MCMW Evaluation Executive Summary

January 2018

Context

The executive summary provides an overview of the first evaluation of the whole system integrated care model My Care My Way (MCMW) introduced by West London CCG (WLCCG) in January 2016. The evaluation was undertaken by Buckinghamshire New University. The evaluation consisted of two parallel studies:

1. A qualitative study undertaken using interviews with MCMW service users, Case Managers, Health and Social Care Assistants (HSCAs) and GPs conducted during the period January 2017 to July 2017.
2. A quantitative study of the impact of MCMW on service utilisation, this included all patient's recruited to the MCMW service in 9 GP practices during the period 1st September 2015 to 31st October 2016.
    - Using the WSIC de-identified database these patients were matched to a sample of patients from a local CCG (selected because it uses a range of similar services e.g. CIS) and separately to patients registered to wave 3 GP practices in West London CCG.
    - Service utilisation by this cohort of patients was evaluated during the time period 1st November 2016 to 19th October 2017. The final date was used as this was the last date on which there was a substantial volume of patient data at the time the analysis was conducted.

The evaluation was undertaken at an early stage in the mobilisation of the MCMW service. To date, the service has rolled out to 24 of 44 practices across WLCCG and since roll out commenced in January 2016, the service has gone through a process of iterative development and learning to develop and refine the model of care. As a result, this evaluation must be seen

in the context of evaluating a new and emerging service, at an early stage in its journey to deliver integrated care across WLCCG.

The strategic intention behind the My Care My Way (MCMW) service was to commission the service through a 'pump-priming' approach, in addition to existing community health and care services across WLCCG. The intention was to change the balance of provision by shifting acute activity and flow into the community, reducing unplanned activity and increasing the proportion of planned interventions. This was to be achieved through better case and condition management and facilitated self-care of elderly patients; more integrated care delivery to enable more timely and holistic support, focused on an integrated assessment of and response to the patient.

The next step on the CCG's Whole Systems commissioning journey is to review the changes achieved to date across the out of hospital system and identify opportunities to remove duplication and increase efficiency through further integration. This intention is reflected in the West London Integrated Care Strategy (November 2017) which sets out the local system's strategy to more closely integrate community provision across both health and social care including the MCMW service by forming an Integrated Community Team, which will launch in 2018/19. It is the intention to evaluate the next phase of the CCG's journey towards greater integration and accountable care to show how the local system has built on the foundation created by the MCMW service and other whole systems services such as the Community Living Well service.

Background to the Evaluation

At the time of the evaluation 24 of the 44 GP practices in NW London were participating in MCMW. To support these GP practices 26.7 WTE Case Managers (CMs) and 30.2 WTE Health and Social Care Assistants (HSCAs) were recruited and attached to participating GP practices. The CMs had a variety of professional backgrounds including District Nursing, Acute hospital nursing, mental health nursing, social work or an allied health professional background. The HSCAs also had a variety of backgrounds, some had trained as health professionals in other countries but were not on the UK register, others had experiences including health promotion roles such as health trainer or primary care navigator roles. Case Managers and HSCA were allocated to participating GP practices to support the implementation of MCMW.

Patient recruitment to MCMW commenced in September 2015. By October 2017 a total of 4,861 (24%) patients aged 65 and over had enrolled on MCMW from a total population of 20,370 patients aged 65 and over registered at the participating GP practices[1]. All patients in the 24 participating GP practices are stratified using the electronic frailty index (eFI). The proportion enrolled in MCMW from each tier of the Frailty Index by October 2017 across all 24 GP practices is given below:

- 77% of tier 3 patients have been recruited to MCMW
- 58% of tier 2 patients have been recruited to MCMW
- 25% of tier 1 patients have been recruited to MCMW[2]
- 4% of tier 0 patients have been recruited to MCMW[2]

The evaluation of the MCMW services spans the period 1st September 2015 to 19th October 2017.

