



Independent evaluation of the North East Hampshire and Farnham Vanguard

Farnham Integrated Care Team

January 2017

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Executive Summary

The Farnham Integrated Care Team (ICT) supports patients from the five practices in Farnham that serve a population of 47,000 people. The team formed and started reviewing and supporting its first patients in October 2015, and since then has continued to grow and develop. There is a Core Team that includes a GP, Community Matron, ICT Coordinator, Adult Social Care Assistants, Mental Health Practitioners, Pharmacist, Making Connections Coordinator, Dementia Practitioner and Rapid Response Matron. And an Extended Team that brings into play a wide range of roles that may be needed when planning a patient's support and action plan. The Team meets weekly and is well attended ("standing room only").

The patients supported by the ICT are described as being at the top of the needs triangle - highly complex patients that require integrated case management. The numbers of patients referred to the team increased significantly last August, to around 20 per month, and the size of the active caseload increased to around 40.

The Team routinely collect patient reported outcomes (R-Outcomes) when they are newly referred and once they have been supported. The scores for patients at referral are typically very low – comparable or worse than patients in care homes. All of these scores increase significantly following support from the Team, for example (on a 100 point score):

- 34 point improvement in being limited in what I can do
- 24 point improvement in being able to get the right help if I need it
- 22 point improvement in being involved in decisions about me
- 19 point improvement in not being anxious yesterday

Eight case studies were reviewed and themes identified. These gave further evidence of the high level of need of the patients being referred and the large impact that the team are able to make.

Effective teamwork is an essential part of the ICT model of care. Staff from a wide range of professions and organisations come together to provide holistic care and support to those patients identified as being at greatest need. A team evaluation using the Normalisation Process Theory instrument found good evidence of effective teamwork and development. Team members demonstrated good team spirit and a shared sense of ownership and the ability to find solutions in the face of problems and resource constraints. There was room for improvement on feedback to team members on the impact the team was having and in external relationships with some partner organisations. The Team has used this evaluation to inform their continued development.

Analysis by the Commissioning Support Unit (CSU) of 65 patient ICT patient records found evidence of reductions in the 90 day period following referral of 55% in A&E attendances (from 102 to 46) and 45% in emergency admissions (from 62 to 34). Whilst this is a positive finding, it is recognised that it is based upon a small cohort of patients and the analysis will be repeated in the coming year.

An economic evaluation has used this evidence of reduced emergency activity to model potential annual cost savings. In the past year, the team have potentially saved £303,900 in the tariff value of emergency care for the 109 patients they supported. The incremental costs of establishing the team were £137,000. They plan to support a minimum of 250 new patients in 2017/18, which has the potential to save £713,000. The activity analysis and economic evaluation will be repeated in the coming year to test these savings.

1. The Farnham Locality

- 1.1 Farnham is situated in the west of Surrey on the border with Hampshire. The Farnham locality is made up of the following five general practices:

Practice	Population
Holly Tree Surgery	5,645
River Wey Medical Practice	6,535
The Ferns Medical Practice	10,642
Farnham Dene Medical Practice	11,602
Downing Street Group Practice	12,492
	46,915

Holly Tree, River Wey and The Ferns are all based at the Farnham Centre for Health at Farnham Hospital. Farnham Dene practice has two surgeries, one at the Farnham Centre for Health and one at Lower Bourne. Downing Street Group Practice is located in central Farnham.

Farnham Hospital is a modern community hospital combining these four General Practices, inpatient and outpatient community and rehabilitation services provided by Virgin Care and general acute outpatient services provided by Frimley Health.

- 1.2 Farnham is healthier and wealthier than England and Surrey as a whole. Residents aged 65-84 years account for 16.9% of the population compared to 15.1% in Surrey and 14.6% in England. The total population is projected to increase by 5% by 2020 and by far the greatest increase will be the over 85 year olds which are projected to increase by 29.8%, compared to a very small increase in the size of the working population of just 1.4%. There are small pockets of deprivation and worse health outcomes in the north of Farnham.
- 1.3 The Farnham practices and locality have a history of collaborating to improve services and quickly recognised the opportunity that the Vanguard offered to advance their ideas for new ways of working. Wessex AHSN are working with the locality to evaluate four of these:
- Integrated Care Team
 - Referral Management service
 - Pre-diabetes education
 - Urgent Care Centre

2. The Farnham Integrated Care Team

- 2.1 Discussions between the Vanguard team and a small core of Farnham clinicians about creating an ICT took place in April and May 2015. Farnham had the right ingredients to pioneer this new model of care, with a commitment from the key local primary and community care clinicians and the space to get started. Things moved at pace and the first team discussions about patients were happening in July 2015 with the following months seeing the membership of the Core ICT being firmed up and the systems and processes underpinning the organisation of the weekly meetings and actions developing.

2.2 The Core Team is made up of the following roles:

- GP clinical lead
- Community matron
- ICT Coordinator
- Two Adult Social Care Assistants (from the older people social care team and from the Frimley Hospital team)
- Two Mental Health Practitioners
- Pharmacist
- Making Connections Coordinator
- Dementia link practitioner
- Rapid response matron.

