Evaluation

The South Somerset experience
South Somerset

• Brief overview of Symphony
• Outline the different approaches and different evaluations South Somerset has been involved with – formal and informal
• What has been helpful (and what less so)
• Plans for the future
Proportion of the population aged 65+ by LSOA - 2013

Proportion aged 65 and over by LSOA 2013

- 50% or more
- 25% -
- 20% -
- 15% -
- Less than 15%

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Proportion of the population aged 65+ by LSOA - 2023

Proportion aged 65 and over by LSOA 2023

- Red: 50% or more
- Blue: 15% - 20%
- Light Blue: 20% - 25%
- Dark Blue: 25% - 50%
- Very Dark Blue: 50% or more
- Grey: Less than 15%

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Proportion of the population aged 65+ by LSOA - 2033

Proportion aged 65 and over by LSOA 2033

- 50% or more
- 25% -
- 20% -
- 15% -
- Less than 15%
The Data Set

Average costs by age group

Average cost per patient (£)

Agebands in years

- 20-24: £569
- 25-29: £632
- 30-34: £615
- 35-39: £581
- 40-44: £647
- 45-49: £592
- 50-54: £638
- 55-59: £739
- 60-64: £953
- 65-69: £1,086
- 70-74: £1,587
- 75-79: £1,930
- 80-84: £2,697
- 85+: £4,465

The costs increase significantly for age groups 80-84 and 85+.
The Data Set

Morbidity (number of ETGs) by age band

Patients (%) vs. Age band (Years)

Number of conditions:
- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7+

The Data Set
## The Data Set

<table>
<thead>
<tr>
<th>Regression variables</th>
<th>Age</th>
<th>Number of conditions</th>
<th>Age, Number of conditions</th>
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</thead>
<tbody>
<tr>
<td>Variation explained</td>
<td>3.36%</td>
<td>18.76%</td>
<td>19.30%</td>
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</table>
The Data Set

Patients with one and multiple ETGs

<table>
<thead>
<tr>
<th>Condition</th>
<th>Patients with one ETG</th>
<th>Patients with 1+ ETGs</th>
<th>Total Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension (17,777)</td>
<td>4,955</td>
<td>5,116</td>
<td>10,071</td>
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<tr>
<td>Asthma (12,769)</td>
<td>2,627</td>
<td>6,209</td>
<td>8,836</td>
</tr>
<tr>
<td>Anxiety (7,962)</td>
<td>1,078</td>
<td>2,362</td>
<td>3,440</td>
</tr>
<tr>
<td>Cancer (5,932)</td>
<td>1,078</td>
<td>1,620</td>
<td>2,738</td>
</tr>
<tr>
<td>IBS (5,688)</td>
<td>1,865</td>
<td>1,700</td>
<td>3,565</td>
</tr>
<tr>
<td>Diabetes (5,676)</td>
<td>829</td>
<td>1,559</td>
<td>2,388</td>
</tr>
<tr>
<td>Skin infections (5,086)</td>
<td>1,945</td>
<td>1,294</td>
<td>3,239</td>
</tr>
<tr>
<td>CAD (4,695)</td>
<td>706</td>
<td>1,084</td>
<td>1,790</td>
</tr>
<tr>
<td>Hypothyroidism (4,275)</td>
<td>981</td>
<td>1,179</td>
<td>2,160</td>
</tr>
<tr>
<td>Skin trauma (3,611)</td>
<td>1,334</td>
<td>873</td>
<td>2,207</td>
</tr>
<tr>
<td>Stroke (2,665)</td>
<td>269</td>
<td>641</td>
<td>910</td>
</tr>
<tr>
<td>Tendinitis (2,578)</td>
<td>739</td>
<td>742</td>
<td>1,481</td>
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<tr>
<td>Gastr signs symptoms (2,144)</td>
<td>724</td>
<td>548</td>
<td>1,272</td>
</tr>
<tr>
<td>COPD (1,989)</td>
<td>206</td>
<td>432</td>
<td>638</td>
</tr>
<tr>
<td>Breast disorders (1,951)</td>
<td>259</td>
<td>565</td>
<td>824</td>
</tr>
<tr>
<td>Fractures (1,546)</td>
<td>511</td>
<td>382</td>
<td>893</td>
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</tbody>
</table>
The Data Set

