Department of Health | Department for Communities and Local Government | Local Government Association | NHS England

Better Care Fund Task Force

Making it Better

A guide to resources for improving Better Care Fund plans

V. 3 – Updated 1st September

The Better Care Fund

Contents page

The aim of this support pack is:

- To bring together a selection of resources that should help you in putting together a revised Better Care Fund plan
- Provide detail of the additional support that will be provided over the coming weeks and months

Contents

Introduction

The Better Care Fund narrative

NHS and social care services are now caring for **people with increasingly complex needs** and multiple conditions.

There is consensus that to respond to this **care should be organised around the person** who needs it, and that person's care team should work together to keep them better for longer.

The Better Care Fund is one of the most concrete steps ever towards making this change happen everywhere. This is the start and pooled budgets are here to stay.

Areas put in draft plans in April, and local areas are now revisiting these to make sure they are as clear and strong as possible to **kick start the change we need** from next April.

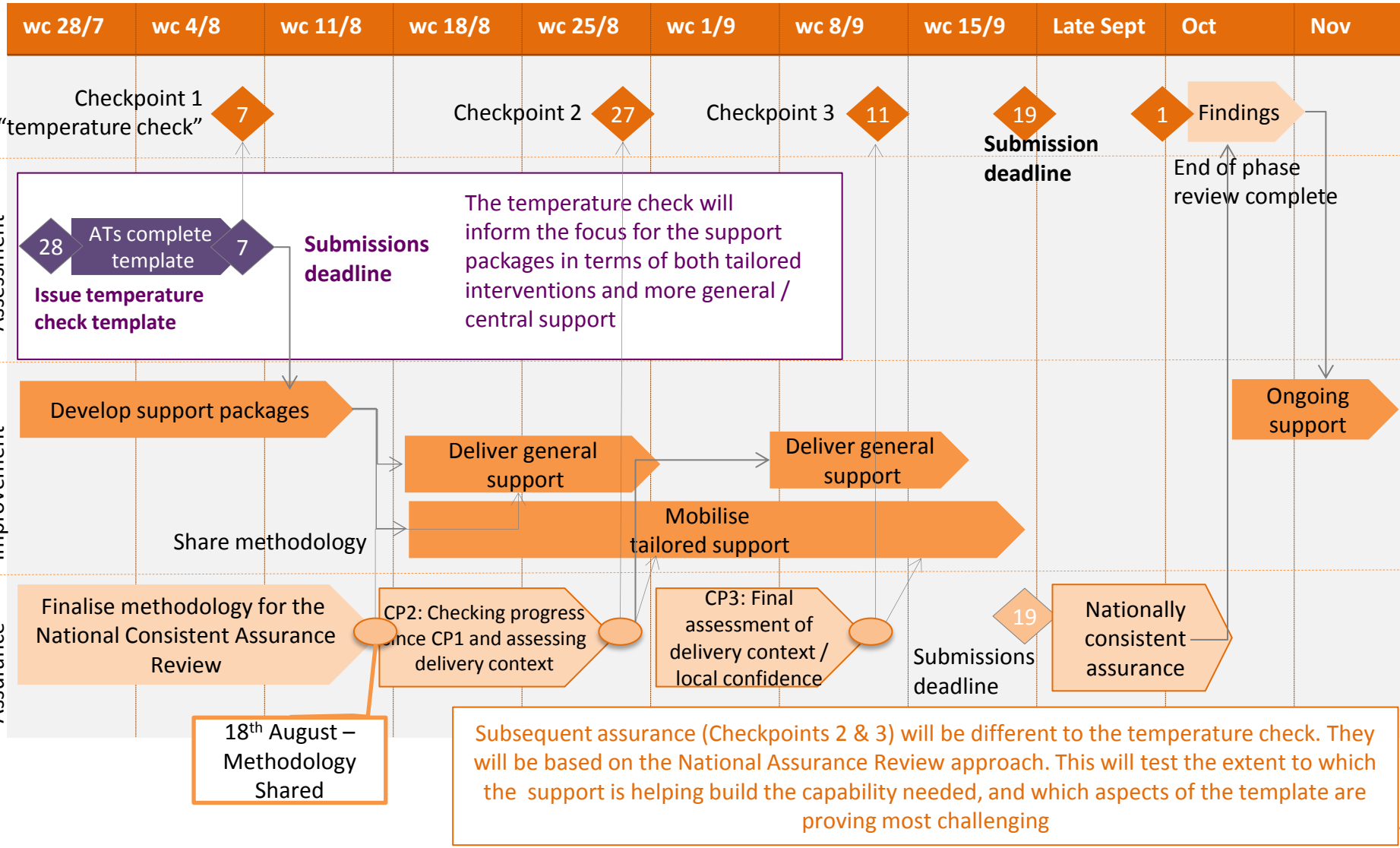
As ever with system transformation – **success depends on the *people* who are leading it** to make it happen locally – people taking bold steps to move away from their old ways

The BCF has accelerated and made happen **conversations that have never happened before** about joint working across agencies.

Now we want this to happen everywhere and **we are committed to support local areas to achieve this**. Local areas teams and local government regions will have a crucial part to play.

It is challenging, and will undoubtedly get harder before it gets easier – but we have seen in small pockets **the immense value of the prize for patients, users, families, carers and staff.**

Timeline for BCF plan assessment, improvement and assurance



Making it Better – A programme of support

- The Better Care Fund is an ambitious change programme. We acknowledge that the process of updating plans is a challenging task.

- In view of that programme of support is to be delivered as partnership between the national and local level, coordinated via NHS and LG regions. This pack is one element of that support.