2.3 The ICT Coordinator came into post in October 2015 she is key to the effective organisation of the ICT. The role includes coordinating the weekly ICT meeting and preparing and gathering the information required for each of the patients that will be discussed; identifying people from outside of the core team that will need to be part of a patient's discussion and inviting them (see extended team below); producing action plans for each patient based on the team discussion and tracking their completion; booking in patients for team review discussions and collecting and submitting the data that underpins the service.

2.4 The Extended Team brings in to play a wide range of roles that may be needed to provide input (in person, telephone or skype) to discussions about individual patient's and support the resulting action plan. It includes:

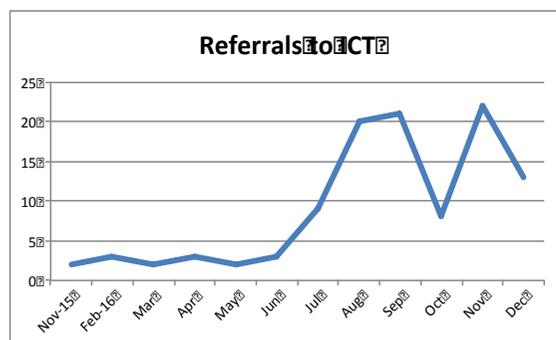
- GPs
- Therapists (OT, Physiotherapy, Speech and Language Therapy)
- Practice nurses
- Specialist nurses (diabetes, continence, muscular sclerosis, Parkinson's, respiratory, heart failure)
- Ambulance paramedic
- Hospice staff
- Community matron for nursing homes
- Continuing care team
- Complex care pathway team

The Team meetings are well attended – “standing room only”.

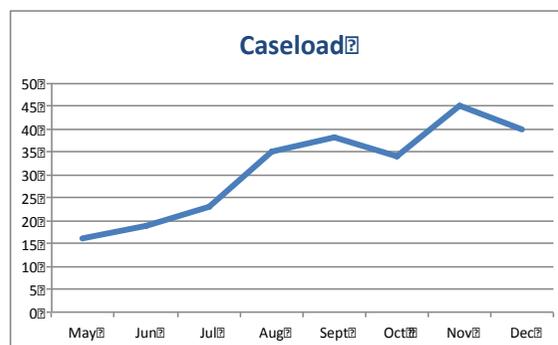
2.5 The ICT cares for patients over the age of 18, though in practice the majority of the caseload is older people. The patients are described as being at the top of the needs triangle– highly complex patients that require integrated case management. They are identified using both reactive and proactive sources of information. Ambulance service IBIS alerts, multiple A&E attendances and hospital Medically Fit for Discharge reports are regularly reviewed. Practices identify patients with multiple long term conditions and numbers of QOF conditions, or who have fallen, have mobility problems or are isolated. The majority of referrals come from GPs, though referrals are also received from across the partner organisations (e.g. community staff, mental health, social care, Making Connections).

- 2.6 The ICT Coordinator receives all new patient referrals and arranges for them to be discussed at the next weekly ICT meeting (Wednesdays 1pm to 3pm). Roles from the Extended Team that will be needed are identified and invited. The team discussion will agree a number of actions that need to be undertaken by the Core and Extended team members and these are captured by the ICT Coordinator in an Action Plan and Tracker. The ICT Coordinator monitors and records completion of these actions and progress will be discussed by team members informally on a daily basis and together at the weekly meeting. Decisions to discharge a patient will be based on a professional consensus following review of the actions that have been taken and how the patient has responded. If a patient's situation changes they will be referred back to the ICT.
- 2.7 The service is relatively new and still evolving and developing. An expanded Hub is being constructed at Farnham Hospital to provide a bigger base for team members to be co-located and to hot-desk. A new rota was introduced for a GP to come to the hub each day to review the reactive sources of referral information, such as the Medically Fit for Discharge list and this has developed further with use of a paramedic practitioner. The ambition is to increase the size of its caseload and to proactively identify more patients with a moderate to lower level of need. The ICT is going to pilot the use of risk stratification and frailty tools to help with this. The ambition is for the team to meet more than once a week.
- 2.8 The ICT has collected activity information for submission to the Vanguard PMO from the outset. The format and content of these activity records have evolved and changed over time. The table on the following page summarises this recorded activity.

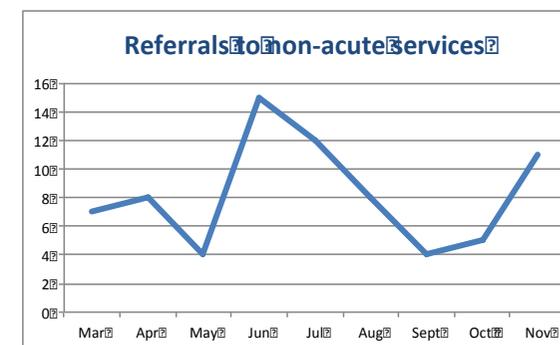
	Feb 16	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of ICT meetings held	4	5	4	4	5	4	5	4	4	5	4
New patients referred	3	2	3	2	3	9	20	21	8	22	13
Individual patients discussed	31	63	29	17	54	38	99	83	74	126	79
Referrals to non-acute services		7	8	4	15	12	8	4	5	11	6
Patients discharged	11	13	8	0	11	2	14	19	10	24	15
Caseload				16	19	23	35	38	34	45	40
IBIS avoided conveyances*									18	20	15
A&E/ emergency admits avoided**						4	12	21	9	4	0
Av. Core Team attending meetings	6	7	7	2	8	6	6	6	7	7	6