Average costs for patients with diabetes by setting and number of other ETGs

<table>
<thead>
<tr>
<th>Setting</th>
<th>Number (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>829</td>
</tr>
<tr>
<td>plus 1</td>
<td>1,529</td>
</tr>
<tr>
<td>plus 2</td>
<td>1,362</td>
</tr>
<tr>
<td>plus 3</td>
<td>898</td>
</tr>
<tr>
<td>plus 4</td>
<td>527</td>
</tr>
<tr>
<td>plus 5</td>
<td>279</td>
</tr>
<tr>
<td>plus 6 or more</td>
<td>222</td>
</tr>
</tbody>
</table>

Average cost per patient (£)

Number of ETGs

- cc
- sc
- cm
- mh
- ae
- op
- ip
- pc
The Data Set

Average costs for patients with dementia by setting and number of other ETGs

<table>
<thead>
<tr>
<th>Setting</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia:</td>
<td>N= 51</td>
</tr>
<tr>
<td>plus 1:</td>
<td>N= 89</td>
</tr>
<tr>
<td>plus 2:</td>
<td>N= 109</td>
</tr>
<tr>
<td>plus 3:</td>
<td>N= 119</td>
</tr>
<tr>
<td>plus 4:</td>
<td>N= 68</td>
</tr>
<tr>
<td>plus 5:</td>
<td>N= 52</td>
</tr>
<tr>
<td>plus 6 or more:</td>
<td>N= 58</td>
</tr>
</tbody>
</table>
The Data Set

Initial Cohort:
People with 3 or more conditions*

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>1,012,520</td>
</tr>
<tr>
<td>Primary Care Prescribing</td>
<td>917,361</td>
</tr>
<tr>
<td>Acute IP/DC</td>
<td>5,490,741</td>
</tr>
<tr>
<td>Acute OP</td>
<td>818,975</td>
</tr>
<tr>
<td>Acute AE</td>
<td>170,747</td>
</tr>
<tr>
<td>Mental Health</td>
<td>705,741</td>
</tr>
<tr>
<td>Community Hospital IP</td>
<td>983,730</td>
</tr>
<tr>
<td>Community Hospital OP</td>
<td>1,965</td>
</tr>
<tr>
<td>Community Hospital MIU</td>
<td>1,512</td>
</tr>
<tr>
<td>Community Services</td>
<td>782,709</td>
</tr>
<tr>
<td>Social Services</td>
<td>2,580,688</td>
</tr>
<tr>
<td>Continuing Health Care</td>
<td>987,178</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td><strong>14,453,867</strong></td>
</tr>
</tbody>
</table>

Number of patients: 1,458

How the data shaped the project

- Adults with multiple long term conditions – not frail elderly
- Multi-morbidity model, not disease pathways
- Identification of high cost, defined cohort
- Identification of commissioning budget
- Ability to track changes to activity and cost

*Conditions included:
- Diabetes
- Cardiac Disease
- COPD / Occupational Lung Disease
- CKD / Renal failure
- Depression / Anxiety
- Dementia
- Stroke
- Cancer
Currently 85% of resources are used by ~20% of the population, the challenge therefore is to develop new care models that deliver high quality, effective, cost efficient care for all of the population.

**Population cost pyramid, South Somerset**

~£150m total cost; Primary, secondary, community\(^1\), mental health and social care

<table>
<thead>
<tr>
<th>Population segments</th>
<th>Cost breakdown</th>
<th>Care models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex patients with many conditions</td>
<td><del>50% (</del>£75m)</td>
<td>Patient-centred, holistic coordinated care</td>
</tr>
<tr>
<td>High Cost (over £7k/yr)</td>
<td>~5k</td>
<td>→ Complex Care Hubs</td>
</tr>
<tr>
<td>Less complex patients with fewer conditions</td>
<td><del>35% (</del>£55m)</td>
<td>Proactive chronic condition management</td>
</tr>
<tr>
<td>Moderate cost (£1-7k/yr)</td>
<td>~20k</td>
<td>→ Enhanced Primary Care</td>
</tr>
<tr>
<td>Mainly healthy patients</td>
<td><del>15% (</del>£20m)</td>
<td>Efficient primary care, proactive health and well-being services</td>
</tr>
<tr>
<td>Low cost (under £1k/yr)</td>
<td>~90k</td>
<td></td>
</tr>
</tbody>
</table>

The top 4% of population drive 50% of the cost; the top 22% drive 85% of the cost.

