EVALUATION REPORT

HOSPITAL AVOIDANCE RESPONSE TEAM

RoseRegeneration

Rose Regeneration
FOR AGE UK LINCOLN & SOUTH LINCOLNSHIRE
ON BEHALF OF THE LILP CONSORTIUM

Lincoln & South Lincolnshire age UK

LHP

LINCS INDEPENDENT LIVING PARTNERSHIP H.A.R.T Hospital Avoidance Response Team

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HART EVALUATION

INTRODUCTION

Rose Regeneration was commissioned to undertake an evaluation of the Hospital Avoidance Response Team (HART) Service provided by Age UK Lincoln and South Lincolnshire to the Lincolnshire Community Health Services NHS Trust. This service is delivered within the wider umbrella of a partnership consortium of key housing, care and support providers in Lincolnshire – Lincs Independent Living Partnership (LILP)[1].

HART is available across Lincolnshire and can offer support to people at home for up to 72 hours. HART is able to respond to both admission avoidance and support timely discharge from hospital. The team works closely with Lincolnshire Community Health Service NHS Trust (LCHS), Lincolnshire County Council (Adult Social Care), United Lincolnshire Hospitals Turst and Lincolnshire Reablement Service to optimise resources to enable people to remain at home or return home as soon as possible.

The response team deliver the service in all districts of Lincolnshire with the exception of East Lindsey, where a subcontracting arrangement is in place with Walnut Care.

The service is operating within its third year, having been recommissioned from its original pilot for a further two years, demonstrating the need for this service at all times of year and showing the move away from the core winter pressure months, which have now become an all year round pressure for the NHS due to the demand placed on health care services.

Since its inception in its first pilot form the service has accepted 2522 referrals of people needing support to either avoid hospital admission or to be discharged from hospital.

Following funding changes, the key performance indicators for the HART Service are to accept 130 referrals a month.

The staffing structure for this service includes the Response and Technical Services Manager, Senior Team Leader, four Team Leaders and 15.6 Response staff, when at full recruitment capacity.

This evaluation ran between October 2018 and January 2019 and covered the detailed performance period from April 2018 to January 2019.

APPROACH

Rose Regentation followed best practice within the HM Treasury Magenta Book in the context of their evaluation. This involved a three stand approach, namely:

Impact Evaluation – an assessment of the outputs and outcomes delivered by the service, including a social return on investment analysis considering the broader “social goods” arising from it.

Process Evaluation – a consideration of the baseline context for the design of the service, the development of a theory of change to underpin the analysis of the systems developed to address the challenges faced, and a review of the operation of the systems themselves, including an

[1] Other LILP members are: St Barnabas Hospice, Lincolnshire Home Independence Agency, Lincolnshire Housing Partnership and LACE Housing.

assessment of Strategic Added Value (the application of local and organisational knowledge and insight to the development of the service).

Economic Evaluation – an evaluation of the economy (value for money) and efficiency (progress against targets) delivered by the service – including an assessment of unit costs and comparison with other services which have some degree of similarity.

We set out our approach in more detail in a methodology note at Appendix 1.

IMPACT EVALUATION

QUALITATIVE ASSESSMENT

As part of the evaluation process a number of key informants were interviewed. These included:

Staff delivering the scheme (including the Chief Executive of Age UK Lincoln and South Lincolnshire), staff within the commissioning organisations for the scheme and beneficiaries of the scheme. Group meetings were also held with staff delivering the scheme to talk through the emerging findings from the evaluation. We also spent a day observing the operation of the call centre responsible for managing the telecare service provided to HART clients.

These meetings helped us develop a qualitative appreciation of the impact of the service. We supplemented them through consideration of the case studies developed as part of the reporting framework for the service.

INTERVIEW OUTCOMES

Key insights from the interactions above are set out below:

- The service fills a distinctive gap in service provision and has made a materially important contribution to the quality of life of its beneficiaries. Its "unique selling point" is providing intensive short term service to enable its clients to overcome their immediate challenges and in a good proportion of cases achieve personal independence.
- Clients who have been supported by the service are almost universally positive about it.
- The staff working in the HART service derive significant satisfaction from the service they deliver.
- The service is well understood and valued by those responsible for planning the discharge of patients and has become a core component of their hospitable discharge planning. Having HART staff directly involved in patient discharge planning has enhanced the use of the service.
- Notwithstanding the linkages between HART staff and the discharge teams within the Lincolnshire Hospitals, the distribution of referrals is not well managed by those making the referrals. Far too many referrals come from the statutory sector at the end of the traditional working week. This has the effect of making it very difficult to plan for and resource every referral, as the HART resources (as required) are spread over a pattern of response aimed to cover 7 days per week and 24 hours per day.
- There is scope for more work to build the admission avoidance impact of the service. Whilst it is clearly valued by those GPs and other organisations which use it there is the potential to significantly extend its penetration in this context.
- There is sometimes a dislocation between the aspirations of those referring people onto the programme and the appreciation by proposed clients that it is the right service for them as an individual. Relatives and carers are often quicker to acknowledge the need for the service than its recipients. The effectiveness of referrals is sometimes compromised by a lack of understanding on the part of those making them as to the type of individuals and situations it can support.
- There is significant interaction with the longer term reablement services provided by the County Council and the management of this interface is crucial to the achievement of long term sustainable outcomes for the clients.
- There are challenges recruiting and retaining some of the HART staff, which do not appear to be linked to the experience of working in the service itself, but rather a very tight local labour market.

- HART is highly regarded by commissioners who see it as a service with ongoing potential to make further inroads into the management of hospital admissions and avoidance. This is a positive challenge in terms of the number of staff available, particularly in the short term, to widen the reach of the service.
- When referrals are refused this is often because of the system knock on of other factors within hospitals: "*We will get an influx of referrals towards the end of the week, none at the weekend and a few at the start of the week, which reflects the activity within the hospitals and the perceived lack of planning for discharges. This is often why we have to decline referrals due to capacity, because they all come in on the same day.*" - CEO, Age UK Lincoln and South Lincolnshire.

CASE STUDIES

We present below narratives from a number of case studies and client interviews:

Quote from a client with mobility challenges, living independently with the support of HART...

> *Every facet of my care package has been fantastic, from top to bottom. I've had a single bed moved down from upstairs into the sitting room, and I can still go upstairs and sleep in my own bed...on Thursday I have a physiotherapist coming out, I've had a wheelchair, and a small three wheeler trolley. It's great. The whole care package has been very efficient.*

Quote from HART employee about support for an individual recuperating after a glaucoma operation:

> *Even though we sometimes do very little at a HART call, as the service user is very independent it is very important to them to have our presence due to their nervousness in a new situation.*

Feedback about support for an 89 year old living independently following a fall:

> *This service also provided her with peace of mind and to her family, knowing their mum and grandma had access to urgent support should they be unable to attend straight away.*

Quote from HART case study about support for an individual with several co-morbidities:

> *He was discharged from hospital after a week and HART were requested to support with basic personal care/meal prep. Mr. W has 3 sons who appeared to be very concerned about their father and appeared to want help as much as possible, but Mr. W felt that control was being taken away from him, so the responders were reminded to speak with Mr. W as much as possible first and then his sons secondly. By doing this he made his own decisions and felt more independent.*

Case study concerning a fall client:

> *We received a hospital avoidance HART referral for Mr. S one day in November at 22:00 hours. EMAS (East Midlands Ambulance Service) had attended due to Mr. S suffering a fall, and he had lain on the floor for a long period. He refused to go into hospital despite being advised to do so by EMAS. HART was requested to offer support at home for a few days and an urgent referral was also made to Adult Social Care and his GP. HART accepted the referral for 3 calls a day, initially 72 hours. Temporary*

telecare was installed and a temporary keysafe was provided. A referral for permanent telecare was made as requested by Mr. S.

Report concerning a HART client who was also a carer for his wife with dementia:

The team leaders worked with the responders, the family and the discharge teams to help liaise with Adult Social Care and get a care package arranged. During this time the HART team continued with extra visits until the care package started. A telecare unit and keysafe were also requested. The HART intervention saved a hospital admission and kept the family together at home. It ensured the transition to the care providers was smooth and stress-free for already vulnerable people who were incredibly thankful for our support.