New patients supported by the ICT are increasing



The active caseload is also increasing



There doesn't appear to be an increase in referrals to non-acute services e.g. Making Connections

* IBIS avoided conveyances are recorded when an ambulance crew access the patient's IBIS plan when they attend a call and on this basis are able to avoid the need to convey the patient to hospital

** A&E/ emergency admissions avoided are recorded when the Team's professional opinion is that this occurred.

3. Patient reported outcomes

3.1 R-Outcomes

Information was collected for this review using the R-outcomes measures. These are a set of validated short generic patient reported outcome measures (PROMs) being used by Wessex AHSN as a way to evaluate innovations and new services. This review used four of the R-outcomes measures:

HowRu – Health Status

People record how they feel physically and mentally and how much they can do in terms of loss of function and independence. It asks how are you today? – meaning the past 24 hours. It has been validated against other measures including SF12 and EQ-5D.

Choose one answer to each question

How are you today? (past 24 hours)

	None	A little	Quite a lot	Extreme
Pain or discomfort				
Feeling low or worried				
Limited in what you can do				
Require help from others				

Health Confidence Score

To what extent do you agree or disagree with these?

	Strongly agree	Agree	Neither agree nor disagree	Disagree
I know enough about my health				
I can look after my health				
I can get the right help if I need it				
I am involved in decisions about me				

Health Confidence Score

This score monitors people’s confidence in their ability to manage their own health and engage with health care providers. The first two questions address personal capability, while the second pair is informed by provider engagement. This measure is closely associated with the concepts of empowerment, perceived self efficacy, activation and engagement.

Personal Wellbeing

This is a short generic measure of happiness or subjective wellbeing and is closely based on the Office of National Statistics personal wellbeing questions used in the Annual Population Survey.

Personal Wellbeing Score

To what extent do you agree or disagree with

	Strongly agree	Agree	Neither agree nor disagree	Disagree
I am satisfied with my life				
What I do in my life is worthwhile				
I was happy yesterday				
I was NOT anxious yesterday				

Choose one answer to each question

How are we doing?

	Excellent	Good	Fair	Poor
Treat you kindly				
Listen and explain				
See you promptly				
Well organised				

HowRwe – Patient experience

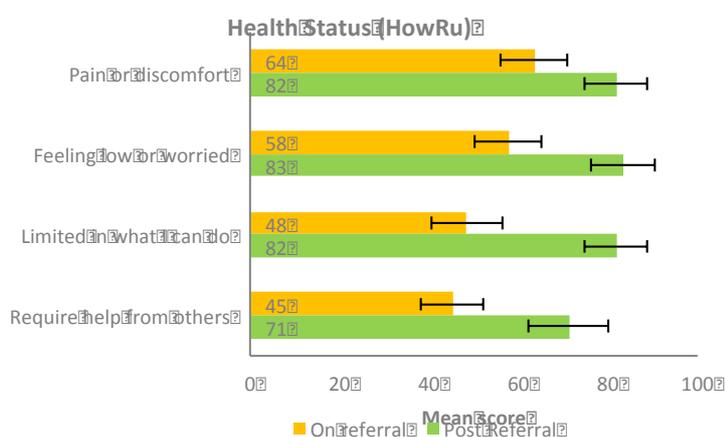
This is a patient reported experience measure of patients’ perception of their care. It includes both relational (clinical) aspects of their care, such as kindness, listening and explaining as well as systems (administrative) aspects such as promptness and organisation.

3.2 Results

The ICT supported the collection of R-outcomes measures for **53** patients at first contact and **22** patients who had received their support, between December 2015 and December 2016. All of the results show mean scores on a 0-100 scale. If all respondents choose the best response, the score is 100. If they choose the worst, the score is 0. What we are looking for is evidence of an improvement in reported scores from the two separate cohorts of patients and whether those improvements are statistically significant.

The results are set out in the following four charts. The yellow bars represent how patients scored themselves when the service first made contact with them, and the green bars show the scores for patients who have been supported by the ICT. The lines at the end of each bar signify the confidence intervals for each score – where the bars do not overlap, the observed change is statistically significant.

Health Status



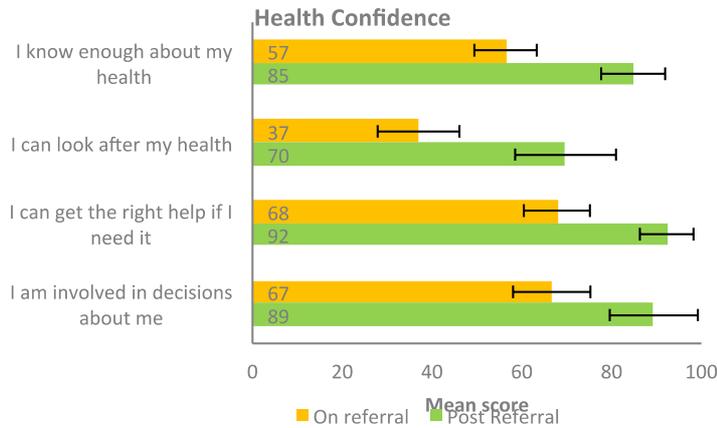
On referral, people referred to the ICT have low health status. We compared the ICT on-referral scores with ICT post-referral scores and those measured in a survey of over 10,000 care home residents.