Source: South Somerset Symphony project data 12/13, Oliver Wyman analysis
Note: 1 Community service activity (e.g. district nursing) data not allocated to individual patients, therefore not included here.
Staff and partner organisation feedback

Staff worked together in groups to explore their frustrations with the current system and their future hopes for themselves, patients and carers. Common frustrations included...

For staff

Poor communication between providers and or teams
- Barriers between providers
- Risk sharing & funding tensions
- Lack of 7 day & 24 hour service
- Lack of resources & time
- Too many people involved causing confusion, duplication & delays
- Unclear and complex pathways
- Lack of responsibility & ownership

Shared info & systems
- Lack of care planning & continuity
- Lack of respect & understanding for different professional roles
- Top down targets & focus on targets not quality

For patients

Gaps in services available
- Fragmentation
- Inefficient use of resources
- Delays in decision making
- Information not shared

Can’t access or navigate services
- See the condition not the patient
- Lack of responsibility

Communication
- Inequality
- Fragmented & lack of continuity
- Patient journey not joined up
- Falling through the net
Staff and partner organisation feedback

Shared hopes included:

For staff
- Efficiency
- Real, sustainable change
- Integrated services
- Integrated IT
- Clear understanding of roles
- Fewer boundaries
- Single point of access/contact

- Increased patient commitment to their own care
- Reduced pressures
- Easy navigation
- Staff feel valued
- Patient focused
- Prevent crisis
- Seamless care/continuity
- Single care plan
- Holistic approach
- Transport co-ordination
- Responsive services

- Reliability
- Time
- Improved discharge

- Single point of contact
- Communication & co-ordination

- Responsive process
- Clear pathways and signposting
- Seamless services
- Timely, supported discharges
- Easy, timely access
- Support for carers
- Support to stay healthy
- Crisis support 24/7

- Avoid admissions
- Single point of contact
- Clear, single care plan
- Care continuity
- Shared information
- Choice and control
- Services closer to home
- More quality time

Height of the words and phrases is proportional to the number of times they were used by staff groups.
Vision:

‘Leading innovation and integration for a healthier, more independent population.’

Objectives:

_Informed people, empowered to take responsibility for their health and wellbeing._

_An ambitious and adaptive workforce, working creatively to deliver exceptional care._

_A seamless, integrated and responsive network of care services, working together to do the right thing for patients._
## Outcomes

<table>
<thead>
<tr>
<th>Focus</th>
<th>Me and my carer(s), taking account of all my conditions and our physical, mental, social and emotional needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome</td>
<td>I am helped to manage my conditions and live in the way I want to the best of my ability</td>
</tr>
<tr>
<td>Feature(s)</td>
<td><strong>ACTIVE INVOLVEMENT</strong> I am listened to and involved in planning and making choices about my care in a way that suits me. <strong>POSITIVE RELATIONSHIPS</strong> I have one key person who takes ownership for coordinating all aspects of my care. They make me aware of all the options and keep me informed about what’s happening. They understand me and I trust them. <strong>EASY ACCESS</strong> I can contact my care coordinator when I need to. I am given access to information, education, advice and expertise to help manage my condition. Support and services are available as close to my home as possible and I know there is a 24/7 response available if I need it. <strong>SEAMLESS COORDINATION</strong> I receive seamless timely, coordinated care with easy, efficient transitions from one service to another. Professionals across all services have access to an up-to-date shared record of my condition, needs history and services and treatments I am receiving.</td>
</tr>
</tbody>
</table>
| Enablers | • Caring, compassionate, competent and knowledgeable staff work in multi-disciplinary teams across organisational boundaries with up-to-date, shared records, facilitated and supported by organisations and systems.  
• Patients and carers are asked for feedback on services and see improvements happen as a result. |
We have focused on three new care models we think could have most impact for the population of South Somerset