Summary of Findings

The principles of MCMW found to be working in the patient and staff interviews are:

- Single point of contact – all Tier 2 and 3 patients and where relevant their carers knew to contact either their CM or HSCA and many were using them regularly as their first point of contact if they had any concerns about any aspect of their health and social care.
- Individualised Care - Care being given to patients is being tailored to the needs of the patient and carer and services are being coordinated around the individual needs of the patient and carer.
- Case Managers and HSCA are developing an in-depth understanding of the patients and families' needs and priorities and organising care around these needs.

Working together Case Managers and HSCAs are:

- Reviewing and streamlining medications to bring medication management in-line with the patients' cognitive and functional abilities.
- Reviewing and streamlining referrals to the wider system, removing duplication and referrals that are not aligned to the patients' and family priorities.

[1] Taken from the November 2017 monthly statistical report.
[2] Data on the total number of tier 0 and 1 patients in some GP practices missing from the monthly Report

- Providing expert support for patients with drug and alcohol problems and managing the impact of these problems on services.
- Providing more effective signposting to mental health services where required.
- Addressing unmet social care needs.
- Addressing social isolation through social prescribing.
- Organising the extended GP appointments at the hubs and in GP practices.

Crisis Management - There was no evidence of patients involved in the qualitative review having experienced a health crisis since enrolling on MCMW in the patients interviewed

GPs valued the CMs and HSCAs very highly and saw considerable benefits for patients in the role.

Additionally Case Managers and HSCAs have:

- Enabled GPs to work more efficiently and spend more time using their high level clinical skills and less time on administrative demands.

Extended GP appointments have:

- Enabled GPs to get a much better understanding of patient care needs and integrate their management of the patient's health conditions.
- Reduced the number of GP practice appointments, particularly serial appointments by patients with complex conditions.

Where extended appointments have occurred in the hubs they have:

- Enabled MDT working especially engaging pharmacists in care planning.
- Facilitated improved communication between GPs and specialist hospital consultants.

The MCMW model works because of the case management perspective brought to the role by CMs and HSCA. CMs and HSCA are providing a kind of wrap around care for patients making the system work for the patient, not setting any boundaries on the needs they will address but seeking solutions to patient needs from across the system. This is unique in the patients and GPs experience and it works - from sorting out a plumber to fix a broken boiler to helping an elderly patient to manage nuisance calls from callers asking for her bank details.

The MCMW model is based on solid relationships between the patient/carer, CM/HSCA and GP and trust between all three parties. It is a care model not a health promotion / disease management model. The MCMW model is supporting patients and families to come to terms with the deteriorating health trajectory of the patient. This is crucial to facilitating anticipatory and advanced care planning which are key to proactive care management (Oliver, Foot, & Humphries, 2014).

Service Utilisation by MCMW Patients compared to the Control Group

Findings from the analysis of service utilisation by MCMW patients compared with the control group from a local CCG are given below:

MCMW is reducing unplanned crisis interventions across the system of care.

- Although not statistically significant, there was a trend of reduced utilisation by MCMW patients of all measures relating to unplanned care including:
    - A&E attendance
    - Non-elective admissions
    - Out of hours GP call-out.

To have identified indicators of cost avoidance on this early sample is promising.

There was evidence that planned care was higher in the MCMW cohort compared with the control from a local CCG:

- There was evidence that the number of elective inpatient admissions was higher in the MCMW group. However, the increased number of elective admissions did not translate to differences in total inpatient cost as length of stay was lower in MCMW patients.
- The number of outpatient appointments was significantly higher in the MCMW group, on average 0.9 more appointments per person.
- When examining measures of primary care utilisation, the MCMW group were found to have significant higher numbers of primary care planning appointments, outward referrals, and instances of prescribing, visits and total primary care interactions. This reflects the investment made by the CCG in MCMW, the utilisation of the hubs and extended GP appointments.