On referral ICT scores for *Pain and discomfort* (64) and *Feeling low or worried* (58) are far below those of care home residents (80 and 79 respectively). Post referral the scores are similar (82 and 83 respectively).

For *Limited in what I can do* and *Require help from others* the ICT on-referral scores were 48 and 45 respectively; these scores are comparable to those recorded by care home residents (46 and 64 respectively). Post-referral the scores are much better (82 and 71 respectively).

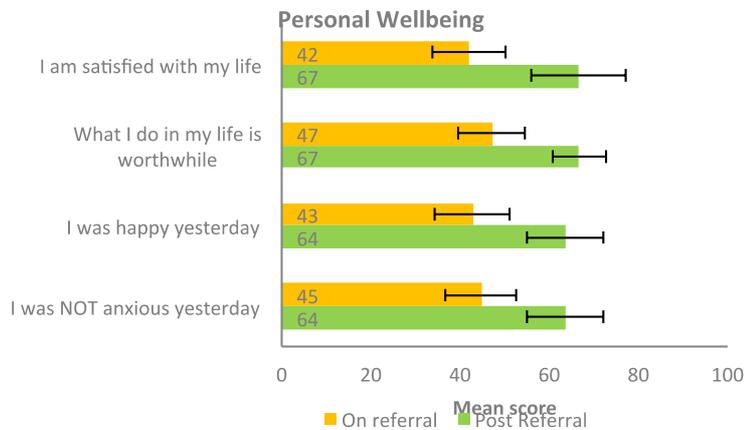
These findings confirm that people referred to ICT are in acute need, but appear to improve considerably. The differences between post-referral and on-referral scores are *Limited in what I can do* (34 points), *Require help from others* (26 points), *Feeling low or worried* (25 points) and *Pain or discomfort* (18 points).

Health Confidence



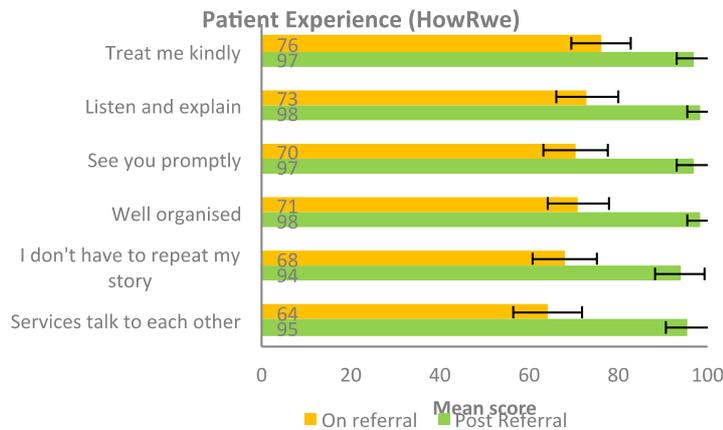
The on-referral score for *I can look after my health* (37) is very low and confirms that these people perceive themselves to be in high need of help. The post-referral score (70) shows a large improvement (33 points). The on-referral score for *I know enough about my health* (57) is also low, and shows a large improvement to 85 (28 points).

Personal Wellbeing



The on-referral scores for personal wellbeing are all low (mean 44), indicating again that people being referred to ICT are generally very unhappy. The post-referral scores are substantially better (mean 65, up 21 points).

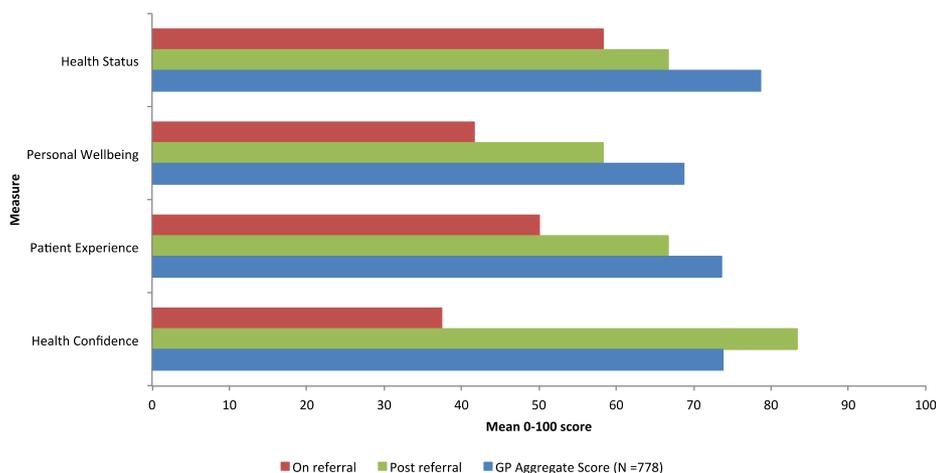
Patient Experience (howRwe)



The on-referral scores for patient experience reflected people's prior experience of care, with lowest scores for *Services talk to each other* (64), *I don't have to repeat my story* (68), *See you promptly* (70) and *Well organised* (71). Clinical aspects had the highest scores with *Listen and explain* (73) and *Treat me kindly* (76). Post-referral all patient experience scores were very high (range 94-98). The biggest improvement (31 points) was for *Services talk to each other*, which is of course one of the objectives of the ICT.