- Integrated care and support requires systems change and cannot be achieved overnight, but we know that pooled budgets are here to stay. The work that is being done now is absolutely critical and will put every single area on a firm footing as we move towards new models of care that are fit for the purpose of our population today.

- The support that is being put in place will help you develop a robust plan and roadmap for delivering integrated care. The Better Care Fund Taskforce recognises that support needs will be required well after the submission of plans on 19th September, to address the challenges faced in terms of set up and implementation.

Making it Better – A programme of support

Support will be available on the following basis:

1 – **Open access resources** – available for all, including:

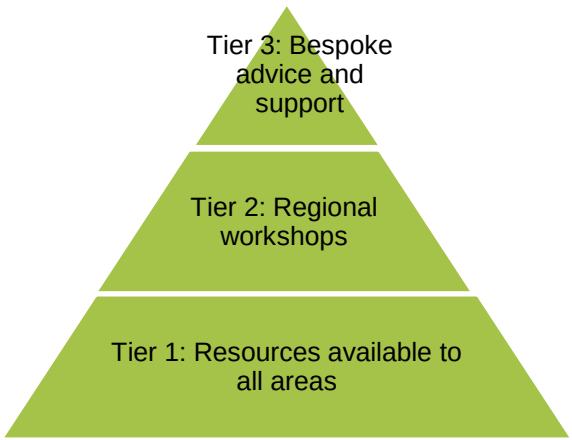
- Links to tools and support (contained in this pack)
- Additional "how to guides"
- Webinars

2 – **Regionally delivered support** – co-ordinated via regional teams, including:

- Regional clinics
- Peer to peer support, co-ordinated via regional teams

3 – **Bespoke advice and support** – where possible, bespoke advice and hands-on support will be provided in areas with the most complex challenges

To facilitate this support programme, we are placing teams of 6-7 people per NHS England Region (North, Midlands & East, London, South), to work with the most challenged areas within that region, full time from Monday 18th August to Thursday 18th September 2014.



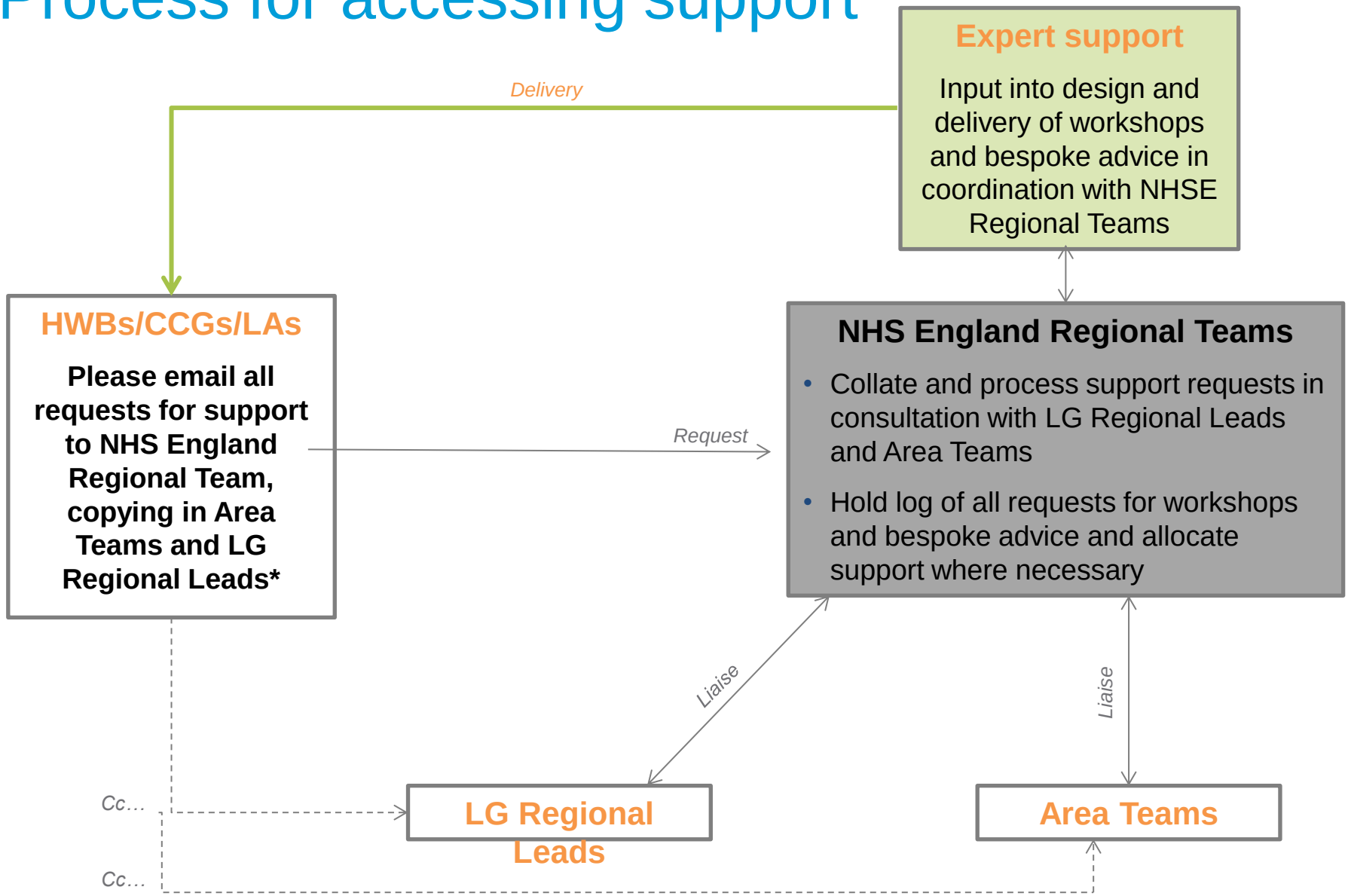
How to access support?