Quote from strategic stakeholder:

The key factor limiting the growth and expansion of the service is access to the staffing it needs to enable it to meet any new obligations. It is a unique and important component of the preventive framework in Lincolnshire.

Quote from Telecare Centre Team about operating flexibly:

Delivery partners really responded to the needs of customers. At LHP we don't use or carry cash and we had a HART client that wanted to keep the monitoring but pay in cash. So Age UK (Lincoln and South Lincolnshire) visits her quarterly to check she is okay, collect cash payment for the monitoring, and we then bill Age UK (LSL). For her it's a lifeline as she doesn't use cards and wants to be able to pay in cash. As a member of the Lincs Independent Living Partnership we think as one and act as one to support our customers – the experience should always be seamless for the customer.

Quote from a commissioner:

It gives me enhanced discharge capacity and reduces the length of time patients are waiting. We're putting 100% more capacity into HART over the winter period – that's 10 beds worth of impact straight away from doing that – and that's conservative as it could 37 beds per hospital depending on the time of year, but particularly at Christmas and New Year when primary care and social care are clogged. From the patient's perspective – feedback of the service is positive – the quality is high. I've never had one complaint or moan about HART in 19 months and I don't have any other service that I've not had a complaint about.

OBSERVATIONS AT THE TELECARE CALL CENTRE

We spent a day with the Lifeline Team who operate the HART telecare service and our detailed findings are set out below:

Operation:

Monitoring of HART by telecare sits within the lifeline team at LHP.

There is capacity in-house / within the existing team at LHP to deliver HART. The centre is open 24/7 and receives some 30,000 calls per month (NB: this figure includes calls from clients, named contacts, agencies e.g. care, test calls when equipment is installed etc.).

HART is an extension of LHP's work with vulnerable client groups, extra care/supported housing and empathy in having a conversation with a resident/client to assess a situation and understand their needs.

During every call this conversation with a client is key to understanding the situation and assessing their needs, e.g. a recent situation where a client asked for their named person to be called because they were feeling unwell. The call handler had a conversation with them about why they were feeling unwell and found out they were experiencing shortness of breath and chest pains. The call handler called an ambulance, stayed on the line until the ambulance arrived and notified their named person.

LHP has a framework and systems in place to assess each call. LHP staff keep the call open until the responder/other support arrives. The 'dashboard' for all calls flags if the caller is a HART client and has a profile for each client (i.e., address, medical history, named contacts, key safe information, information about any calls made and actions taken). The system also flags repeated calls which are investigated further (e.g. have a client's needs changed/deteriorated? Are they isolated or lonely? etc.)

HART enables a client to have a telecare unit installed in their home for 72 hours (if/where appropriate). If they decide they would like telecare after they have exited HART there is a £25 one-off installation charge for subsequent telecare and then a £2.85 charge per week for the telecare service.

The telecare not only provides support for individual clients but also means the named persons on their file can call the centre if they are unable to contact the client (this provides family and friends with reassurance).

Reflections based on discussions with the telecare team:

The reporting process for HART means the commissioners know how many referrals have been made to LHP for telecare, but not the number of calls received, the type of call or their duration. The reporting also means that the centre do not always hear the outcome of the calls they have received (e.g. hospital avoidance, admission and discharge). Currently, it is not possible to identify, for example, how many calls are resolved without needing to refer to primary or secondary health and care providers. It would be useful to collect information for the commissioners on the volume/ type/action to calls and understand the unique contribution HART is making (i.e. by finding out from clients what they would have done if the telecare had not been there).

It may also be helpful if the centre had more medical information about clients to pass on should a responder or ambulance be required (e.g. medication in addition to general medical conditions).

Hospital avoidance, early help / intervention and prevention are key areas of work for LHP. It would be interesting to consider how all parties, including the commissioners, can learn from the avoidance pathway followed, i.e. the customer service / experience and the community service being delivered, and how this is reducing the number of ambulance call outs and hospital admissions. More engagement by primary care with HART could enable a bigger impact in hospital avoidance.

It may also be useful for HART responders to spend a session at the centre and vice versa [shift shadowing] to share learning and practice from across the service (e.g. for the responders to let the call handlers know if there are any additional useful questions/information they could gain from clients before they visit and/or for the call handlers to understand the different types of support provided by responders in people's homes).

It is very clear that the installation of telecare makes a significant contribution to the ongoing independence of vulnerable people and that HART makes a significant contribution to this through having it as a core element of the service it provides.

SUMMARY

The qualitative assessment of the impact of HART identifies a service which is:

- Valued highly by clients, partners and commissioners.
- Increasingly integrated in a wider pattern of healthcare provision in Lincolnshire.
- Makes a significant and positive change to the lives of vulnerable individuals.
- Has scope for even more significant impact with some more modest investment and further engagement by the statutory sector.
- Makes a major contribution to joining up the range of interventions supporting an individual for the longer term through its activity, planning for the support of each client during the 72 hours of its custodianship.

Our quantitative assessment of impact below builds on this human exposition of the impact of HART.

QUANTITATIVE ASSESSMENT

HART collates information about its performance in the form of monthly updates to the Lincolnshire Community Health Services NHS Trust. At a headline level these demonstrate that during the first six months of the operation of HART:

976 individuals were accepted onto the service and £565,100 of savings (£245,100 net) were delivered to the NHS.

We have applied a social return on investment analysis to the performance data for HART to provide a broader assessment of its impact.

Social Return on investment is a means of ascribing a value to the wider outcomes delivered by an initiative which have traditionally been seen as too hard to quantify. This involves describing the outcomes achieved by an initiative and then identifying a financial proxy which can be used to attribute a value to that outcome.

All identified outcomes are adjusted to take account of the external factors which impact on them, in the case of HART in the context of:

- Deadweight – an assessment of what proportion of the outcome might have arisen without the project
- Attribution – the extent to which other organisations have contributed to the outcome achieved
- Drop Off – the ectend to which the outcomes claimed will diminish over time
- Displacement – the extent to which the positive benefits delivered by the initiative have impacted negatively on other initiatives addressing the same issue

The source for our financial proxies is the Social Value Engine[2], an online platform containing approaching 200 peer-reviewed sources for financial proxies developed by Rose Regeneration in partnership with East Riding of Yorkshire Council and accredited by Social Value UK.

[2] *https://socialvalueengine.com*

The Social Value Engine provides a context for each financial proxy by linking it to the most appropriate domain within the Bristol Accord[3] (an acknowledged frame of reference for assessing the sustainability of a community – see Appendix 3). This enables us to not only provide an overview of the social value delivered in relation to each outcome but to quantify it in terms of its contribution to the sustainability of the geography with which we are working.

Working with practitioners within HART we identified the most appropriate financial proxies to quantify the outcomes achieved by the service. These are set out in the grid below:

HART	Financial Proxy (inc. Bristol Accord Reference)
Number of acceptances	5b Cost of stress counselling to help service users maintain their stability
	8f Cost of a community health visit
Number of admissions avoidances	8f Average cost of hospital admission
Number of supported discharges from hospital	8f Average cose of an inpatient stay in hospital
Number of clients transferred onto an independent pathway	1c Value ascribed to living in a good place
Number of clients transferred onto reablement services	3e Cost of therapy
Number of clients transferred to care provider	8f Average cost of one year in residential care
Number of clients transferred to be supported by family	1e The value of feeling more confident in being with family and other people
Number of clients where onward referrals into other appropriate services are made	8a Savings from joint working
Ambulance Call Out Avoidance	5b improved health and wellbeing for local residents

Using HART performance data from April - November 2018 we were able to ascribe the following volumes of activity to each outcome area – This enabled us to perform the analysis as set out in the following table:

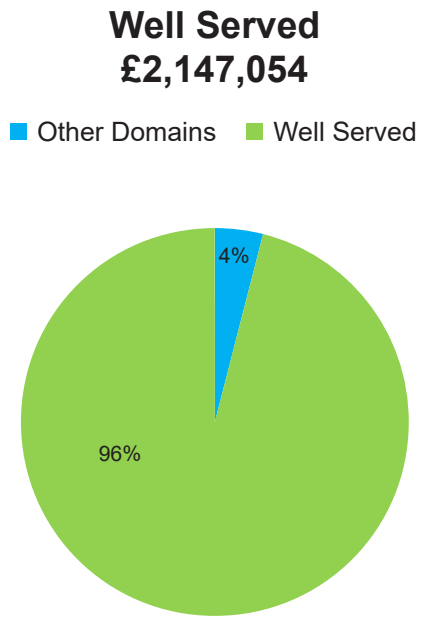
[3] *http://www.eib.org/attachments/jessica_bristol_accord_sustainable_communities.pdf*