**Extensivist/ Complex Care**

Holistic care system providing coordinated, comprehensive care to the most needy and frail patients

- Highest need patients at risk of imminent crisis or significant decline
- Current uncoordinated care and inadequate access leads to unnecessary admissions and poor management

**Enhanced Primary Care**

Team based care that provides comprehensive and convenient medical care to patients

- Condition severity ranges from independent and low acuity (e.g. diabetes) to systemic and complex (e.g. liver disease)
- Require support to manage their disease day-to-day and proactive care during flare-ups

**Systematised surgery**

Outpatient centres delivering high efficiency care in a convenient setting

- Delivers significant improvements for patients
- Focus on achieving scale in specific specialties
- Provides opportunities for specialisation for surgeons
- Improves efficiency of delivery

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**Hub Team**

- Keyworker
- Extensivist
- Care Coordinator

**Patient with Chronic Condition**

**Health Coach**

**Complex, Poly-chronic Patients**

**Carer**
## Complex care logic model

### Rationale
With an increasing aging population with chronic diseases there is unprecedented demand on services which is unsustainable both in terms of cost and care provision. The complex care service will provide intensive support for people with multiple conditions including senior medical support, care coordination and personalised care plans to support better patient self-management.

### Inputs
- Funding: Transformation funding of £13.4m
- Staff: Acute, Community, Social care, management, Primary care — 8 WTE in hub (Drs, Care Coordinators, Key Workers)
- Space: Base for Hub staff to work and consult with patients X3
- Shared knowledge: Training of staff in new roles, Voluntary sector, co-development with patients

### Activities
- Setting up of 2 further hubs
- Development of a shared vision of personalized and coordinated care by clinical time management and patient empowerment.
- Create single point of access for patient through Keyworker role
- Development of individual clinical and care pathway by care co-ordinator and patient involvement.
- Providing access to other service providers.
- Development of shared electronic care record with robust IG (including patient access)
- Communication strategy to share outcomes with key stakeholders
- Appointment of new roles: Extensivist: Key worker; Health coaches; Care co-ordinators
- Development of SOP for complex care operations and team functionality
- Workforce development and integration with EPC, Mental health, pharmacy, physio/OT
- Develop a governance structure
- Develop a Management structure
- Develop and agree service KPIs

### Outputs
- 1500 patient being cared for staff in 3 hubs
- 100% of patients involved with care plan and decision-making process
- 100% of patients with a named Key worker
- No. of GP appointments as first interaction with primary care
- Shared electronic care record
- SOP with Communication strategy relating to outcome information
- Number of roles filled and candidates meeting all progress milestones.
- Attrition rate reduced for staff
- Staff survey results
- Service staff stability score
- SOP in place to describe operational and function of team
- Service management team in place with ToR and SOPs
- Governance management team in place with ToR and SOPs
- KPI Dashboard displaying patient contacts & unplanned inpatient attendance, as well as clinical governance data including incidents, complaints & PALS

### Outcomes
- Improved patient experience of care with greater involvement, choice and improved activation by year 1
- Improved access to local / appropriate Services / information by year 1
- 1500 patients with established care plans
- Reduced feelings of loneliness by year 1
- Improved mental wellbeing of patients by year 1
- Reduced A&E attendance by 1400 per annum, bed days reduced by 6700 by year 4
- Reduced mortality rates in acute care by year 2
- Sharing of information to integrate care to improve care, reduce duplication and develop one shared record accessible to all care staff by year 1
- Motivated, flexible workforce by year 2 with Extensivist and GPs co-operating as one
- Continual development of innovative roles which improve care by year 1
- Cost effective use of resources with co-location with mental health, DNSs, SS and voluntary sector by year 2
- Coordinated services reviewed in light of the existing tools already developed through the Symphony Outcome Group by year 1
- Patient supported in managing own health by year 1

### Impacts
- Improved patient experience of care
- Continued access to local / appropriate services so patients manage own health and stay in own home where appropriate
- Reduced health inequalities
- People have a say in priorities and care provided in health and care system
- Motivated, flexible workforce
- Co-ordinated care results in sustainable model of care which is financially viable
- Economic benefits due to reduction in waste and duplication across the system
- Integrated IT systems