For **Tier 1** support, please go the NHS England and LGA websites for the latest resources.

To express interest in the support available at **Tiers 2 and 3**, please email your NHS area and regional teams, and your LG regional leads.

Please see overleaf for more detail.

Process for accessing support



Dates for regional BCF clinics

- We are hosting workshops across the country to provide support in completing the technical sections of your BCF plan as follows:

- Due to feedback received from local areas, these will be held as “clinics” with bookable slots for HWB teams to receive hands on support on their plans from expert facilitators. The dates are as follows:

	Region	Location
Monday 1 September	Middle and East	Derby
Tuesday 2 September	South	Bristol
Wednesday 3 September	North	Manchester
Thursday 4 September	Middle and East	Cambridge
Friday 5 September	London	London
Monday 8 September	Reading	South
Tuesday 9 September	North	Leeds
Wednesday 10 September	Middle and East	Birmingham
Thursday 11 September	London	London
Friday 12 September	North	Manchester

- If you have not yet booked a slot, please email your NHS/ LG regional lead.

What support will be available?

A good plan will include….	Relevant template section	Topics on which support is available	Support pack slides	Webinar?	Regional workshop ?	Bespoke advice?
The case for change A clear analytically driven (i.e. risk stratified) understanding of where care can be improved by integration	Part 1: Section 3)	• Risk stratification and population profiling • Evidence based planning	Slides 16-20 And see 'How to' Guide: The BCF Technical Toolkit	✓ 3rd Sept, 14-15.30 on Risk Strat.	✓ See slide 8 for dates of BCF clinics	✓ In place from 18/8/14
A plan of action A coherent and credible evidence based articulation of the delivery chain that shifts activity away from emergency admissions	Part 1: Section 4) Annex 1: (The delivery Chain, The evidence base)	• Evidence based planning	Slides 21-32 And see 'How to' Guide: The BCF Technical Toolkit	-	✓ See slide 8 for dates of BCF clinics	✓ From 18/8/14

What support will be available?

High level objective	Relevant template section	Topics on which support is available	Support pack slides	Webinar?	Workshop ?	Bespoke advice?
Strong governance Including clear local management and a credible way of tracking the impact of interventions and taking remedial as well as robust contingency plans and risk sharing arrangements	Part 1 Section 4) b)	• Tracking impact • Leadership and engagement • Regulatory frameworks – Section 75	Slide 13 Slides 33-38 And see 'How to' Guide: The BCF Technical Toolkit	-	✓ See slide 8 for dates of BCF clinics	✓ From 18/8/14
Protection of social care and Alignment with wider sector planning	Part 1 Section 6) and 8) Annex 2	• Leadership and engagement	Slides 10-15	-	✓ See slide 8 for dates of BCF clinics	✓ From 18/8/14

1: Leadership & Engagement

1: Leadership & Engagement

Overview

- The resources in this module are grouped around the following themes common to successfully leading and delivering system transformation:
    - Leading system change, including securing a shared vision and objectives
    - Effective governance arrangements that share risk
    - Widespread, meaningful stakeholder engagement and co-production
- The module draws on a wide range of sources covering a broad range of scenarios and services across the health and care landscape, and recognises that many areas are already making significant progress in bringing together organisations and moving to more collective way of working

Which sections of the BCF Planning template is this relevant to?

Part 1: 1b Authorisation and signoff
Part 1: 2 Vision for health and care schemes
Part 1: 4 Plan of Action
Part 1: 5 Risks and contingency
Part 1: 6 Alignment
Part 1: 8 Engagement

1. Leadership & Engagement

- Successful system transformation involves engaging all local partners and stakeholders in the ‘case for change’, including a shared sense of local challenges and intended solutions, and resulting implications for delivery arrangements.

- The Local Vision programme supports leadership development and system change; to find out how the programme could facilitate and support the production of local planning, contact John.Jarvis@localleadership.gov.uk

- For an example of how a pioneer secured buy-in from stakeholders, access the North West London integration toolkit
- For guidance around the ‘do’s and don’ts’ in leading system change, read *The Revolution will be Improvised*
- For a guide to collective leadership, read the King’s Fund’s *Developing collective leadership for health care*

For more general resources around leading change:

- System Leadership’s case studies, stories and guidance
- King's Fund leadership development programme
- King’s Fund learning network

1. Leadership & Engagement

Governance and shared accountability through health and wellbeing board

- All local areas require clear management and credible oversight arrangements for implementing their BCF plans, including contingency planning and tracking of any necessary remedial action

- The LGA's health and wellbeing system improvement can support boards in developing their system leadership role: contact Caroline.Tapster@local.gov.uk for details

- For a set of scenarios describing integration or reconfiguration situations boards may face, use this LGA development resource
- To access every local area's health and wellbeing strategies and related report, go to this map
- To assess a board's strengths and development opportunities, complete the LGA's self assessment tool
- To access leadership courses for leading councillors, go to the Leadership Essentials development programme

1. Leadership & Engagement

Involving providers in governance structures

Localities around the country are using a range of methods to involve providers in local governance arrangements and service improvement planning.

Leicestershire has created an executive to oversee delivery of the BCF. Led by a CCG clinical chair, it has senior representation from community, acute and ambulance trusts. It meets monthly and has responsibility for existing joint work programmes as well as new initiatives to be established under the BCF.