Comparison with General Practice patients

The Farnham practices have also been collecting R-Outcome from the patients attending the practice for appointments. It is interesting to see how the ICT scores at referral (red) and once supported (green) compare with the general patient population (blue) and how the gaps close. The ICT patients report higher health confidence once



they've been supported.

4. Case studies

The team provided eight patient case studies for the evaluation team to review.

These eight case studies covered a wide range of patients and situations. What they all had in common were the complexity of the patient's situation – covering clinical and physical concerns and issues, cognitive and mental health issues, relationships, care and carers and their physical environment. All of the case studies describe people at a low point and in decline which looks set to continue. They can be triangulated with the particularly low R-Outcome scores recorded for Health Status (see page 8), which are far below those recorded by Care Home residents.

Four themes were identified from these case studies:

A quick response

The team is able to respond quickly with a home visit by the most appropriate team member(s). This first visit could be by a GP, community matron, mental health practitioner, pharmacist etc. This allows the team to understand in detail the range of issues and needs for each patient that can be turned into a plan and set of actions.

A joined up response

The case studies describe the complexity of the patient's situation when they visit. The subsequent plan and actions can be wide ranging and the team joins these up around the needs of the individual. Actions typically include:

- Clinical diagnosis and treatment, medication review, cognitive assessments and referrals to specialist support
- New plans for the care patients are receiving from agencies – and assessment and support for carers
- Physical adaptations and improvements to their home
- Support for patients wellbeing with for example, input from the Making Connections service to link them to local clubs and befriending services
- An IBIS plan that helps the ambulance crew understand all of the above and what can be done in an emergency that avoids taking them to A&E.

Problem solving

A timely and joined up response is not always easy. The team often has to use their collective experience, initiative and connections to solve problems. In one case study an 85 year old man who had been discharged from hospital was in rapid decline and reviewed by the team on Friday, and the family didn't want him to go back into hospital. The GP felt that if he was rehydrated his clinical state might improve and the Community Matron sourced the equipment for administering subcutaneous fluids and additional nursing support for the weekend. It worked, his mental and physical state improved and he was able to be removed from the ICT active case load.

Impact on patients

The case studies provide many examples of the impact that the team can make on patients' lives. There are examples of how 999/ 111 calls and use of A&E have been avoided, which is good for the patient and good for the health and care system. And there are many examples where the timely and joined up response can be seen to have improved how patients report their Health Confidence (e.g. 24 point improvement in 'I can get the right help if I need it') and their Personal Wellbeing (e.g. 21 point improvement in 'I was happy yesterday') – described on page 9.

Example case study 1

A 92 year old lady living alone with increasing confusion, poor short term memory recall and hoarding tendencies. Her home is in a state of disrepair, with a lack of heating, hot water and electricity. Encouraging the patient to accept help was challenging, she denied that there was a problem and said that everything could be managed independently. Any appointments would need to be completed at home.

Adult Social Care referred her to ICT and to Waverly Care and Repair. A safe and warm grant was accessed to pay for the repairs to her home and she accepted respite care whilst these were done. She was checked for sore areas and skin deterioration and the care workers agreed to provide daily checks. Blood tests found a positive UTI which was treated with antibiotics. A diagnosis for a specific dementia was made that has allowed medication that may prevent a rapid cognitive decline. Recognising slight malnourishment, the team also arranged an extra care call to ensure she was eating her lunch and drinking.

Example case study 2

This patient has a Learning Disability, borderline personality disorder, is bariatric and has a congenital hip disorder. She lives alone and her home is in a bad condition and is at threat of eviction. She doesn't attend planned appointments at her surgery for treating leg sores and urinates in her wheel chair because she has difficulty accessing the toilet. She doesn't allow the care agency to support her with personal care. She was referred to the ICT because of a deterioration in mood and fresh incidents of self harming, having not self harmed for over two years.

Social services key worker and OT identified that her current toilet was not suitable and arranged for a larger toilet to be installed by the Council. The housing department is arranging a new hygienic floor to be laid.

The Community Learning Disability Team have arranged six maintenance sessions on how to cope/ care for herself in a crisis.

The Community nursing team is treating her leg sores and completed a continence assessment.

The GP is setting weight loss goals and looking in to the possibility of a gastric band.

Social services have completed a review with the care agency.

A grant has been applied for her to have a holiday at a centre specialising in supporting disabled people. While she is on holiday, more adaptations to her home are planned.

The patient's mood is improving and is looking forward to her holiday. She feels that people are working together and have a shared understanding and want to make a difference.