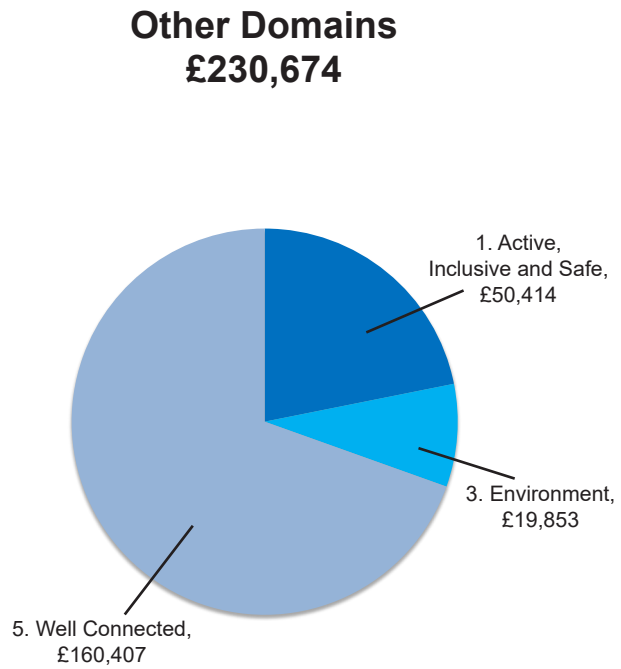
Output	Outcome	Financial Proxy	Unit Cost £	Units	Deadweight	Attribution	Drop-Off	Impact (Current Year) £	Source
Ambulance Call Out Avoidance	5b. Improved health and wellbeing for local residents	Ambulance journey to hospital and A&E attendance	264	32	20%	0%	0%	6,758	https://www.socialvalueengine.com/calculator/public-health-interventions-sep-2014.pdf
Clients moved to an independent pathway	1c. Improved social inclusion and access to community resources	Average local authority spend per head	1,733	52	50%	50%	50%	22,529	http://socialvalueengine.com/calculator/proxysource/RA_Budget_2016-17_Statistical_Release.pdf
Transferred to reablement	3e. Growing	Cost of therapy	80	499	50%	50%	50%	9,926	http://socialvalueengine.com/calculator/Can%20I%20get%20free%20therapy%20or%20counselling.pdf
Clients transferred to care providers	8f. Improved community health and service provision	Average cost of one year residential care	32,344	156	50%	50%	50%	1,261,416	http://www.payingforcare.org/care-home-fees
Clients transferred to family support	1e. Reduced social isolation for community members	The value of feeling more confident in being with family and other people	824	13	50%	50%	50%	2,678	http://socialvalueengine.com/calculator/12-1127-valuing-adult-learning-comparing-wellbeing-to-contingent.pdf
Onward referrals	8a. More substantive links between organisations and service providers	Savings from joint working	6	744	5%	25%	5%	3,207	http://democracy.havering.gov.uk/documents/s20257/Transformation%20Report%20October%202016.pdf
Supported clients	5b. Improved health and wellbeing for local residents	Cost of stress counselling to help users maintain stability in the face of stressful circumstances	457	780	10%	75%	50%	80,203.5	http://socialvalueengine.com/calculator/sroi_real_jobs_evaluation_accredited.pdf

Supported hospital discharges	8f. Improved community health and service provision	Average cost of inpatient stay in hospital	3,695	809	10%	50%	50%	1,345,165	http://socialvalueengine.com/calculator/public-health-interventions-sep-2014.pdf
Admission Avoidance	8f. Improved community health and service provision	Average cost of hospital admission	294	167	20%	50%	33%	19,639	https://www.researchgate.net/publication/277025550_The_Economic_Burden_of_PTSD_in_Northern_Ireland
Client Interaction	8f. Improved community health and service provision	Cost of a community health visit	45	4,680	10%	75%	50%	47,385	http://socialvalueengine.com/calculator/Community%20Health%20Workers%20in%20Cancer%20Outreach.pdf
Total Present New Social Value (taking into account 3.5% inflation)								**2,384,258**	

These outcomes were delivered for a cost of £320,000. This provides a social return on investment of £8.45 per £1.

In terms of the specific areas of impact relating to the above outcomes, they fall substantively (96%) into the Improved Community and Health Service provision within the Well Served domain of the Bristol Accord (set out in the pie chart on the left). In terms of the other domains the service has delivered a series of gross social values on the basis set out in the pie chart on the right.





PROCESS EVALUATION

The initial proposal to Lincolnshire Community Health Service NHS Trust, which was then translated into the service specification set out at Appendix 2, provides the context for the development of the service, namely: "*HART in the community offers support to people who have been assessed as needing short term support. The service model replicates that of the Hospital Discharge model, but prevents unnecessary admission to hospital and promotes the appropriate use of community resources. It also provides the person with the confidence and the encouragement to retain their independence.*"

Following our interviews and reviews of key evidence associated with the delivery of the programme we have developed the following theory of change for the initiative.

HART

Long term Goals

Clients: Supporting people to maintain their independence in a home of their choice.
Age UK/LILP: Developed a pioneering and award winning service - sharing learning and practice with other organisations across the UK, widening the preventive impacts delivered by HART through (i) offering additional services such as transport, falls, care homes, palliative care; (ii) further building the capacity of the organisations that HART works with, e.g. carers in crisis, trusted assessors; and (iii) wider operational efficiencies through community connectives and improve health and care navigation.

Outcomes

Clients: Providing short term interventions to provide a safe environment, practical support and emotional support for people to remain or return to their own home. A small number of clients (6%) are supported for more than 72 hours while other provision is put in place. This number will increase over the winter pressure period.
Age UK/LILP: Coordination of community resources to support confidence and independence in older and vulnerable people.
Commissioners: A county-wide service that facilitates admissions avoidance and supports hospital discharge. Age UK/service delivery partners make onward referrals into other services (if/where appropriate) to support clients to gain further independence.

Outputs

The overall target for the service is to accept a minimum of 130 clients a month; and a minimum of 160 clients per month between December 2018 and March 2019 to support winter pressure on the NHS.
Admission avoidance - % of individuals/month; ***supported discharge from hospital*** - % individuals/month (identifying the number who require a 'bridging the gap' service); ***reduction in occupied beds days and the return on investment; outcomes for individuals*** - level/type of service the individual received once transferred from HART; ***individual experiences; number of people breaching 72 hours support***; and ***number of accepted referrals vs number of rejected referrals and reasons why.***

Activities

For clients: Support to avoid hospital admission, resettle after discharge or remain in their home if their carer is absent. This includes help to: (re)gain confidence and capabilities and reduce the risk of muscle deterioration and frailty. The service is available 24 hours a day, 7 days a week, 52 weeks of the year.	**For health and care professionals/practitioners**: HART provides wraparound care and support that fits in the Admission Avoidance Pathway and enables people who are medically fit to be discharged.	**For Age UK & service delivery partners**: Developing a holistic, person centred, responsive service to clients that plugs gaps for 72 hours before ongoing support is put in place or the client is going on to an independent pathway.	**For LILP**: Local organisations embedded in the community coming together with external agencies to co-design a service to maximise resources, leading to vulnerable people improving their wellbeing and independent living.

HART offers a flexible, very short period of support (up to 72 hours) at home with activities of daily living - including personal care, support with medication and confidence building. There are three strands to the service: (1) helping people needing short term support in order to avoid an admission into a secondary care setting; (2) enabling people to return home as they become medically fit for discharge but are being prevented due to external reasons; (3) a 24/7 response service, which is installed by the responder and monitored by Lincolnshire Housing Partnership at no charge to the individual, enabling them to have access to responders 24/7.