Bath and North East Somerset has created two fora to involve providers – a strategic advisory group chaired by the health and wellbeing board chair comprising local health and care providers which sits alongside its health and wellbeing board; and a transformational leadership group which feeds into the development of CCG plans.

Wandsworth has created a partnership board, which meets after its health and wellbeing board and involves a wider cross-section of stakeholders including providers. Its agenda mirrors board decisions, providing avenues to engage and prioritise decisions.

Plymouth has given all major providers full membership on its health and wellbeing board – this includes housing and police as well as the local hospital and community health services.

As well as extending its health and wellbeing board to include providers, **Barnsley** has also established six programme boards to oversee implementation of the Better Care Fund. Covering thematic service areas including unplanned care or ageing well, the programme boards provide oversight for the delivering of local BCF projects.

Essex has also increased the size of its health and wellbeing board to include providers. The board will be vested with responsibility for the pooled budget, supported by a programme board to drive integration locally. In addition the county's CCGs are considering inviting a member of the local authority to their meetings to support streamlined decision-making.

1. Leadership & Engagement

Stakeholder engagement and co-production

Good quality stakeholder engagement is a crucial phase in developing your Better Care Fund plan.

- See here for a practical example of Sunderland engaged a range of staekholders in developing their case for change and vision

- Click here to access National Voices' Narrative on person-centred care and support
- For development tools around implementing person-centred care, go to Think Local Act Personal's Making it real programme resources
- For a step-by-step guide to involving patients in service redesign, go to King's Fund: Experience Based Co-Design Toolkit or for an introduction to patient activation, read the fund's *Supporting people to manage their health*
- For a guide and resource suite to involving patients in NHS commissioning and service delivery, click on NHS England: Transforming participation in health and care
- For help in how to measure patient experience, read the Health Foundation's *Measuring what really matters* or *Helping measure person-centred care*
- For advice in implementing experience-based design in healthcare, go to NHS Institute: Experience Based Design
- For learning from the integrated care pioneer programme around developing integrated teams: *Guide to Building Effective Teams*

Leadership & Engagement - Additional support available

Tier 3 - Bespoke advice and support:

Where there are particular challenges with agreeing a plan locally, some bespoke support will be available, that will draw on a range of external expertise from consultants or peers from across the NHS, local government and providers. This could take the form of peer support and facilitated discussion to work through the challenges within the local system to agree a proposed way forward

2. Risk stratification and Financial & Analytical Modelling

2. Risk stratification and Financial & Analytical Modelling

Overview

Better Care Fund plans will need to be grounded in robust analysis to understand:

- The sources of need and demand for care and support in the local area, and which sections of the population are at high risk of future hospital admissions
- The potential impact of delivering integrated care, in terms of changes in activity levels and the consequential financial impact

Which sections of the BCF Planning template is this relevant to?
Part 1: 3 The Case for Change
Part 1: 7 Joint assessment and accountable lead professional for high risk populations
Part 2: All tabs

See here for a case study from Sunderland on "Using social care data for risk stratification and impact analysis"

2. Risk stratification and Financial & Analytical Modelling

Risk stratification and population profiling

1. **Importance of understanding sources of need and demand**
   - A key step in planning integrated care is building up a detailed, analytically driven profile of need across the population
2. **Primary organising characteristics**
   - When deciding how to profile or group your population, it is necessary to have a primary organising characteristic, such as: type of condition and age, social and demographic factors, utilisation risk (risk stratification), behaviour
3. **Risk stratification and population profiling**
   - In order to support understanding your local population and to target appropriate interventions to have maximum impact, statistical risk models can be used to identify or predict individuals who are at high risk of future hospital admissions
   - These risk stratification tools can be used to target care to prevent inappropriate emergency admissions
   - Risk stratification approach can be complementary to grouping by other primary organising characteristics

Care spending estimate tool' for population segmentation and modelling. Monitor have developed a tool to help areas quickly segment their population and estimate the spend associated with each segment.

For a detailed, worked example of how a local area has undertaken population profiling and risk stratification, please see: Chapter 4 of North West London's Whole Systems Integrated Care

See slides 47-49 for the legal and information governance requirements to support risk stratification

2. Risk stratification and Financial & Analytical Modelling

Financial modelling of impact of proposed interventions

Below sets out some proposed key steps to impact modelling:

1. **Defining the aim of the proposed interventions**
   - A clear definition of the problem helps to keep the model complete and easy to grasp.
   - Need to translate aim into changes to costs, activity and outputs
2. **Understanding current care and future needs**
   - Understand the population group's characteristics, map out the current services that are being provided and who is providing them, and understand the baseline costs of current services
3. **Designing interventions**
   - Consult with commissioners, providers, staff and service users, drawing on published evidence where available, to determine:
     - Scope of intervention (how many staff, seeing how many patients, for how long, covering which conditions)
     - Likely impact on costs, benefits and outcomes
4. **Modelling the financial impact**
   - Understand where savings could come from – the most likely place for savings to come from integrated care is in non-elective admissions and other acute services
   - Establish methodology for estimating these savings
   - Calculate the possible savings for the particular group i.e. total cost attributable to relevant area of saving for group x potential % savings estimated with chosen methodology = potential estimated savings

2. Risk stratification and Financial & Analytical Modelling

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2. Risk stratification and Financial & Analytical Modelling

Modelling reductions in emergency admissions – a tool from PHE

PHE has worked with local authority colleagues in the Northern and Yorkshire region to develop **a tool to support Health and Wellbeing Boards (HWB) to set reductions in emergency admissions** for the performance related pay element of the BCF.