6. Team observation and survey

- 6.1 Effective team work is an essential part of the ICT model of care. Staff from a wide range of professions and organisations come together to provide holistic care and support to those patients identified as being at greatest need. Together, they aim to overcome the ‘old’ model of siloed care for the benefit of patients.
- 6.2 The team evaluation has sought to understand the experience of the staff involved in developing the service and whether this has met their aims of moving from a “fragmented” to an “integrated” way of working as a team. Two members of the evaluation team attended an ICT away day on 4th October 2016 where they surveyed the team members, ran two focus groups covering all of them and undertook a non-participation observation of the 8 hour event.
- 6.3 Normalisation Process Theory¹ (NPT) is a validated instrument that has been widely used to evaluate quality improvement interventions in health care. The focus is on factors (beliefs and behaviours) that promote or inhibit (enablers and barriers) the implementation of an intervention, in this case the ICT. The factors are divided into four themes:
- Coherence:** the mobilisation of a practice – how it is conceptualised and held together in action
 - Cognitive participation:** participation in a practice – how members decide to engage and actually engage
 - Collective action:** enacting a practice – how the work is organised and activities structured and constrained
 - Reflexive monitoring:** the appraisal of a practice – how it is appraised and the effects of appraisal, i.e. how it is ‘understood’ and what changes the team make

In addition to these four factors, some additional questions were added relating to the **ICT relationships with external partners**, which featured as an outcome in the ICT logic model.

The results from the survey, focus groups and observation will now be described.

Survey participants were asked to rate each question on a scale of 1-10 where 1 equals completely agree and 10 equals completely disagree. Average scores below 3 represent a positive score. Nine complete surveys were received and analysed.

6.4 Coherence

This theme measures how a practice is conceptualised and held together in action. The following table sets out the results from nine team members:

Coherence (1 = completely agree and 10 = completely disagree)	1	2	3	4	5	6	7	8	9	10	Av score
1. The intervention is distinct from previous ways of working but can easily be integrated into existing work	3	1	4	0	0	0	0	1	0	0	2.78
2. Team members have shared understanding of the purpose of the intervention and of specific responsibilities required	4	1	3	0	1	0	0	0	0	0	2.22

¹ May and Finch 2009; Finch et al 2015

3. Team members understand how the intervention affects the nature of their work	3	1	4	0	1	0	0	0	0	0	2.44
4. Team members can see potential value of the intervention for their work	6	1	0	1	0	0	0	1	0	0	2.22

The average scores for all of these questions are less than 3 and represent positive ratings by the team members. This means that, overall, participants could integrate the ICT into their work easily, they understand its purpose, implications and potential value for their work.

The focus groups and observation provided additional evidence of high levels of coherence. Many participants showed a common understanding of the benefits that the ICT could bring to their work, including breaking down barriers across health disciplines and social care; a greater understanding of each other's roles; being proactive and preventing crises²; being innovative by looking at different ways of working and educating; and putting patients at the centre of the new model.

It was noted how formal structures, such as the role of the ICT coordinator and team meetings, helped the team to identify and be focused on key issues. Flexible ways of working (such as adding a last minute patient to the agenda) and friendly relations among members have contributed to the effectiveness of the team. Value was given to face-to-face communication.

However, participants from Adult Social Care raised some concerns about how the ICT can be integrated into existing work with a sense that they sit on the edge of the team and their role (at the time of the fieldwork) was still unclear.

6.5 Cognitive participation

This theme measures participant's active participation in the ICT. The following table sets out the results from nine team members:

Cognitive participation (1 = completely agree and 10 = completely disagree)	1	2	3	4	5	6	7	8	9	10	Av score
5. Key individuals drive the intervention forward and get others involved	5	0	4	0	0	0	0	0	0	0	1.89
6. Team members are open and willing to work in new ways	3	4	2	0	0	0	0	0	0	0	1.89
7. Team members believe that contributing to the intervention is a legitimate part of their work	2	4	3	0	0	0	0	0	0	0	2.11
8. Team members continue to support the intervention	5	1	1	1	0	0	0	1	0	0	2.44

Average scores for these questions lie between 1.9 and 2.5, demonstrating that members highly value their participation in the team.

² For example, avoiding a hospital admission by treating a blocked catheter at home

The commitment and drive of the Clinical Lead and Mobilisation Manager were identified as being important people and the ICT meetings being the key vehicle for making progress together. The observation identified many good examples of good leadership styles from participants and a light, friendly approach to improving team members. The Clinical Lead’s leadership style was identified as being effective – understated, not overpowering and driving the collective action of the team.

The team was observed taking a shared sense of ownership and having the ability to find solutions in the face of problems and resource constraints. Team spirit was high which contributed to productive and creative discussions.

6.6 Collective action

This theme measures how the work within the team is organised, how activities are structured and constrained. The following table sets out the results from nine team members:

Collective action (1 = completely agree and 10 = completely disagree)	1	2	3	4	5	6	7	8	9	10	Av score
10. The intervention does not disrupt working relationships	3	3	1	1	0	0	0	0	1	0	2.78
11. Team members trust the intervention and trust each other	6	1	1	1	0	0	0	0	0	0	1.67
12. Work is seen as appropriately allocated to staff who have the required skills	3	3	2	1	0	0	0	0	0	0	2.11
13. Sufficient training is provided to staff	2	2	0	4	1	0	0	0	0	0	3
14. Sufficient resources are available to support the intervention	1	1	1	3	1	0	1	1	0	0	4.22
15. PM team adequately support intervention	2	3	1	3	0	0	0	0	0	0	2.56

Mixed results were recorded for this theme. Some questions were rated positively, such as trust in the team and work allocation and skills availability. Less positive were the responses to the questions concerning training and resources.