Initial condition for change

HART stands for 'Hospital Avoidance Response Team' and is a service commissioned by LCHS to support people to remain in their home, ensuring they are safe and maintain their independence. The lead provider of the service is Age UK Lincoln & South Lincolnshire (service provision and delivery), supported by Lincolnshire Housing Partnership (monitoring and wellbeing calls) and Walnut Care (subcontracted care provider). Age UK Lincoln & South Lincolnshire and Lincolnshire Housing Partnership are both members of Lincs Independent Living Partnership. Established in 2013 with 3 other voluntary organisations, LILP aims to deliver services and support for vulnerable people across Lincolnshire to improve and maintain their wellbeing. HART was a pilot project from December 2015 - March 2016 and became a contracted service thereafter. HART provides a 24/7 service that supports people to avoid unnecessary hospital admissions and delayed hospital discharge, i.e. to help reduce attendance at A&E, emergency admissions, protracted hospital stays and other delayed transfers of care.

It is our view that this provides a robust structure for the development of the HART service. It would be useful to have readily accessible data to quantify the size and scale of the hospital avoidance challenge in Lincolnshire. We accept, however, that it is not possible to quantify this due to the ever changing nature of individual cases and the fact that no single organisation has responsibility to collate information in this context. We do note, however, that a monthly referral target of 130 has now been agreed for the service, based on developing experience of the size and scale of the cohort of people supported by HART in its pilot incarnations. The operational arrangements for the delivery of the HART service are set out in the following process diagram.

This system is underpinned by a suite of key recording and referral forms, including a risk assessment matrix, all of which provide an extensive underpinning for the service. It is important to acknowledge the underpinning rationale for this service is its responsive nature and it is therefore significantly dependent on effective referral mechanisms.

PERFORMANCE DATA

HART provides monthly performance updates to the Community Trust. We have analysed trends in the following areas:

- Number of Referrals
- Reasons for Call Rejections
- Admission Avoidance
- Supported Discharge from Hospital
- Number of people breaching 27 hours of support
- Re-admissions whilst supported with HART
- Outcomes of the Individual
- Funders Return on Investment
- Bridging Gap Days inc. Return on Investment
- Response Call clients vs Responsive Call Outs

HART became a commissioned service (following a highly successful pilot period) in April 2018. We have reviewed its performance data for the 8 months to the end of November 2018. Key cumulative results are set out below:

- Referrals: 1,464
- Acceptances: 976
- Rejections: 488

This works out at 182 referrals per month. 33% of referrals were rejected. This involves an average of 123 accepted referrals per month. ***It is very clear from our analysis that the relatively poor planning of referrals within the discharge system contributes significantly to the need for the service to make rejections. It is our view that if discharges were more effectively distributed across the whole week (rather than mainly issued on a Friday) the overall level of rejections would fall by a good margin.***

The reasons for rejections were: staff availability (414), inappropriate referral (9), 2 person visit required (65).

The distribution of referrals was as follows: Admission Avoidance (17%), Supported Discharge (83%).

The number of individuals breaching the 72 hours support requirement is very small at 4%.

The key next steps routes for referrals are:

Reablement – over 50%, support requirement cancelled 20%. Less than 10% of clients are re-admitted to hospital directly after HART support.

The value of the service delivered during this period is estimated as follows:

- Pro-rata of full service cost: £320,000
- Year to date savings: £565,000
- Return on Investment: £245,000

The distribution of referrals was as follows:

CCG	Hospital Discharge	Admission Avoidance
LWCCG	367	83
LECCG	367	73
SWLCCG	211	54
SLCCG	258	40
Total Per Month (rounded)	150	31

Key issues arising from this analysis are:

- The relatively high level of rejected referrals – principally linked to uneven pattern of service referrals which puts undue stress on limitations within the staff capacity of the service, with a particular challenge linked to the geographical distribution of staff, around supporting 2 carer based visits.
- The very agile nature of the support offered in the context of accepted referrals with lead times for dischsarge, for example, being as low as an hour.
- The relatively modest proportion of admission avoidance referrals compared to hospital

discharge referrals.

- The very efficient approach to ensuring that in the vast majority of cases the 72 hours care package is not breached.
- The relatively high proportion (over 20%) of accepted referrals, which are cancelled (in almost all cases prior to starting). It would be useful to consider what proportion of these referrals were admission avoidance and what proportion were hospital discharge based.
- The relatively higher number of referrals to the service. In the north of the county there are 61% compared to 39% in the south. Stakeholders suggested that this disparity, in part at least, was occasioned by the tighter labour markets and greater challenges facing HART recruitment in the south of the County, but the most significant factor here is the uneven pattern of referrals onto the service.

A number of these issues are important in considering the impact of the service. However, none of them are materially linked to the systems adopted by the service, but which we mean that the way the service is run has no causal link to these problems. Indeed a number of Strategic Added Value approaches have been established within the service to respond to some of these issues.

STRATEGIC ADDED VALUE

HART management has recognised the challenges in a diffused and sparsely populated area of maximising their impact in terms of admission avoidance. It has sought to address this by working closely with key referral bodies. This is an ongoing priority.

HART has become very effectively embedded within the hospital discharge agenda as a key partner working with United Lincolnshire Hospitals NHS Trust. It has been acknowledged as having a pivotal role in initiatives such as the Perfect Week[4] initiative, which seeks to maximise the discharge of patients from hospital to the community.

HART has recognised that perhaps its greatest challenge relates to recruitment and retention and is actively involved in a range of activities to ensure it maximises its impact in relation to these workforce challenges.

HART has developed very effective transition relationships with facilities such as the reablement service, which accounts for its very low proportion of clients where the 72 hour support threshold is breached.

HART provides a “bespoke” response to the package of support for those referred to it, creating virtuous connections between wider supporting organisations, which often continue in the context of an individual, beyond the short term package of HART support.

[4] *See https://www.ulh.nhs.uk/content/uploads/2016/02/Item-9.2-Lincolnshire-Perfect-Week-2.pdf*

ECONOMIC EVALUATION

An economic evaluation looks at the cost and pace at which the service under analysis has been delivered. In the context of HART performance against profile and the unit cost of delivery are important factors in making an assessment of effectiveness.

Peformance against profile – In simple terms the number of referrals received in running close to profile in terms of the average of 130 accepted referrals per month. This could be higher if the level of rejections could be managed by a better structured pattern of referrals, which was balanced through the working week.

Peformance in context – HART is in essence a "test and learn" initiative. Accessible statistics are not readily available in terms of the scale of the admission avoidance challenge in Lincolnshire and it is therefore difficult to make an assessment of the scale of the overall challenge HART is addressing in this context.

Statistics are available for delayed transfers of care from the NHS. These indicate that the figure for United Lincolnshire Hospitals Trust was running at around 1000 days per month during the last 12 months[5].

The average number of delayed days per patient is not straightforwardly collected. However we do know that the average length of stay at ULHT (median) is 2 days[6]. This suggests the figure of 1000 relates to around 500 patients per month (in practice this may be fewer than 500 as those with delayed transfer characteristics are likely to have more acute needs than the average patient and their transfer may therefore be more complex to achieve and take more than 2 additional days). It is nonetheless useful to use this figure to provide a basic benchmark for the scale of HART's performance.

Taking an average of 150 referrals for hospital discharge per month (and reducing it by 20% to take account of cancelled referrals) indicates that HART is supporting around 120 discharges per month. ***This equates to 24% of delayed discharges per month using the average of 2 days figure.***

PERFORMANCE CHALLENGES

There are two clear distinct performance challenges, which relate to the availability of staff and the uneven pattern of referrals – with over 300 referrals rejected (between April and November 2018) being linked either to unavailability of staff, the need for a 2 person visit to a client, or a glut of referrals towards the end of a given week.

UNIT COSTS

The service is contracted on a fixed fee basis, paid monthly. In the eight months of our assessment it has achieved 976 accepted referrals at a cost of £320,000. This equates to £327.86 per referral. Assuming an average support package of 72 hours plus 12 hours for arrangement and exit (3.5 days) this equates to £93.67 per day. Non-nursing based residential care, (which by comparison is less intensive) according to the Money Advice Service[7], has a unit cost of £80.19. Nursing based care has an annual cost of £107.67.