The excel based tool brings together historic and forecast data for non-elective admissions at HWB level, alongside four sub-indicators. Although the data contained within the tool does not directly match the BCF payment for performance metric, the tool is a useful resource for presenting historic trends and identifying potential factors that may be driving overall emergency admissions locally. Also presented is historic and forecast data for delayed transfers of care.

The draft version of the tool has been made available here. Comments or questions about the tool can be directed to northernandyorkshirekit@PHE.gov.uk Following feedback, a final version of the tool will be published later this month.

Risk Strat and Modelling - Additional support available

Tier 1- Resources available to all areas:

- We have a now published a "How To" Guide, which provides tips and advice for completing the technical sections of the BCF planning templates and includes specific chapters on "population segmentation and risk stratification" and "financial analysis". The guide is available on the NHS England and LGA websites.
- Recordings of the below webinars are all available to view
  - Introduction to benefits and financial modelling
  - Risk Stratification and Information Governance
  - Financial analysis and modelling

Tier 2- Regional clinics:

- We are hosting workshops to provide support in completing the technical sections of your BCF plan. These will take the form of "clinics" with bookable slots, and as part of these you will be able to access support on risk stratification, and financial and analytical modelling. Please see slide 8 for dates.

Tier 3- Bespoke consultancy support:

- Hands on support to areas who require help to get their analytics suppliers to support modelling work for plans including demonstrating how risk stratification informs proposed interventions
- Further, where possible, bespoke consulting support will be available to areas who require more 'hands on' analytical support with modelling their interventions

3. Evidence based planning

3. Evidence based planning

Overview

The evidence base for the different range of interventions is vast – the purpose of the following slides is to highlight some key findings for 5 different types of interventions and approaches.

- Self-care
- Falls prevention
- Case management and care co-ordination
- Intermediate care, reablement and rehabilitation
- Focusing on reducing emergency care
- Role of Primary Care

The list is not exhaustive, nor are the categories mutually exclusive. There may be other interventions that you wish to consider implementing locally.

For each type of intervention there is a brief description of its purpose and what the evidence currently says.

For overall summaries of the evidence base please see:
'Integrated care value case toolkit'(LGA)
'Making best use of the better care fund' (King's Fund)

3. Evidence based planning

Using the evidence base to inform local commissioning plans

- Once you have a clear understanding of the case for change in your area and the issue you are trying to address, you will need to consult evidence based guides (such as those referenced on previous slide) to understand the best ways of addressing those needs.

- However evidence needs to be looked at through the lens of your local context…
  - Do you have the same contextual factors in place in your local area which led to success elsewhere?
  - And if not, how might that affect the success of your intervention?

- Over the following slides we highlight some useful “local practice examples” which will help you to understand the specific local conditions and success factors behind effective integrated care schemes

- NICE’s Commissioning Support and Benchmarking tools can help you to commission evidence based services along care pathways and calculate associated costs and savings.
- Below are three resources from this collection which may be useful when commissioning integrated care:

End of Life Care commissioning support (supports Quality Standard 13)
EOLC commissioning and benchmarking tool (CMG42)
Integrated Commissioning for the prevention of CVD (CMG45)

3. Evidence based planning

Self-care
People with long-term conditions account for 70% of inpatient bed days. Self-management programmes, which aim to support patients to manage their own conditions. Shown to reduce unplanned hospital admissions for some conditions (COPD and asthma)

Evidence for cost savings is more equivocal (Naylor et al) but messages from research suggest:

- Tailoring interventions to the condition (e.g. structured education for diabetes self-care; behavioural interventions for depression)
- Involving patients in co-creating personalised self-care plans
- Telephone health coaching
- Change programmes to encourage lifestyle change

For more detail on the evidence base to support self care, please reference:
Naylor et al (2013) *'Long term conditions and mental health - the cost of co-morbidities'*
Purdy S (2012) Avoiding hospital admissions: what does the research evidence say? London: the King's Fund
De Silva D (2011) Helping people help themselves: a review of the evidence considering whether it is worthwhile to support self-management. London: The Health Foundation
A NICE Local Practice example is available at: Self-care support for long-term conditions

For guidance on making a local business case for self-care, please see the work done by the NESTA people powered health programme: 'The business case for people powered health'

3. Evidence based planning

Falls prevention

Identifying people at risk of falls and developing preventative interventions reduces hospital admissions and the use of residential care homes.

For the economic case for investing in falls prevention, see:

- 'Fracture prevention services: an economic evaluation' (Department of Health, 2009)
- The study by Tian et al (2013), 'Exploring the system - wide costs of falls in older people in Torbay', used patient-level linked datasets to explore the health and social care costs for patients in the year before and after a fall. It showed that in the 12 months after a fall, community care costs increased by 160%, social care costs by 37% and acute hospital costs by 35%

For guidance on how to assess and prevent falls in elderly people see NICE clinical guideline 161:
'Falls: assessment and prevention of falls in older people'

For a recent independent evaluation of a falls prevention service, see Campbell et al (2013) , which evaluated the impact of Northamptonshire Crisis response service, which worked alongside the ambulance service to prevent elderly admissions to hospital following a fall. The research shows that a crisis response service can have a positive impact. Link. See page 65 of the LGA Evidence Review: 'Integrated care evidence review, November 2013'

3. Evidence based planning

Intermediate care, reablement and rehabilitation

The National Audit of Intermediate Care (2013) categorises four types of intermediate care: **crisis response** – services providing short-term care (up to 48 hours); **home-based intermediate care** (multi-agency team, usually health led); **bed-based intermediate care** (delivered away from home, for example in community hospital) and reablement – services to help people to live independently which are provided in person's own home by a team of mainly care and support professionals.

