direct referrals from primary care	Referrals from social care staff	Direct referrals from community agents	Direct referrals from person
1.4 - Counterfactual [what would have happened if SW@H didn't exist?]	Limited data providing understanding what would have happened in lieu of SW@H	Intermediate stage between limited data and 'good enough' data	'Good enough' data providing understanding what would have happened in lieu of SW@H	Intermediate stage between 'good enough' data and excellent data	Excellent data providing understanding on what would have happened in lieu of SW@H
2. STAFF					
2.1 - Training and support of integrated team members	Training organised separately by individual employing agencies	Training organised collectively by employing agencies	Training provided separately by each employing agency	Training provided jointly by all employing agencies	Working in multi-agency environment with mutual support
2.2 - Responsibilities of integrated team members	Within tightly defined parameters of competence	Within locally adjusted parameters of competence	Bespoke to the overall responsibilities of the team	Flexible between team members	Discretionary to meet needs of individual

Domain	Descriptors – for each of the 12 dimensions below, which cell below best describes current progress? More transactional ⟷ More transformational				
2.3 - Redeployed capacity of staff	Limited data indicating the staffing impacts of SW@H	Intermediate stage between limited data and 'good enough' data	'Good enough' data indicating the staffing impacts of SW@H	Intermediate stage between 'good enough' data and excellent data	Excellent data indicating the staffing impacts of SW@H
2.4 - Support and education for integrated team	No support or education provided	Incorporated into standard educational programme	Education and support provided (teaching only)	Education and support provided (incorporating feedback)	Education and support provided (incorporating audit and feedback)
3. VALUE-BASED CARE					
3.1 - Patient-reported outcome measures (PROMs)	Limited/no collection of PROMs	Ad-hoc PROMs data collected	PROMs data collected from one defined sample of patients	PROMs data collected from multiple samples of patients and used to improve service delivery	Validated tool, routinely collected, reported on, and used to improve service delivery
3.2 - Patient-reported experience measures (PREMs)	Limited/no collection of PREMs	Ad-hoc PREMs data collected	PREMs data collected from one defined sample of patients	PREMs data collected from multiple samples of patients and used to improve service delivery	Validated tool, routinely collected, reported on, and used to improve service delivery
3.3 - Engagement in service development [initial and ongoing]	Senior management	Service and team management	As previous, plus integrated team members	As previous, plus As previous, plus individual patients/service users groups	As previous, plus individual patients/service users
3.4 - Pathways	Strict compliance with prescriptive defined single pathway	Strict compliance with prescriptive defined multiple pathways	Discretion to move within defined pathway	Discretion to move within and outside defined pathway	An individual led pathway following 'what matters' conversations
TOTAL CELLS PER COLUMN Out of 12	**n=**	**n=**	**n=**	**n=**	**n=**

APPENDIX 1 - REFERENCES

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