[5] *https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2017-18/*
[6] *https://digital.nhs.uk/data-and-information/publications/clinical-indicators/seven-day-services/current/length-of-stay-indicator*
[7] *https://www.moneyadviceservice.org.uk/en/articles/care-home-or-home-care*

In terms of savings delivered to the NHS the service has identified £565,100 gross of savings comprising the service supporting clients to bridge the gap between their package of care starting and through supporting customers to build their confidence leading to an independent pathway. Prior to any netting off of the cost of service delivery, this equates to a saving of £578.99 per accepted referral.

ECONOMY AND EFFICIENCY

Overall HART is performing well in terms of economy and efficiency. It is running close to profile in terms of referrals and its unit costs are comparable with the most useful, albeit less intensive, provision of residential care.

CONCLUSION

HART is an important and highly valued service (by both customers and commissioners) which makes a positive difference to the lives of the individuals and the organisations it supports. We have identified a number of narratives which provide a human face and context for its achievements. These are set out in the qualitative impact section of this report.

HART is making a materially important contribution to addressing the challenge of delayed hospital discharge across Lincolnshire. It supports around 120 hospital discharges and 25 admission avoidances per month.

Based on the scale and volume of overall hospital discharge delays a case can be made that it has contributed to supporting approaching 25% of all individuals affected in 2018/19 to date.

HART is operating to profile and is providing a respectable level of value for money with a unit cost of £93.67 per day per client. With a more even pattern of better focused referrals from third parties it is capable of delivering more support, resulting in a lower unit cost.

Overall performance for the first 8 months of 2018/19 equates to £565,000 gross savings at the level of £579 per accepted referral.

In terms of wider social value HART has delivered the highly creditable achievement of £8.43 per £1 invested.

HART could deliver almost a third more referrals if it was able to extend its staffing capacity. 20% of accepted referrals are not actioned largely due to a difference in perspective between those making the referrals and the clients they refer, and an uneven pattern of referrals.

There is considerable scope for HART to become even more embedded with referral agencies and to increase its impact in terms of admission avoidance.

HART is very good at managing client transition to the next stage in their support package, particularly to reablement services, and a very small proportion of its clients (less than 10%) are re-admitted to hospital following their package of HART support.

If HART was able to increase its capacity on a sustainable basis it could make an even more substantial contribution to the challenges of delayed discharge and hospital admission in Lincolnshire.

HART has a dynamic management team with a sophisticated agenda for further refining the operation of the service.

RECOMMENDATIONS

There is scope to enhance the current service in the following ways:

Working with referring organisations to enhance the referral service to ensure a more balanced pattern of referrals throughout the week.

Extending the client focus for HART – training staff in skills such as end of life support.

The development of support for established unpaid carers to help manage the factors causing them stress.

Exploring the potential for the provision of dementia based support for clients in residential care settings.

The development of “Community Connector” roles to help maximise the effectiveness of admission avoidance.

An enhaced presence in hospital settings to more effectively focus the distribution of hospital discharge referrals.

The development of dedicated transport arrangements to manage the discharge of individuals from hospital.

Enhanced links with the home adapatation services linked to the work of Lincolnshire Home Independence Agency.

The establishment of trusted assessor status for HART staff.

Development of more streamlined referral processes for individuals post HART to initiatives such as the well-being service in Lincolnshire.

APPENDIX 1 – METHODOLOGY NOTE

Process Evaluation

To produce a theory of change for HART we:

- Discussed the background to the development of the service with the relevant members of LILP.
- Linked the conceptual development of the service to the STP and other strategic frameworks, which underpin the delivery of particularly community health services in Lincolnshire.
- Considered the performance data for HART and the insights offered in terms of the design and configuration of the service.

Having established a clear theory of change for the service we then looked at how the operating systems for the service were planned. This involved describing the current processes the service follows and considering how well they fit with the objectives for the service set out in the theory of change. We did this through a process of desk research in relation to the reporting framework, which underpins the service. We also interviewed a sample of the individuals delivering the service and those agencies it supports (particularly at LCHS and ULHT). During this process we had regard to:

- Positive unintended consequences arising from the systems developed for the service
- Negative unintended consequences arising from the systems developed for the service
- Examples of Strategic Added Value based on the Lincolnshire and community insights of the service provider in the way the service has been developed

Impact Evaluation

This part of the evaluation has two components: Firstly, the need to map the delivery of the outputs from the service and to consider how they relate to outputs negotiated with the client, and secondly, the need to identify the outcomes delivered by the service. Our approach involved ascribing a value to these outcomes using social return on investment as a specific technique. We followed a qualitative and quantative approach.

We used the performance reports, which are compiled for the client to consider overall progress. Having derived a performance overview we interviewed the funding organisatons for the service to ascertain how the delivery meets their expectations. We also discussed with HART staff and stakeholders how effective they perceive the delivery of the service to be.

We valued the impact delivered by the service through a process of ascribing financial proxies to the outcomes it is achieving. These are identified in the service specification for HART within its Aims and Objectives set out below.

HART Aims and Objectives

AIMS

Our aim is to support people to remain in the home of their choice, ensuring they are safe and maintain their independence. We will:

- *Support and resettle people* following a hospital admission
- *Encourage persons to regain their confidence and capabilities*
- *Reduce the risk of muscle deterioration and frailty* by preventing unnecessary hospital admissions or delayed transfers of care

OBJECTIVES

The service will:

- Provide a holistic approach to accessing Health and Social Care services
- Support the Admission Avoidance agenda
- Be person-centred at all times, focusing on the person and not their condition
- Support people to retain or regain their independence
- Work to the Home First mindset
- Support the Transitional Care agenda
- Alleviate the pressures of delayed transfers of care faced by acute hospitals
  Support person flow management
- Integrate into Neighbourhood Teams
- Manage referrals into the service, ensuring the level of support offered is appropriate and proportionate
- Apply a flexible approach to the delivery model by managing our resources to support all CCG areas in accessing the service whilst ensuring maximum capacity can be utilised at all times
- Flex and adapt the service at times of need in the Health and Care sector, i.e. winter pressures

We ran an impact assessment workshop (to underpin the SROI process set out above) with a cross section of delivery and stakeholder representatives to develop a consensus on the outcomes delivered by the service. Once this had been completed we used the Social Value Engine, (https://socialvalueengine.com) an online tool accredited by Social Value UK to identify the financial proxies which best fit the outcomes we have identified.

We also undertook a group discussion with the workshop participants to identify the extent to which the outcomes can credibly be ascribed to the service, deflating their overall value to take account of: deadweight (what would have happened anyway), attribution (which other services might be due some credit for the achievements under consideration), drop off (how long the impact of the achievements will last) and displacement (any negative unforeseen impacts on other projects caused by the service).

Having completed this engagement process through the workshop we used the social value engine to provide an overall assessment of the outcomes delivered by the service and their value.

Economic Evaluation

This aspect of the report involved considering the economy and the efficiency of the service. This entailed assessing whether the service delivered its outputs to profile, at what unit cost and whether this represents value for money.

There are a number of challenges to acknowledge. Firstly, as this is a demand led service, apart from a finite amount of resource (ie the budget for the service), outputs are not specified in detail, although a comprehensive service specification agreed between the two parties does exist and is set out at Appendix 2. Secondly, every individual has a unique set of needs and it is therefore difficult to benchmark the speed and cost of outcomes across the whole programme. Thirdly, this

is a distinctive programme for which it is difficult to provide straightforward comparisons.

Taking account of these caveats we:

- Used the MIS data collected by the service to establish delivery trends and isolate high level unit costs for the delivery of the service
- Leveraged our contacts – taking account of the distinctive nature of the service – to identify some unit cost comparisons with other services seeking to achieve similar outcomes
- Considered the volume of outputs delivered and areas of over and under achievement – this is also a useful means of triangulating the efficiency of the systems described in the process element of the evaluation

The reporting for this service also uses a number of preventive cost assessments to identify cash savings to the NHS and we incorporated these in our assessment of economic impact.

We triangulated our findings with the client before concluding our assumption for this aspect of the evaluation.

Consolidation

Once we had completed the three discrete phases of the evaluation we consolidated them into an overall set of judgements. This involved reviewing all the evidence collected to provide a commentary, setting out the achievement of the programme in context.