In the focus group, participants agreed that work was properly allocated to staff with the right skills and that working in the ICT had had a positive impact on working relationships with everyone treated equally. It was felt that solutions to problems could be identified and turned around quickly.

Poor information technology support and lack of integration across systems were identified as a major obstacle. Participants from Adult Social Care raised concerns about a lack of resources and problems recruiting qualified social workers.

Training and learning had been built into the way the team works including shadowing, ‘fresher’s week’ for new members, and addressing training needs in the weekly meeting. The ICT Coordinator is key to the effective organisation of the team’s activities, meetings and participants, and does this very well.

6.7 Reflexive monitoring

This theme measures how the ICT and its effectiveness is appraised. Members rated the ICT as worthwhile and valued its effect on their work. Results also indicate members' willingness to use feedback to improve their work in the future and their ability to modify their way of working as required by the team. However, awareness of team effectiveness varies across participants and has a less positive score, which suggests that feedback mechanisms may need to be strengthened.

Reflexive monitoring (1 = completely agree and 10 = completely disagree)	1	2	3	4	5	6	7	8	9	10	Av score
16. Team members are aware of the effects of the intervention	1	3	0	3	2	0	0	0	0	0	3.22
17. Team members agree that intervention is worthwhile	6	3	0	0	0	0	0	0	0	0	1.33
18. Team members value the effect of the intervention on their work	4	2	3	0	0	0	0	0	0	0	1.89
19. Feedback about the intervention can be used to improve it in future	6	3	0	0	0	0	0	0	0	0	1.33
20. Team members can modify how they work with the intervention	3	3	2	1	0	0	0	0	0	0	2.11

In the focus groups participants described the value of informal feedback at the ICT meetings on how they were doing, but identified that formal feedback on outcomes such as admission avoidance was limited at present. There were plans to build this into team meetings. Other ways of building in feedback included a team effectiveness questionnaire and case studies describing the impact that the ICT has made on individual patients.

6.8 External relationships

In addition to the four NPT themes, the questionnaire asked three questions exploring the results with their external partners. These scores were generally less positive, with the worse score on the whole survey being participants' views on whether external partners have a good understanding of the ICT programme.

External relationships (1 = completely agree and 10 = completely disagree)	1	2	3	4	5	6	7	8	9	10	Av score
21. Communications between providers need to be improved	0	1	4	1	0	1	1	0	1	0	4.44
22. Those external to ICT have a good understanding of ICT programme	0	1	1	0	0	0	2	3	1	1	6.89
23. Those external to ICT value work of ICT	0	1	1	1	2	3	0	1	0	0	5

Both focus groups recognised that relationships with the acute sector needed to be improved. In one group deep cultural differences between hospital and community health were identified as one of the reasons affecting poor communication and understanding with the hospital. A set of actions were agreed at the Away Day to improve engagement with the hospital including a skills blitz and single point of access for hospital referrals and raising the profile of the ICT.

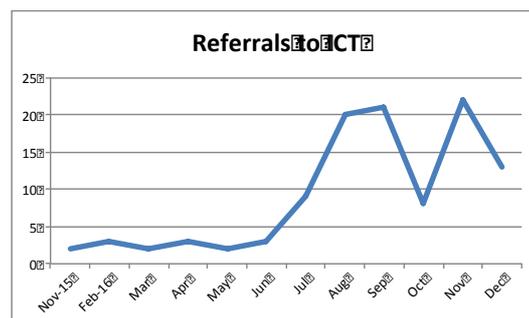
6.9 Conclusions

This team observation has identified lots of positives in the Farnham ICT. It demonstrates that together the team is delivering its goal of moving from “fragmentation” to “integration”. There are lots of examples of a high functioning team able to take collective action to rapidly solve problems and improve their service. There is also evidence of effective leadership from individuals that support the overall collective effectiveness of the team.

As you would expect, the observation also identified some less positive areas that will need attention. Social Care team members described feeling less “integrated” than other members of the team. The team would benefit from regular feedback on outcomes (e.g. avoided admissions and R-Outcomes). A focus on key external relationships, such as those with the hospital, is important

7. Activity impact

- 7.1 Changing the pattern of health care received by its patients and reducing their use of A&E and emergency admissions to hospital is an important aim and outcome for the ICT. By providing a joined up and proactive plan for the patient, that is shared with the ambulance service (via IBIS), the need to go to the acute hospital as an emergency should be reduced. This in turn has the impact of reducing the overall cost of care.
- 7.2 To evaluate whether there has been an impact on the use of A&E and emergency admissions by the ICT patients the South, Central and West Commissioning Support Unit analysed the records of all **109 patients** that had been referred to the ICT in the past year. Using the date of referral as the pivot point, they looked at the A&E and emergency admission activity for the 90 days period before and after.
- 7.3 Unfortunately for this analysis – because the majority of patients were referred towards the end of quarter 3, the CSU 90 day analysis only picked up **65 patient records**. This is a low number on which to base the economic evaluation.