### Contextual factors:
- National policy / regulations such as NHSE Operating model for continuing Healthcare; Intra-agency collaborative working; supply of appropriate workforce; Local evaluation may impact diffusion of care
- Assumptions: 1500 patient cohort; Health economy savings at £5 Million per annum; 3 hubs and workforce to staff: Extensivist in hubs; GP acceptance of new model of care for complex patients

### Enablers:
- Innovations in use of technology: Integrated IT Systems / single care records / Telehealth; Mobile IT / development of Apps
- Innovations in process: Assessment, life coaching; public engagement, strong partnership working; use of data, IG, workforce training

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**Complex care V 5.1**
## EPC Logic Model

### Rationale

Currently, primary care is unsustainable – in terms of workforce (recruitment) and managing case load. Similarly, the demand for care from more complex patients is not sustainable, and new forms of care are needed to manage LTCs more effectively in community settings.

### Activities

- Develop new methods of working – daily huddles to monitor patient activity, proactively working with patients via the health coach role.
- Planning to deliver a patient-centred approach.
- Patient and carer engagement and education – patient experience survey carried out on entry, repeated at 3 monthly intervals.
- Health coaches support & information to help patients manage their own health needs.
- Stakeholder engagement – providers, social care etc.
- GP engagement via 1:1 engagement events, white papers.
- Recruitment of 133 health coaches and 6 care planners.
- Integration of New model of working.
- Training of staff (Masterclass development, ‘train the trainer’).
- Patient population stratification.
- Data gathering and monitoring to measure the effects on admissions, length of stay etc. for EPC vs non-EPC patients.

### Outputs

- Blueprint for EPC: model and implementation approach.
- Pilot practices for EPC (5 initially, 8 in wave 2 and 7 in wave 3).
- Continuous improvement process in place.
- Agreed framework for collaborative working across statutory and voluntary sectors.
- GPs engaged and referring patients to health coaches.
- Patients managing own health resulting in reduced A&E attendance, reduced LoS, and greater self-referral to specialist clinics.
- Competency framework for new roles.
- Dashboard – measuring KPI’s such as un-planned inpatient attendance, average LOS, outpatient apps, patient contacts, time to next routine app, patient engagement and clinical performance.

### Outcomes

- Educational health coaches and care planners in post by year 1.
- Patient cohort stratified. By year 1.
- Masterclass training developed by year 1.
- Continuous review of patient metrics such as FEV1, Weight, Glucose control, by year 1.
- Data available to review, analyse and select areas for continual improvement by year 1.
- MSK, pharmacy, mental health integrating with Primary care by year 2.
- Acute Referrals reducing by 750 by year 2.
- Health coaches educating patients by year 2.
- More care delivered in home and community settings by year 2.
- GP’s operating ‘at top of licence’ enabling proactive health management of patients most at risk of becoming complex by year 3.
- Fully staffed primary care model by year 4.
- Acute admissions reduced by 2000 by year 4.

### Impacts

- Better patient experience.
- Close forecast financial gap.
- Fewer, longer GP consultations.
- Better GP work-life balance by boosting the self-care agenda.
- Sustainable financial and workforce model for primary care (4 years).

### Enablers:
- Workforce planning
- Masterclass training for health coaches
- Outcomes based commissioning

### Assumptions:

- Fully integrated collaborating health economy,
- Removal of primary and secondary care barrier,
- Patient ownership of their care and conditions. There should be a cost reduction of £5 Million by 2020 once EPC has been implemented.

### Contextual factors:

- Generally rural population, pockets of deprivation, inequalities, poor transport, retirees, higher proportion of over-65’s, forecast to increase exacerbated by difficult to recruit staff and esp. GPs/locums...
Overarching logic model

**Rationale**

By 2030, South Somerset is forecast to see a 43% increase in the proportion of the population aged over 65. The challenge is to meet the ever increasing demand matched by a no increase in funding, coupled with a static working age population and the consequential impact inability to recruit. Through high quality, joined up, patient-level data spanning the whole of health and social care, we have stratified our position based on multi-morbidity and complexity and developed new, integrated approaches for each group.