A Department of Health funded review showed that home care reablement is almost certainly cost-effective because of improved outcomes for users. The study showed that in the first year of setting up a service, set-up costs cancel out savings in the first year. Many areas should have already set up reablement services and have thus already incurred these costs.

SCIE Research briefing 36: Reablement: a cost-effective route to better outcomes
http://www.scie.org.uk/publications/briefings/briefing36/
SCIE (2013) Maximising the potential of reablement:
http://www.scie.org.uk/publications/guides/guide49/index.asp

NICE Local Practice Examples:
Management of patients with stroke: REDS (Reach Early Discharge Scheme)
Rapid Response Services: intermediate tier, multi-disciplinary health and social care service
Enhanced home-based palliative care for adults
Early discharge and intensive community rehabilitation for stroke patients

3. Evidence based planning

Case management & Care co-ordination

Case management can be described as a "*targeted, community-based and proactive approach to care that involves case-finding, assessment, care planning and care co-ordination*" (Ross et al, 2011).

Components include:

- Case finding – see risk stratification slides
- Assessment – from April 2015, this will include a carer assessment
- Care planning – including making referrals to various agencies
- Care co-ordination – usually undertaken by a case manager in a multi-disciplinary team
- Case closer (for time-limited interventions)

The evidence base for case management is "promising but mixed' (Purdy, 2010). This is in part due to difficulty in attributing any positive changes to case management when there are multiple factors at play (for example, how to disentangle the effect of case management from any specific interventions that might be planned e.g. falls prevention, reablement, self-care).

3. Evidence based planning

Focusing on reducing hospital admissions: trends

Conditions where hospital admissions can be reduced through active management are known as ambulatory care-sensitive conditions (ASC). A study of trends in emergency admissions between 2001 and 2013 showed that 1 in 5 are ASC (avoidable).

- 5 conditions account for half of all ASC admissions, of which three disproportionately affect older people (urinary track infection/pyelonephritis, pneumonia and chronic obstructive pulmonary disease (COPD)) and the other 2 disproportionately affect young people (convulsions and epilepsy, and ear, nose and throat infections)

- Level of deprivation is strongly linked to rates of ASC admission, especially for COPD. Adjusting to deprivation explains much of the variation between areas, although significant differences remain even after adjusting for age, sex and deprivation. **Therefore better organisation of health and social care can make a difference**.

- There has been successes in reducing ASC admissions, particularly linked to proven innovations in care (e.g. angina and bleeding ulcer). For other conditions substantial policy efforts have had little impact. For example, rates of admission for COPD have not changed significantly since 2001 despite a range of national and local initiatives

Blunt, I (2013) 'Focus on preventable admissions: trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013' QualityWatch, The Health Foundation, Nuffield Trust

3. Evidence based planning

Focusing on reducing hospital admissions: what works

The evidence highlights key three factors for reducing avoidable admissions

- Early identification of ambulatory care-sensitive conditions. This may be through clinical knowledge, threshold modelling (rules based, where people are judged against certain criteria) and in particular predictive modelling (using risk stratification tools discussed elsewhere in this pack).
- Increased continuity of care with a GP
- Early senior review in A & E, and structured discharge planning

Purdy S (2010) 'Avoiding hospital admissions: what does the research say?' London: The King's Fund

Monitor are hosting a series of webinars exploring best practice in mitigating pressure on emergency departments and delivering safer, high quality and more responsive emergency care services. For more information see here

3. Evidence based planning

Role of Primary Care

GP's have a considerable role in developing proactive and personalised care and support https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304139/Transforming_primary_care.pdf

GP's have a vital role to play in related programmes such as self-care, case management and falls prevention

For a detailed case study, see : Tower Hamlets – new GP networks since 2009 'Working to establish GP consortia' . The key features of this case study include:

- Networks of GPs based on Local Area Partnerships (4 GPs per network; 8 networks across the Borough).
- New care funding model based on care packages, providing care rather than just administering it

The development of networks of practices facilitated collaborative working among primary care clinicians and other stakeholders, peer review of achievements, and an element of healthy competition. For more detail, see BMJ Article: Improving MMR vaccination rates: herd immunity is a realistic goal

Evidence base planning - Additional support available

Tier 1 – Resources available to all areas
Monitor are running a series of webinars exploring best practice in mitigating pressure on emergency departments and delivering safer, high quality and more responsive emergency care services.
https://www.gov.uk/government/news/join-our-free-webinars-urgent-and-emergency-care-resilience-and-capacity-planning

Tier 2- Regional workshops: We are hosting workshops to provide support in completing the technical sections of your BCF plan. These will take the form of "clinics" with bookable slots, and as part of these you will be able to access support on evidence based planning. Please see slide 8 for dates.

Tier 3- Bespoke advice and support: There is some bespoke advice and support available from the NICE Field team of implementation consultants. This team works with people at a local level to help them put their evidence based guidance into practice and, where possible, will be available to answer questions such as:

- ✓ Do NICE have relevant guidance or standards that are relevant to our plans and priorities ?
- ✓ Are there any tools that can help with making business cases or evaluating outcomes ?
- ✓ What examples of existing practice around integration might there be in specific areas ?

.