- Both the number of social care appointments and district nurse appointments were not found to significantly vary between the two groups.
- MCMW patients used less A&E and inpatient services in the first seven months of the analysis November 2016 to May 2017 than in the next five months June 2017 to October 2017 when compared to the control group. This indicates that MCMW may be having a small impact on reducing winter pressures.
- Outpatient attendance by MCMW patients reduced considerably in the later 5 month analysis to 0.1 more outpatient appointments per MCMW patient when compared with the control group and became non-significant. This could indicate a stabilisation of the MCMW cohort in terms of addressing outstanding unmet need and stabilising the patients care plan.

Health Economic Analysis

The health economic analysis examined the cost avoidance realised by MCMW compared with the assumptions made in the original MCMW business case and these are given below.

The annualised data indicates an annual cost avoidance of £322 per MCMW patient from a combination of reduced A&E attendance and reduced in-patient costs:

Non-elective inpatient cost annual savings per MCMW patient = £274

- Scaled up to the total MCMW population at the end of the evaluation (n = 4,861 patients) this equates to £1.3 million cost avoided on non-elective inpatient costs per annum compared to the £1.4 to £3.6 million per annum anticipated in the Business Case for West London CCG as a whole when MCMW is fully operational.

Elective inpatient annual savings per MCMW patient = £35

- Scaled up to the total MCMW population at the end of the evaluation (n = 4,861 patients) this equates to £0.17 million cost avoided per annum on elective inpatient costs compared to the £0.1 to £0.5 million per annum anticipated in the Business Case for West London CCG as a whole when MCMW is fully operational.

A&E annual savings per MCMW patient = £13

- Scaled up to the total MCMW population at the end of the evaluation (n = 4,861 patients) this equates to £63,193 or £0.06 million cost avoided for A&E per annum compared with the £0.3 to £0.4 million per annum anticipated in the Business Case for West London CCG as a whole when MCMW is fully operational.

The original MCMW business case anticipated total cost avoidance related to A&E attendance and reduced in-patient costs of between £1.8 and £4.5 million when MCMW is fully operational for WL CCG as a whole. If the identified savings of £322 per MCMW patient per year is applied to all MCMW patients recruited during the period of the evaluation (4,861) this would give an overall cost avoidance of £1,565,242 (£1.5 million) per year, approaching the £1.8 million anticipated in the business case when MCMW is fully operational.

Service delivery costs for MCMW for the year November 2016 to October 2017 (year of the evaluation) are £2,088,828. This covers salary costs of MCMW frontline staff (SCMs/CMs/HSCAs). It excludes management costs, Hub costs and educational costs. The overall cost avoidance of £1,565,242 in the year of the evaluation gives 0.74 annualised return on an investment of £2,088,828. This reduces to an overall cost avoidance of £967,339 per year if the additional outpatient costs, not anticipated in the original MCMW business case, are included in the economic analysis. This gives a 0.46 annualised return on the investment of £2,088,828.

These initial findings are encouraging as they show that the service is beginning to have the intended impact on unplanned spend in the form of reduced A&E attendance and in-patient costs. The cost avoidance assumptions in the business case reflect the outcomes anticipated when MCMW was fully operational. MCMW has yet to be implemented in the remaining 20 Wave 3 practices.

Discussion and Conclusion

It's important to note that many of the MCMW staff took up post during the period of the evaluation. Although there were 25 HSCAs in post in April 2016, there were only 4 CMs and 3 Senior Case Managers (SCMs) in post in April 2016, this had increased to 32 HSCA, 15 CMs and 11 SCMs by March 2017, so effectively the evaluation reflects the first year of the service which was dominated by mobilisation.

The delay in delivery of Net savings is to be expected due to the lag in outcomes delivery associated with this patient cohort.

- A sizeable proportion of the elderly cohort that the MCMW service engaged with initially in 2016 were extremely frail and had not benefited from the intensive clinical management and behavioural support including self-care support that MCMW now offers.
- Early mobilisation of MCMW focused on some of the more vulnerable patients and the impact that the MCMW service could have on this cohort in terms of behaviour change, including self-care behaviours, was therefore less than the healthier (often younger) two thirds of the MCMW cohort.
- The healthier two thirds of the cohort are now being mobilised and are receiving MCMW services. This means that the service can expect a 'lagging' impact on outcomes delivery as the benefits of the service's intensive engagement on this less needy segment of the cohort are only now beginning to bear fruit.