**Activities**

- Develop Complex Care Hub: Patient-centred Service for 1500 patients with multiple co-morbidities
- Design Enhanced Primary Care service: Supporting GPs to offer greater support through Health coaching and innovative approaches
- Create a Joint venture with Primary care: Single capitated budget and resource sharing supported by outcomes based commissioning
- Development of Urgent and elective care work streams in progress (Not started yet)
- Evaluate and monitor ‘activity, finance and qualitative’ data

**Outputs**

- Patient Centred comprehensive care planning for all service users
- Regular documented reviews by key workers for all patients
- Use of new technology to allow access for all staff and patients to notes
- Re-developed workforce and service models
- Novel care pathways so patients seen by wider range of professionals
- Integrated Clinical Governance Framework
- Enhanced access to secondary care advice for GPs
- Single capitated budget
- Outcomes based contract
- Dashboard/metrics of outcome, activity and financial data

**Year 4 Outcomes**

- Improved patient experience of care and improved health outcomes
- Reduction in inappropriate admissions and attendance to A&E by 50% for CHF
- Co-ordinated patient care reducing duplication across the system
- Increased number of patients supported in managing own conditions
- Reduced length of stay (62% Av.Los)
- 31% reduction in bed days per 1,000 pop

**Year 5 Impacts**

- Improved patient experience of care
- Improved patient outcomes with change of focus to prevention
- Shared control and rapid decision-making between all parts of system
- Collaborative working to provide a co-ordinated health care delivery service for all
- Reduced health inequalities
- Motivated, flexible workforce with GPs working at ‘top of license’
- Patients being cared for by wider range of professionals
- Reduction in waste and duplication across the system
- Increased investment in prevention and primary care
- Realisation of cost savings
- Improved visualisation of data to report progress and influence change
- More community engagement to effectively solve issues and develop services

**Inputs**

- Transformation funding (£13.5M)
- Innovative workforce (health coaches, Extensivist role)
- Space to accommodate new teams to manage transformation and to consult with service users.
- Partnership working with primary care, Social care, voluntary sectors, and other providers such as Commercial and technical advisors.
- IM&T technologies- EMISWEB, UMBOT (APPS)
- Co-design of models with staff and service users

**Enablers:**

- Innovations in use of technology: Integrated IT Systems / single care records/ Telehealth; Mobile IT
- Innovations in process: Assessment, life coaching; public engagement; strong partnership working; use of data, IG

**Contextual factors:**

- Generally rural population, pockets of deprivation, inequalities, poor transport, retirees, higher proportion of over-65s, forecast to increase, difficult to recruit staff/ national policy, staff and public behaviours and expectations.
## Evaluations

<table>
<thead>
<tr>
<th>Evaluation focus</th>
<th>Funded by</th>
<th>Evaluation partner</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keyworker training &amp; role</td>
<td>NHS SW education</td>
<td>EDIF-ERA</td>
<td>April – Oct 2016</td>
</tr>
<tr>
<td>Complex care hub</td>
<td>Somerset CCG</td>
<td>Plymouth University &amp; SW AHSN</td>
<td>April 2015 – March 2016, extended to March 2017</td>
</tr>
<tr>
<td>New models of care</td>
<td>NHS England / Vanguard</td>
<td>York University &amp; SW CSU</td>
<td>Aug 2016 - ?</td>
</tr>
<tr>
<td>SELFIE study</td>
<td>EU-funded Horizon 2020 project</td>
<td>Manchester University</td>
<td>Aug 2016 - ?</td>
</tr>
<tr>
<td>PAM learning set</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Evaluation

What has been helpful

• The Symphony data set
• Clear vision and outcomes framework
• Logic model
• Commonality of outcome metrics across evaluations

What has been challenging

• Differing timescales and agendas for different evaluation processes
• Funding issues and procurement of evaluation partners
Symphony cohort – a continuum

Managed by EX & CC
some only need KW, HC or CC

Managed by HC
some also need support from GP plus CC.

HC supported
some patients still need professional input from GP.

complex cases with co-morbidities
high % of professional care
equally shared care
professional care

high risk cases
70-80% of the people with long-term conditions

self care
high % of self care
Plans for the future

• Continue to respond to changing evaluation landscape whilst holding firm to vision and ideals.

• Continue to ensure evaluation framework is fit for purpose with the evolving model of care and context