- 7.4 The following table sets out the change in activity before and after referral to the ICT

	- 90 days	+ 90 days
Number of A&E attendances	102	46
Number of emergency admissions	62	34

8. Economic evaluation

8.1 The economic evaluation takes the evidence of reductions in activity and calculates potential financial savings **using average (median) tariff costs for A&E and emergency admissions**. These savings are modelled to identify the potential savings based upon:

- The annual caseload of the ICT
- How long the benefit of reduced activity lasts for each patient (i.e beyond the =90 day period)

8.2 Step 1 – evidence of reduced activity

Section 7 describes the CSU analysis of activity using comparing the 90 day period before and after referral for 65 patients. This showed the following changes in activity:

	Activity – 90 days	Activity +90 days	% Change
A&E attendances	102	46	-55%
Emergency admissions	62	34	-45%

There are **health warnings** about the size of this sample for economic modeling. Ideally we would be able to model the changes in activity for a larger cohort of patients and over a longer period (120 days). It is recommended that the evaluation is repeated in a few months time.

8.3 Step 2 – model savings to full annual activity levels

The activity analysis in step 1 covers 65 patients. The model assumes that the % change in activity will apply to all of the patients cared for in a year.

Taking an annual activity of 109 new patient referrals that savings would be:

	Cost before	Cost after	Saving
A&E	£22,578	£10,182	£12,396
Emergency admissions	£230,396	£126,346	£104,050
Total	£252,974	£136,528	£116,446

8.4 Step 3 – model how long the change in activity last for each patient

Step 1 provides evidence of whether A&E attendances and emergency admissions are reduced in the 90 day period following referral to the ICT. It is safe to assume that this benefit does not continue at the same rate forever – that it diminishes over time. What is more difficult to predict is how the benefit changes over time. To do this accurately we will need to continue to monitor changes in patient activity over longer periods of time as the service becomes more established.

In lieu of this we have modelled two scenarios to show the potential range of savings:

- **Scenario 1** – if the rate of activity started to increase after 90 days – by 20% in days 91 to 180, by a further 20% in days 181 to 270 and finally by a further 20% in days 271 to 365.

- **Scenario 2** – if the benefit continued at 100% for the whole year (unlikely – but shows upper limit to saving)

The potential annual savings for these two scenarios are summarised in the following table:

		Cost before	Cost after	Saving
Scenario 1 (20% increase in activity per 90 days)	A&E	£91,567	£53,853	£37,714
	Emerg' admiss'	£934,383	£668,230	£266,153
	Total	£1,025,950	£722,083	£303,867
Scenario 2 (reduced activity continues at 100%)	A&E	£91,567	£41,295	£50,272
	Emerg' admiss'	£934,383	£512,404	£421,979
	Total	£1,025,950	£553,699	£472,251

There is a further scenario that uses an assumption for the expected number of new patients supported by the team in the coming year. Scenarios 1 and 2 are based upon the 109 ICT patients supported in the past year. We know that the number of monthly referrals and size of caseload have increased through the year, as has the size of the Core Team. **The Team has estimated that in 2017/18 they expect to support a minimum of 250 new patients.**

- **Scenario 3**– taking the same reduction in benefit modelled in scenario 1 but assuming that 250 new patients are supported in 2017/18.

		Cost before	Cost after	Saving
Scenario 3 (20% increase in activity per 90 days for 250 patients)	A&E	£210,015	£123,516	£86,499
	Emerg' admiss'	£2,143,080	£1,532,639	£610,441
	Total	£2,353,095	£1,656,155	£696,940

8.5 Cost of providing Farnham ICT

The incremental costs of providing the Farnham ICT are:

- GP clinical leadership £38,400
- ICT Coordinator £30,343
- ICT Team Leader £68,448
- **Total** **£137,191**

These aren't the total costs of providing the service – which would include the time commitment of the rest of the Core ICT members; non-staff costs such as equipment, consumables and travel; and overheads such as the premises. It hasn't been possible for these to be calculated at this stage.

8.6 Return on Investment

The return on investment (ROI) is a ratio comparing the value of return (savings) generated by an investment (costs).

Using the incremental costs of £137,191 and the scenario 1 estimated annual savings of £303,867 generates a **Return on Incremental Investment of 121%**.

9. Active ingredients

9.1 These evaluation findings have been shared and discussed with the Team to help identify the active ingredients – the things that contribute to the continued development of the team and its service, to the large improvements in patient reported outcomes, to effective teamwork and to reducing the use of emergency services.

9.2 Together, we identified the following active ingredients:

- The team and its members describe a ‘can-do’ attitude. This is valued and encouraged. Finding solutions and ‘overcoming the system’ to get a result for a patient is celebrated.
- There is a deliberate non-hierarchical leadership style in the team. The team observation found this too. This feels important to the effectiveness of the team and its continued development.
- Linked to this is a respect for each others skills and contribution. Team members described a keenness to understand what others do and to learn from them.
- Which all leads to a willingness to learn and to try things that improve the service. Numerous examples were given of ongoing fine tuning of processes and practices.

9.3 The evaluation team identified some further active ingredients that support the effectiveness of this team:

- There is a good history of cooperation and joint working between the five practices in Farnham and the other community based services in the area. They have built upon and developed this further.
- The leadership is good. The style, ideas and reputation of the clinical lead has played a large part in getting to where they are.
- Having Farnham Hospital and Centre for Health has given a good physical base from which the service can develop.