APPENDIX 2 – HART SERVICE SPECIFICATION

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	PUR2004
Service	Hospital Avoidance Response Team (HART)
Commissioner Lead	Ruth Taylor, Clinical Team Lead, LCHS
Provider Lead	Rosie Davidson, Care Services Manager, Age UK Lincoln and Kesteven
Period	1st April 2017 – 31st March 2018
Date of Review	Quarterly

1. Population needs

HART in the community offers support to people who have been assessed as needing short term support. The service model replicates that of the Hospital Discharge model, but prevents unnecessary admission to hospital and promotes the appropriate use of community resources. It also provides the person with the confidence and the encouragement to retain their independence. This can include ensuring a safe environment, practical support with shopping and personal care, as well as providing emotional support.

2. Outcomes

2.1 NHS outcomes framework domains and indicators

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	x

2.2 Local defined outcomes

HART is a service designed to support people who require a very short period of support (up to 72 hours) at home with activities of daily living, including personal care, support with medication and confidence building.

Following the 72 hour period the HART service will withdraw having been assured at point of referral that either ongoing support will be in place or the individual is going on to an independent pathway.

The person is offered a telecare unit as part of the service, which is installed by the responder and monitored by Boston Mayflower at no charge to the individual, enabling them to have access to the responders 24/7 – thus giving them assurance that support is accessible at any time, should they require it. Installation takes place as the person is being settled into their home.

HART also offers a seamless transition into the Wellbeing Service by prioritizing the assessment process and linking them into the service smoothly and swiftly. The Wellbeing Service carried out a holistic assessment of the person's needs to identify support and equipment which is designed to assist them to retain their independence. This can include ongoing telecare, minor aids and adaptations to the home, up to 6 weeks generic support and continued access to a 24/7 response service.

Referrals into the service can be made for those people who are being discharged from a hospital or care setting or to avoid them being admitted. HART is part of the wraparound care and support that is available to the CAS teams and to GP's in the community

3. Scope

3.1 Aims and objectives of service

The HART service aims to assist in avoiding unnecessary hospital admissions and delayed hospital discharges, i.e. to help reduce attendance at A&E, emergency admissions, protracted hospital stays and other delayed transfers of care whilst at the same time enabling people to regain and retain their independence.

To support people to remain in the home of their choice, ensuring they are safe and maintain their independence. They will:

- Support and resettle people following a hospital admission
- Encourage persons to regain their confidence and capabilities
- Reduce the risk of muscle deterioration and frailty by preventing unnecessary hospital admissions

3.1.1 Objectives

The service will:

- Provide a holistic approach to accessing Health and Social Care services
- Be person-centred at all times, focusing on the person and not their condition
- Support people to retain or regain their independence
- Work to the Home First mindset
- Support the Transitional Care agenda
- Alleviate the pressures of delayed transfers of care faced by acute hospitals
- Support person flow management
- Integrate into Neighbourhood Teams
- Manage referrals into the service, ensuring the level of support offered is appropriate and proportionate

3.2 Service description / care pathway

The service is designed as a county-wide service to facilitate admission avoidance and hospital discharge.

HART Response:

HART will meet a person at home following their transfer from secondary care and help to settle them back home and if required support them with activities of daily living for up to 72 hours. This can include ensuring a safe environment, practical support with shopping and

personal care, as well as providing emotional support. The service is designed to support the individual to manage the transition of their care from a clinical setting to their home environment in a safe and support manner. It aims to accelerate recovery and prevent re-admission.

HART Responders:

- Can support with personal care, medication support, bathing, food preparation, repositioning of a person and ensuring a comfortable living environment
- Can support the person to access the Wellbeing Service and refer them on appropriately, thus providing a holistic assessment of their on-going needs to support them to remain independent
- All responders are trained in the use of and have access to a Mange Lifting Device
- All responders are trained to deliver personal care in accordance with the Care Quality Commissions Essential Standards
- Can collect medication if required
- Can collect light shopping and will ensure that the service user has edible food and beverages availabe to them
- Food parcels can also be provided if there is a requirement

HART Flow:

HART provides the facility to enable people to return home as they become medically fit for discharge but this is prevented due to external reasons. By providing this service the person can be assessed in their home environment, which will lead to a more informed assessment of need. Domiciliary providers, the Reablement service and therapists will then commence their services as assessed from this platform. Referrers need to ensure that if this pathway is chosen that there is an agreed start date for the new provider or service is to begin before the person is discharged.

HART in the Community

HART in the community offers support to people who have been assessed as needing short term support. The service model replicates that of the Hospital Discharge model, but prevents unnecessary admission to hospital and promotes the appropriate use of community resources. It also provides the person with the confidence and the encouragement to retain their independence. This can include ensure a safe environment, practical support with shopping and personal care, as well as providing emotional support.

Core Principles

- Person centred
- Responsive
- Empowering and enabling
- Encouraging independence
- Resourceful

Telecare and Monitoring

The service offers the supply and installation of a Telecare Unit and a monitoring service as part of the package of care. This enables people to have access to HART responders 24/7, which provides reassurance of support at any point in the day or night should it be required. Temporary key safes can be installed at the service user’s property to allow access to the HART Responders. Daily Wellbeing Calls can be arranged and provided by the monitoring centre.

Team Values

- Will always provide a person-centred approach
- Will always involve the person in all decisions made about their support
- Will work collaboratively and with consensus
- Will respect and trust one another
- Will challenge and critically appraise decisions when appropriate
- Will always seek solutions to challenges and issues

Active Members

- Age UK Lincoln and Kesteven – Lead Provider Service provision and delivery
- LHP – Technical support and monitoring
- Walnut Care - Subcontracted Care Provider

3.3 Population covered

Any service user applicable to the service registered with a Lincolnshire GP

3.4 Any acceptance and exclusion criteria and thresholds

What HART can do	What HART can't do
If deemed appropriate, contact emergency services	Provide any medical intervention
Empty catheter bags	Peg feeds
Tilt or turn a service user	Assess blood sugar levels
Medication support	Injections
Bathing or showering	Provider assistance with cannulas
Assistance with toileting	Stoma care
Assistance with dressing	Change catheter bags
Changing soiled linen	End of life care
Support to get in and out of bed	Dress or redress open wounds or sores
Non-injury falls	Support with specialised medication tasks
Assist with mobility	Act on behalf of the care provider, if applicable
Empower and enable	Assist with feeding
Food preparation	General domestic chores
Help maintain a safe living environment	Support with controlled drugs
Ensure house is comfortable	
Ensure daily essentials for living are available	
Provide access or signpost into support services, including Wellbeing Service referrals	

Hospital Discharge and Admission Avoidance Model

Referral received from Clinical Assessment Team or Hospital Discharge into HART Response Team. (accessible 24/7)

Team leader completes referral form and checklist. Referrals are only accepted with an agreed exit pathway ie. Domicialry Care/ Reablement Team

Team leader allocates a responder to be at the property within 2 hours of initial referral or to meet with s/u on arrival from Hospital

On arrival responder gains consent for service to be delivered; completes Care Profile/Plan, Risk Assessment and service user agreement. Temporary Keysafe to be supplied if appropriate. Service pack to be given

Does the service user have Telecare?

Telecare is installed

Contact the monitoring centre via the unit, advising that the H.A.R.T will be acting as the first response for up to 72hours. Email confirmation to the provider will follow from team leader once provider identified

No, Telecare is not installed

A unit is installed, with a visibile sticker to inform other professionals that the unit is temporary. Boston Mayflower are informed and provide monitoring service in partnership with H.A.R.T

The service user is given guidance on how the response service works, encouraging use of the pendant when needed

Does the Service user need planned care as well as responsive support?

Yes, planned care is required alongside responsive support

Team leader coordinates any planned care, service user is advised that calls will be within an agreed time frame. Care plans/profiles are kept in a locked cabinet within the team office. Regulated paperwork is added to the services users welcome pack.

No, planned care is not identified to be needed

H.A.R.T provides a responsive service. If no response is requested within 24 hours a welfare call will take place. This will continue for upto 72hours

After 72 hours or sooner

Onward pathway must be agreed at point of referral being accepted. Handovers agreed where appropriate. Final visit to be arranged with the service user to withdraw from the service. Confirm onwards referrals where appropriate. If telecare pre-installed, notify existing provider of service withdrawal.

