MCMW Self-Care cohort comparison – SROI analysis update by Envoy Partnership- Nov-Dec 2019

This document presents a short analysis of CCG episodes data (GP and Acute), based on the 2016-2017 SROI evaluation model of calculation. The number of participating GP practices has grown from 24 to 39, however we have assumed the same distribution splits of activities taking place. We recommend additional analysis is conducted on these points with forthcoming data if there is appropriate budget to do so. In total for the period including the pilot year (April 2016 – March 2019), there have been 2225 clients referred (who can access a maximum of two referrals if a second round of follow-up sessions is deemed necessary), with 443 potential dropouts i.e. referrals who did not attend or discontinued / passed away. **Social care** resource savings **c.£129,000** have also likely been generated through MCMW Self Care services' preventive effects.

Resource savings to health care only (NB excluding i) value of subjective patient health and wellbeing, and ii) social care resource savings)

Table I illustrates the resource value for GP practices and hospitals for this year's analysis using GP appointment and acute episodes data up to March 2019 from WLCCG. This is then compared against the original analysis for the pilot period, as well as against the pro-rated results for the period to Apr 2017-Mar 2018 which estimated *growth to 1300* clients referred *annually.* **However, it should be noted that instead, actual capacity for the clients referred annually remained between 800-900 per year in the three-year period 2017 to 2019**. We define resource savings as the value of resources freed up for health care services. *These are not necessarily the same as cashable cost savings.*

Table I). Resource value to health services from MCMW Self-Care SROI update 2019 (values all rounded to nearest ,000)

Areas of resource saving (includes second referral)	Total reductions Pilot year to Apr'16-Mar'17 (Annualised on c.800 patients)	Total Value Pilot year to Apr'16-Mar'17 (Annualised on c.800 patients)	Average incidence per patient 2017-'18 MCMW	Average incidence per patient 2018-'19 MCMW	Change in average incidence 2018-'19 MCMW	Average Annual reductions 2018-'19 v 2016-17 baseline (based on c.2225 actual completions over 3 yrs)	Average Annual Value using data from 2018-'19 (based on c.2225 actual completions over 3 yrs)
GP Practice level		*£102,000*					*£144,000*
Diverted GP hours: research & enquiries	340 hours	£18,000	**30 GP** practice visits per patient (Self Care) Previous forecast estimated **2-3 visit reduction** per patient	**24 GP** practice visits per patient (Self Care)	**6 annual GP visits actual reduction per patient** x 2225 patients **Plus** Diverted hours GPs & HSCAs/CMs	300 hours	£16,000
Diverted HSCA & CM hours: research & enquiries	1025 hours	£21,000				900 hours	£19,000
Avoided GP hours from prevented need	590 hours	£32,000				940 hours	£51,000
Avoided HSCA & Case Manager hours from prevented need	1480 hours	£31,000				2800 hours	£59,000

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Hospital level total	**5.8 PAM increase**	*£106,000*				**6.85 PAM increase**	*£151,000*
Reduced need for Hospital spells	51 incidences	£68,000	1.19 episodes @12 bed days	1.89 episodes @ 7.8 bed days	-	89 incidences	£108,000
Reduced need for A & E	54 incidences	£6,000	1.23 episodes per incidence	2.5 episodes per incidence	-	110 incidences	£11,000
Reduced need for Outpatient visits	579 incidences	£32,000	8 episodes per outpatient	No WLCCG data provided	-	641 incidences using 2016-17 rates	£32,000

In our analysis, the social prescribing model leads to annualised resource savings to GP practice staff - including HSCAs and Case Managers - valued at **£144,000 in 2018-2019,** compared to £102,000 for the pilot phase, (and compared to our previous growth forecast of £150,000 for YE March 2018). According to GPs and HSCAs, 'diverted hours' are the number of hours per week that they personally would have lost on research and enquiries for non-medical wellbeing needs, without the Self-Care directory in place. 'Avoided hours' reflect the reduced number of patient's GP visits after completion of Self-Care sessions.

Therefore, the estimates are specifically for: i) diverted consultation hours and related work hours from an average of two social prescribing consultations per referred patient, and ii) avoided consultation hours for patients who reduced their need to visit their GP practice after completing their sessions i.e. **reduction by 6 visits per year, as per WLCCG data.**

Annual resource savings for hospitals are valued at **£151,000** for 2018-2019, compared to £106,000 for the pilot phase, (and compared to previous growth forecast of £154,000 to YE March 2018). These relate to reduced need for hospital spells, emergency admissions (A&E) and outpatient visits, triangulated through improvement in PAM scores for the relevant Self-Care services. As per the PAM system's own evidence base, each 1 point PAM improvement sees a 2% reduction in hospitalisation rate.

GP consultations

We analysed *173,100 GP appointments* from My Care My Way patients, using anonymised WLCCG data from April 2018 to March 2019. We identified the number of unique IDs in each month. The average number of GP appointments for Self-Care users excluding cancellations **fell to 24 per yea**r (for comparability to the 2018 SROI report).