This support will be particularly helpful once you have made decisions about the types of approaches and schemes you will be funding / delivering through the BCF in your area.
To contact the NICE field team, please email : fieldteam@nice.org.uk

4. Tracking the Impact of Integrated Care

4. Tracking the Impact of Integrated Care

Overview

- Measuring the outcomes of integrated care schemes and new ways of working is crucial in order to be able to understand what is working well locally and what needs to change

- To this end, Better Care Fund plans need to outline:
  - a credible way of measuring the outcomes of *individual or grouped schemes* that are being funded
  - how outcomes data will be used as part of management, oversight and governance structures to *track impact across the system*

Which sections of the BCF Planning template is this relevant to?
Part 1: Plan of action
Part 1: Annex 1: Feedback loop
Part 2: HWB benefits tab

4. Tracking the Impact of Integrated Care

Defining key outcomes and metrics for measuring integrated care and support

- When defining which outcomes you are choosing to measure, you will need to think in an integrated way, across the five outcomes domains

- This choice of outcomes should also be informed by a clear and analytically driven understanding of the “case for change” in your area. To help you select a set of outcomes for measuring and tracking progress, you can refer to:
  - Chapter 3 of the NWL London tool kit, which maps example outcomes across 5 NHS / Social care outcomes domains : 'How do we define outcomes and metrics?'
  - And CCG and LG outcomes benchmarking support packs

- In order to understand whether priority outcomes are being achieved you will need to identify a set of metrics that are supported by regularly available and robust data. Metrics might be derived from existing data sources or from a bespoke data collection tool

- PIRU have written a report outlining a range of suitable metrics to measure progress towards integrated care. This resource will help you to identify which metrics will be most useful locally: 'Integrated care and support pioneers: indicators for measuring the quality of integrated care'

- NB - NICE quality standard statements contain measurable indicators to help assess quality improvement, suggesting types of information to be collected and possible sources

4. Tracking the Impact of Integrated Care

Evaluating integrated care schemes

- The Better Care Fund is an opportunity to commission new ways of working and new schemes, and to build a local evidence base about what is working. To this end you should consider how to generate the most robust evidence of impact from the new schemes that you are funding
- As part of this, you may wish to undertake or commission evaluations of specific schemes / interventions.
- A key first step would be the development of a logic model or theory of change. For guidance on how to do this, and how to develop an approach to evaluation, please see:
  - Public Sector Transformation Network Guide to Evaluation 'Supporting public service transformation: cost benefit analysis guidance for local partnership'
- For specific advice on how to set up robust evaluations using well matched counterfactual groups please see pages 14 / 15 of the above guide.
- The Newquay Pathfinder Evaluation report provides an example of a robustly conducted evaluation: 'People, place, purpose: shaping services around people & communities through the Newquay pathfinder'

Using data to track system impact

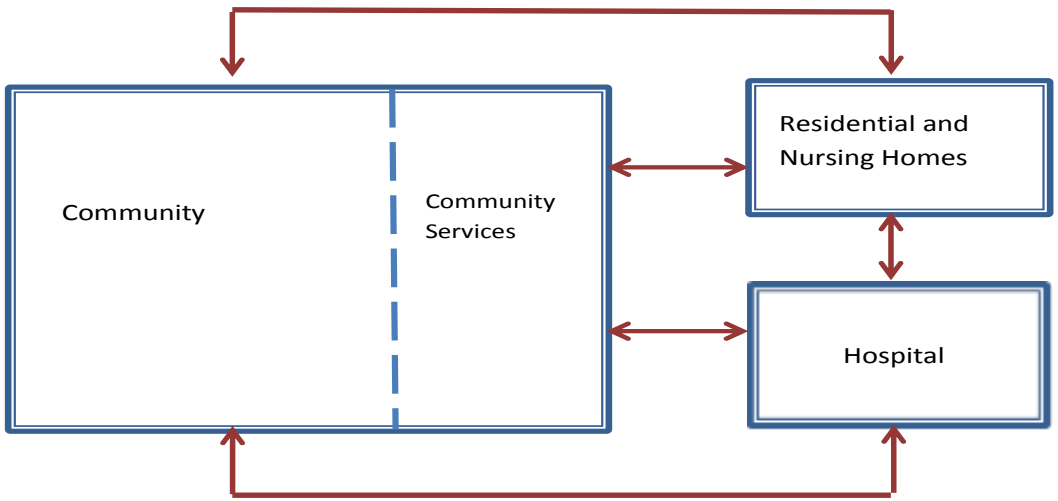
- It will be necessary to look at the overarching impact of your integrated care and support plan across different parts of the system. To this end you may wish to develop an integrated scorecard approach – see next slide for an example of what data this might draw on.

4. Tracking the Impact of Integrated Care

Illustrative Health and Wellbeing Board Integration Scorecard

System data of HWB population

- Permanent admissions to residential / nursing care (65+) per 100,000 population (BCF)
- Proportion of LA spend on Residential and Nursing Homes



- Proportion of people aged 65+ discharged direct to Residential care

- Proportion of people (65+) who were still at home 91 days after discharge from hospital into reablement or rehabilitation services (BCF)
- Proportion of all deaths that occur at home (or care home) 65+

- Avoidable Admissions (BCF)
- Delayed transfers per 100,000 population (BCF)
- A & E (type 1) 4 hr performance
- Length of stay / Treated without an overnight
- Non-elective admissions & re-admissions (30 days and 90 days)

Using data to track system impact – **an example of an integrated scorecard**

This work is taken from the "Locality Benchmarking Scorecard Programme" jointly sponsored by ADASS and AQuA to improve integration of health and social care for frail older people in the North West region. The programme collects, benchmarks and shares a "whole system" dataset in the form of a "Locality Scorecard."