Temporary telecare equipment requested to be kept

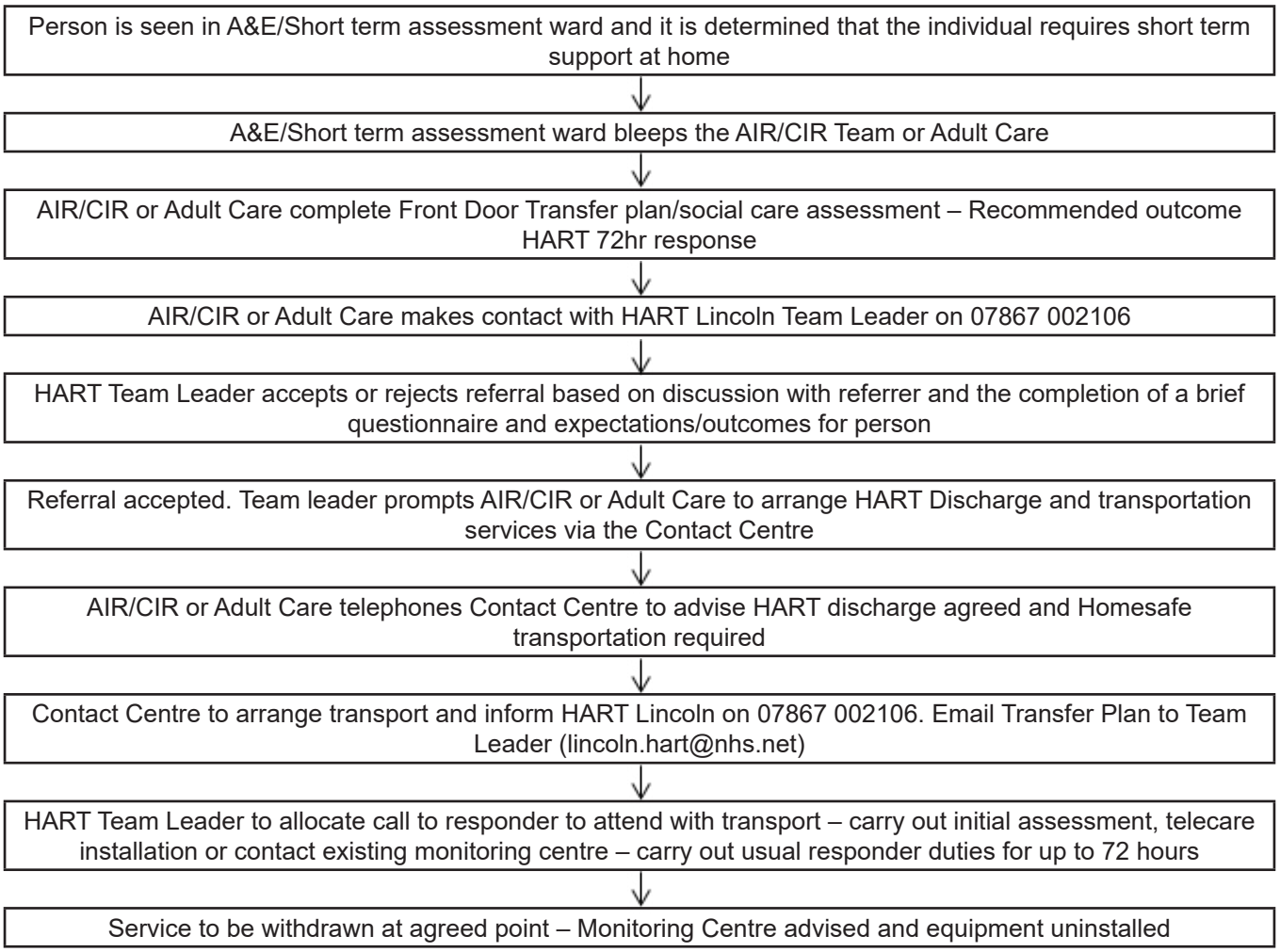
On the provision that an assessment has been arranged within 7 day, or a private agreement is confirmed, telecare can be left. Monitoring services to be advised.

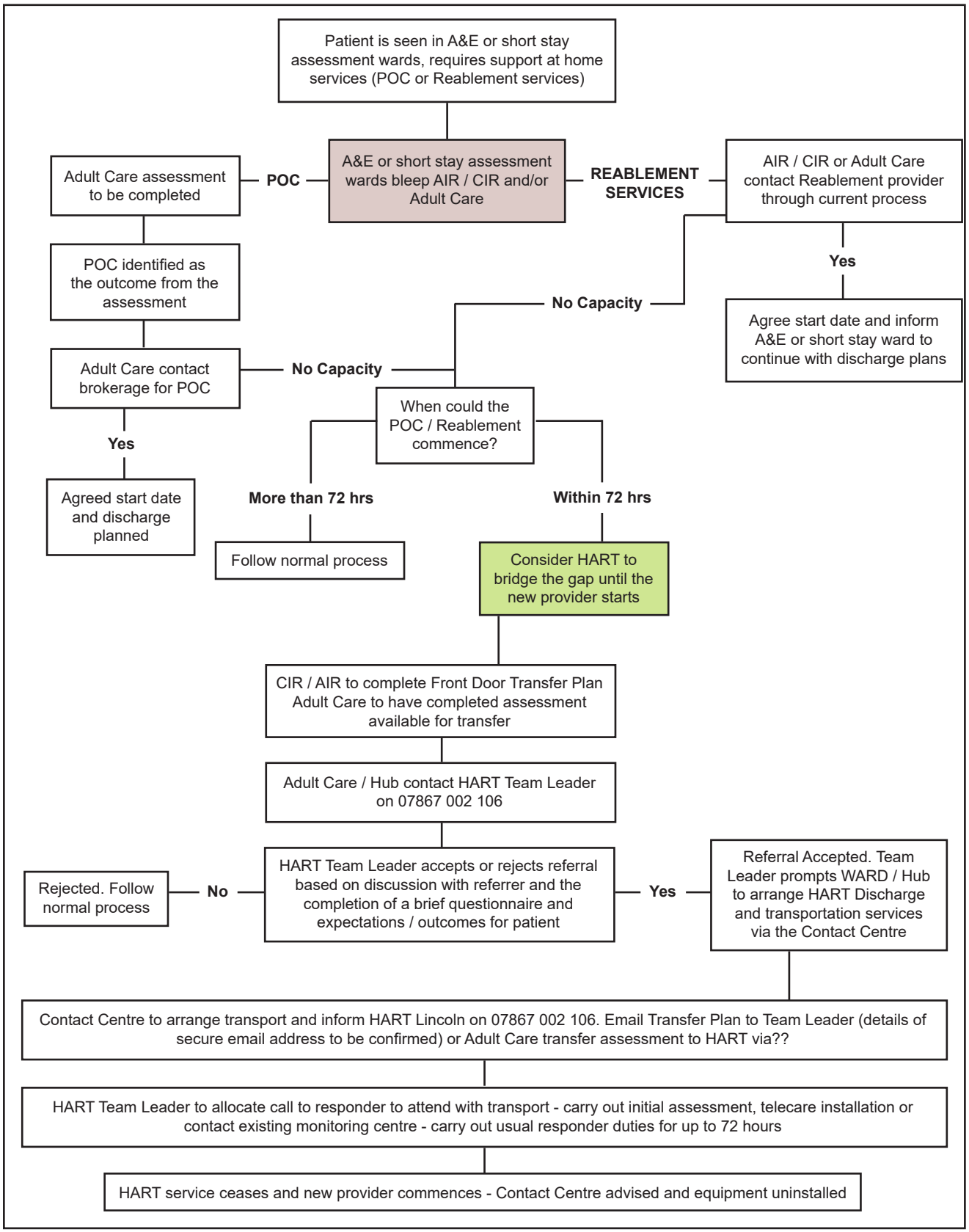
Service user does not want to keep telecare

Telecare removed. Boston Mayflower advised.