PAM score

We analysed *over 7,000* PAM scores entries at various baselines and follow up dates, i.e. meaning 2017 cohort with follow ups in either 2018 and/or 2019, and 2018 referrals with follow ups in 2019. This represents a more reflective view of long term impact, especially considering that some service users pass away in the year their PAM is taken, and only 8-9% of follow ups are produced in the same year as the baseline ('in year' PAM follow up). We included 4,155 unique individuals in this year's analysis, ranging from cohorts in YE 2017 to YE March 2019.

With this approach, we calculated an **average improvement of 6.85 PAM points** (each point provides 2% reduction in hospitalisation according to the Insignia PAM software provider). **This is higher than in our 2018 report**, which reported a 5.8 PAM point score improvement over 2017-2018 (11.6% reduction). The proportion of referrals reporting improvements increased from 62% in 2017, to 70% for the 2018-2019 cohort.

Benefit period

In the updated SROI, PAMs data and CCG data clearly shows **impact on the levels of need continues 2 years or more** after the intervention, for at least half of all referrals. We have therefore taken a two-year benefit period into account for patients, rather than the original conservative estimate of a one year benefit period. For the purposes of SROI, a 'drop-off' in attribution and impact has to be estimated for benefits created beyond one year, to avoid overclaiming, and also to reflect the likelihood that the impact is less strong and less attributable over the longer term. Given that over 60-70% of the cohort reported improved PAM scores under self-care, our judgment is that drop off in year two impact is low, at around 25% drop-off. Attribution drop-off has been judged to be 50% for year two of benefit i.e. half the attributable effect on year two outcomes. Ideally, we would conduct a follow-up round of primary research with patients and GPs to triangulate this, but this was beyond this report's scope.

We have used a 3.5% discount rate to bring forward the present value of year two benefits, as per NICE guidance – this is to account for inflation when using money as a measure of value in year two i.e. what £1 will buy in year one will be less in year two due to inflation. (However, we would caution that this would need to be reviewed, given that actual costs of GP clinics and acute treatment have increased significantly higher than inflation since 2017).

This SROI update therefore indicates that the total attributable return is estimated to be fairly similar to the original report, albeit with fluctuating growth rates in referral numbers than originally forecast.

After accounting for the **attribution** and impact drop-off over a **two-year benefit period**, and effects due to other contributing factors and double-counting of patient pathways, we estimate an SROI of **£3.20 per £1 invested (at 2017 unit cost prices)**. This includes the value of subjective health and wellbeing improvement, and c.**£1.65-£1.80** resource savings to GPs, hospitals, *and* social care.

When claiming only one year of benefit gained, the 'attributable' annualised SROI for YE 2019 is similar to the original forecast, c.£2.40-£2.60 (previously £2.80 due to higher growth rate forecasted in referral numbers).

We have used **2017 unit cost prices** where appropriate in order to provide comparability with the original baseline, however, the SROI in reality is higher, considering that unit costs for hospital stays and outpatients has increased significantly since 2017-2018. **If using 2018-2019 WLCCG unit cost prices for acute episodes, the SROI with two year benefit period could increase to approx. £3.80-£4.00 per £1 invested.**

Summary recommendations

1. Increase diversity and number of referrals to improve reach e.g. through cardiovascular and respiratory rehab, **secondary care** units, and **social care** – this is being achieved in other Counties, such as 'Exercise by Referral' across 8 councils in Derbyshire County, where more value is created.
2. Pseudonym ID numbers across WLCCG data must be made consistent when shared by the CCG, as it is unnecessarily making it challenging to track unique patient IDs from one CCG dataset to another, and makes analysis more costly and time-consuming.
3. Make identifiable KCSC vs. non-KCSC referral IDs in 'SystmOne'.
4. WLCCG and KCSC must collect routine feedback from GP clinic staff, through a simple short secure online questionnaire.
5. Sound decision to increase number of clinics, however, staff need to be more proactive and confident in the directory and patient pathway,
6. Reduce dropout rate costs: Some additional funding and resource should be considered for i) Providers to be responsible for encouraging and hand-holding patients more proactively leading up to their first sessions; and ii) improving referrers' promotional knowledge and materials.
7. Review number of some sessions for second referral/re-referral to improve capacity.

Caveats and assumptions

We would caveat that we have based our calculations using the same key ratios from the health and wellbeing impact measures from the primary research conducted by Envoy via the 2017 patient and GP staff surveys. We would recommend conducting another round of primary surveys for this year's analysis, as the estimates may slightly be affected.

As mentioned above, we have assumed the same 2017-2018 distribution splits of activities taking place. We recommend additional analysis is conducted on these points with forthcoming data if there is appropriate budget to do so, as the activities and nature of provision will likely have evolved. Also note that outpatient data was not provided in the same format for 2019 update, but we have pro-rated this to an annual basis.