There is evidence that it can take up to five years before the economic benefits of primary and community care investment are realised and these are often found to be a reduction in growth in the use of unplanned hospital services, rather than a reduction in net utilisation (Charles, 2017).

Policy and evidence-based support for MCMW

The next steps in the NHS Five Year Forward Review (NHS England, 2017) recognises that:

> "Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single,

unconnected ‘episodes’ of care. Increasingly we need to manage systems – networks of care – not just organisations. Out-of-hospital care needs to become a much larger part of what the NHS does. And services need to be integrated around the patient.” (NHS England, 2017).

The work of MCMW is enabling many of the principles outlined in the Five Year Forward Review to be implemented in practice within WL CCG.

Taken together previous research has demonstrated that the following changes in practice impact positively on clinical care, patient behaviour and reduce use of unplanned care:

- Improved patient activation and engagement in health (Greene & Hibbard, 2012; Hibbard, Mahoney, Stock, & Tusler, 2007)
- Improved patient education and self-care management (Cramm et al., 2014; Dixon-Fyle, Gandhi, Thomas, & Spatharou, 2012)
- Improved patient / GP continuity (Barker, Steventon, & Deeny, 2017; Busby, Purdy, & Hollingworth, 2017; Tammes et al., 2017)
- Improved communication between specialist and generalist clinicians (O’Malley, Reschovsky, & Saiontz-Martinez, 2015)
- Medication optimisation (Duerden, Avery, & Payne, 2013; NICE, 2015)
- Integration of health and social care (Cameron, Lart, Bostock, & Coomber, 2013; Philp, Mills, Thanvi, Ghosh, & Long, 2013; Purdy, 2010)
- Reduction in isolation and loneliness of elderly patients (Centre for Policy on Ageing, 2014)

The above evidence-based practices were all identified as emerging behaviour and practice changes facilitated by the introduction of MCMW.

The Hubs

The hubs have a particular role to play in facilitating the implementation of the evidence base in the next iteration of MCMW in particular:

1. Improving communication between generalist and specialist clinicians at scale and improving communication between community and hospital clinicians.

2. Aligning care for more patients with protocol based disease management guidelines. The hubs could become centres for the implementation of protocol based disease management informed by the hospital based clinical specialists working out into the community and ensuring that GPs, community based specialist nurses, DNs, Practice nurses and CMs are all following the same agreed disease management protocols at scale.
3. Becoming centres for patient education in disease management at scale e.g. running expert patient groups, patient education programmes such as DAFNE and DESMOND for diabetes and self-help groups for patients and carers at scale. As well as being repositories of local knowledge for third sector activities.

Additionally the findings indicate that much of the MCMW practice evidenced in this evaluation facilitates the implementation of best practice as set out in the NHS Five Year Forward Review, the Mental Capacity Act and NICE guidelines when caring for elderly patients experiencing multi-morbidity (National Institute for Health Care and Excellence, 2016). These represent important principles of care which underpin high quality clinical practice but are difficult to implement in a fragmented, episodic care system.

To conclude:

- MCMW has provided a good foundation for integrating care in West London. Both patients and carers spoke very highly of the service, in one case describing it as 'remarkable.'
- GPs spoke very highly of the service.
- Morale among the case managers and HSCA is high.
- Previous research of integrated care models has not been able to identify any cost avoidance during the mobilisation period. This study has found early evidence of cost avoidance.
- Findings from the quantitative evaluation reinforce the qualitative findings that MCMW is reducing unplanned crisis across the system of care.
- Overall, whilst the economic case is not yet compelling, when the planned activity to reduce duplication is taken into account (i.e. Integrated Community Team mobilisation) the case is strong to continue this service's positive trajectory.
- The demands of an aging population are increasing, MCMW is facilitating the implementation of evidence and policy based practice in out of hospital care.

Despite the limitations of the economic analysis, there are few other alternatives available and there is no evidence that the current system is working any better.

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