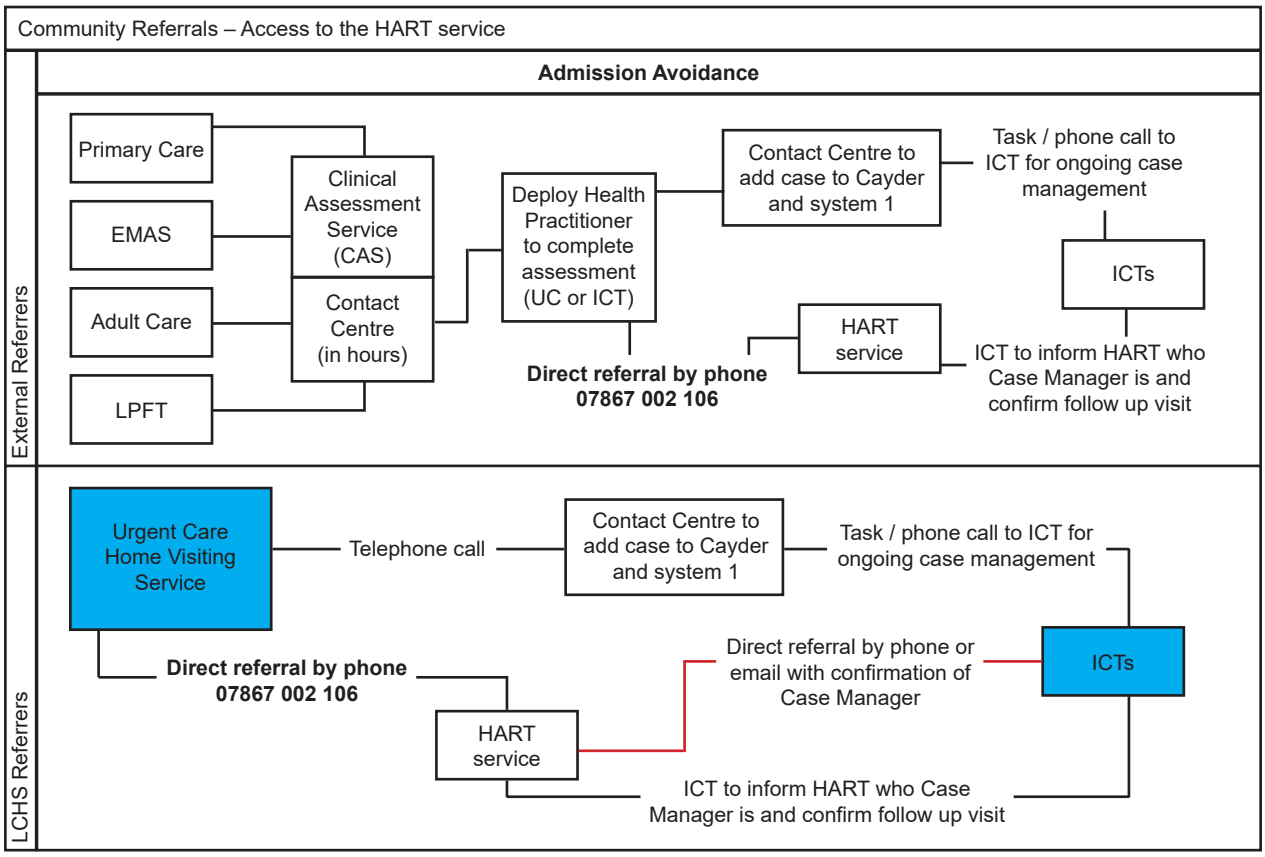
Hospital Discharge Model

Option 1: 72 hour response




Patient is seen in A&E or short stay assessment wards, requires support at home services (POC or Reablement services)
A&E or short stay assessment wards bleep AIR / CIR and/or Adult Care
POC
Adult Care assessment to be completed
POC identified as the outcome from the assessment
Adult Care contact brokerage for POC
Yes
Agreed start date and discharge planned
No Capacity
When could the POC / Reablement commence?
More than 72 hrs
Follow normal process
Within 72 hrs
Consider HART to bridge the gap until the new provider starts
REABLEMENT SERVICES
AIR / CIR or Adult Care contact Reablement provider through current process
No Capacity
Yes
Agree start date and inform A&E or short stay ward to continue with discharge plans
CIR / AIR to complete Front Door Transfer Plan Adult Care to have completed assessment available for transfer
Adult Care / Hub contact HART Team Leader on 07867 002 106
HART Team Leader accepts or rejects referral based on discussion with referrer and the completion of a brief questionnaire and expectations / outcomes for patient
No
Rejected. Follow normal process
Yes
Referral Accepted. Team Leader prompts WARD / Hub to arrange HART Discharge and transportation services via the Contact Centre
Contact Centre to arrange transport and inform HART Lincoln on 07867 002 106. Email Transfer Plan to Team Leader (details of secure email address to be confirmed) or Adult Care transfer assessment to HART via??
HART Team Leader to allocate call to responder to attend with transport - carry out initial assessment, telecare installation or contact existing monitoring centre - carry out usual responder duties for up to 72 hours
HART service ceases and new provider commences - Contact Centre advised and equipment uninstalled

Admission Avoidance Model



3.5 Service Hours

This is a 24 hour a day, 7 days a week, 52 weeks a year service.

3.6 Service Response Times

HART to respond and arrive at a person's home within two hours of either:

- Notification from Mears that the person has pressed their personal alarm
- Notification of discharge from hospital setting
- Notification of referral from community practitioner

Wherever possible an estimated time of arrival to be agreed in advance.

3.7 Interdependence with other services / providers

- Wellbeing Service
- CAS Service
- General Practitioners
- Community Nurses
- Secondary Care
- Domiciliary Care
- OHPs
- Reablement
- Social Care

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Care Quality Commission (CQC)

4.2 Applicable local standards

HART will:

- Comply with regulations and fundamental standards set out by the Care Quality Commission
- Monitor quality outcomes with interventions with people and implementing evidence-based changes to improve outcomes
- Monitor activity and staff performance
- Comply with contract monitoring requirements
- Ensure all staff are competent to safely and effectively perform their tasks
- Monitor and proactively respond to complaints and adverse incidents according to the organisation's protocols

5. Key Performance Indicators

Contractual Key Performance Indicators

Activity Performance Indicator	Method of Measurement	Frequency of Monitoring	Where / When discussed
Service User experience	Service Users and Carers satisfaction surveys: • Actual number of returned surveys versus number of surveys issued – by month and year to date • Mode score from surveys completed – by month and year to date Service Users and Carers complaints: • Actual number of complaints received – by month and year to date • Recurring themes Service Users and Carers compliments: • Actual number of complaints received – by	Recurring themes	Contract Review Meeting

	month and year to date • Recurring themes		
Number and percentage of accepted referrals versus number of rejected referrals and reasons why (e.g. inappropriate referral / capacity issues)	Actual numbers and percentages – by month and year to date Minimum target of 90% accepted referral rate across the year	Monthly	Contract Review Meeting
Re-admissions to hospital – the percentage of service users re-admitted to hospital whilst receiving the services of the Prover and reasons	Actual re-admissions as a percentage of total number of accepted referrals – by month and year to date	Monthly	Contract Review Meeting

Soft Key Performance Indicators

Performance in these areas is not necessarily down to the HART service, but nevertheless it is important to monitor them to help inform current and future healthcare services across the wider health economy.

Activity Performance Indicator	Method of Measurement	Frequency of Monitoring	Where / When discussed
Bridging gap days	Actual number of days the HART service was provided during the month and year to date Target not appropriate		
Number of Service Users breaching 72 hours support	Actual number of service users that breach 72 hours – by month and year to date Minimum target of zero		
Response calls	Actual number of service users who requested a responsive service versus number of actual responsive call outs		

APPENDIX 3 – THE BRISTOL ACCORD

The Bristol Accord was developed in 2005 when the UK had the Presidency of the European Union. In a piece of work led by Rt Hon John Prescott it established a methodlogy for judging the relative sustainability of communities. This work built on analysis by Sir John Egan (who conceptualised sustainability in the context of a system of domains set out in a schematic entitled “The Egan Wheel”). This was adapted in the context of the Bristol Accord into 8 areas of judgement set out in the diagram below namely:

The unit of analysis at which this system operates is very wide ranging from neighbourhood to national level.