Tracking the Impact of Integrated Care - Additional support available

Tier 1- Resources available to all areas:

- We have a now published a "How To" Guide, which provides tips and advice for completing the technical sections of the BCF planning templates and includes specific chapters on "Outcomes and Impact measurement". The guide is available on the NHS England and LGA websites.
- PHE are developing a 'fingertips' tool to give local areas access to Better Care Fund indicators such as delayed transfers of care and social isolation. The tool enables users to compare data with other local authority areas and to the national average. The tool is a national extension of the Midlands and East social care profile and is in draft form. To access a test profile you will need to enter a username and password via http://test.erpho.org.uk/adultsocialcare. For access to the site and feedback please contact Justin Robinson at Justin.robinson@phe.gov.uk

Tier 2- Regional clinics:

- We are hosting workshops to provide support in completing the technical sections of your BCF plan. These will take the form of "clinics" with bookable slots, and as part of these you will be able to access support on evaluation and approaches to tracking the impact of integrated care. Please see slide 8 for dates.

Tier 3- Bespoke consultancy support:

- Where possible, bespoke consulting support will be available to areas who require more 'hands on' analytical support with developing approaches to evaluation and tracking the impact of integrated care

5. Guidance on regulatory frameworks

5. Guidance on regulatory frameworks

Overview

In this section we provide guidance on how to navigate the regulatory systems around:

1. Section 75 joint finance agreement under s.75 NHS Act 2006 and risk sharing agreements
2. Procurement patient choice and competition rules under The National Health Service (Procurement, Patient Choice and Competition)(No. 2) Regulations 2013
3. Information Governance

Which sections of the BCF Planning template is this relevant to?
Part 1: Section 1a. Plan Details
Part 1: Section 3: Case for change
Part 1: Section 7: National conditions

5. Guidance on Regulatory Frameworks

Forming a Section 75 agreement- under Section 75 of the NHS Act 2006

- In order to start a pooled budget, partners must have a signed section 75 agreement in place, which outlines from which budgets money will be taken to be pooled. Section 75 agreements are not new, and many areas have them in place. However, having an agreement for the BCF that is overarching, is a newer concept.

- Example section 75 agreements are Oxfordshire, which concentrates on integration and prevention, and Enfield which deals with a specific treatment area. Further, Bevan Brittan have prepared a template s.75 agreement with an explanatory note. This will need to be adjusted to reflect your local situation, but gives you a solid place to start.

- Agreements must follow correct accounting arrangements- remember that a host partner must be selected, who will be responsible for accounting, and agreements must not try and avoid tax. Use the Manual for Accounts, the CIPFA Accounting code, and the IFRS 11 Joint Arrangements to make sure your agreement is sound.

- Guidance on how to do this exercise is available in the following areas:
  - The Audit Commission has two detailed documents (still found in the National Archives), called *Clarifying Joint Financing Agreements* and *Means to an End*
  - The HFMA also have specific documents called *Better Care Fund: Managing the pooled budget* and *The Better Care Fund*. However, these are only available to members.
  - CIPFA also have a useful documents relating to pooled budgets available for purchase.

5. Guidance on Regulatory Frameworks

Forming a Section 75 agreement and developing risk sharing arrangements

- In order to start a pooled budget, partners must have a signed section 75 agreement in place, which outlines from which budgets money will be taken to be pooled. Section 75 agreements are not new, and many areas have them in place. However, having an agreement for the BCF that is overarching, is a newer concept.

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5. Guidance on Regulatory Frameworks

Risk Sharing

- BCF plans require specific risk sharing arrangements between commissioners and providers, and between commissioners across health and social care.

- In response to feedback, the BCF Taskforce has now developed suggestions for what to cover in your response to the risk sharing elements of the template. This has been prepared by the Task Force in consultation with NHS England, other health ALBs and professional bodies.

- This document can be found on the NHS England BCF website.

- Since pay for performance targets are set for an entire health and wellbeing board area, CCGs may want to use Section 75 agreements to make sure that varying degrees of performance do not unfairly penalise CCGs who have attainted the agreed target. Provided all CCGs agree, the section 75 agreement could be used to adjust for this by redistributing the funding to match CCG performance.

5. Guidance on Regulatory Frameworks

Procurement, Patient Choice and Competition Rules (PPCCR)

- When developing proposals to deliver better integrated care in their local area, commissioners and providers should be mindful of the procurement, patient choice and competition rules.
- There is a lot of detailed and technical guidance available on Monitor's website. For a quick run through the core issues, you may find these hypothetical scenarios helpful: 'Hypothetical case scenarios: procurement, patient choice and competition regulations'
- Also, Monitor held a Web-ex with the Integration Pioneers and the attached transcript addresses key issues that were raised as part of that high level discussion
- The full range of guidance is available on Monitor's website: Procurement choie & competition in the NHS, guidance on mergers
- If you have specific questions on how the PPCCRs apply to your BCF plan, you can email Monitor at cooperationandcompetition@monitor.gov.uk

5. Guidance on Regulatory Frameworks

Complying with Information Governance requirements

Confidential personal information is protected by law and should not normally be shared against the wishes of the individual concerned, whether for care or any other purpose.

However, it is generally accepted that people who use health and social care services understand that social workers, doctors, nurses and other professionals will need to share confidential information among the care team and with other professionals along the care pathway in order to provide effective care.

Data sharing for care purposes:
There should not be any problems in people working in multidisciplinary teams sharing and receiving PCD (personal confidential data) for the purposes of providing direct care. This means that social workers that work with health staff should have access to necessary info. There should be no legal barriers in this kind integrated working happening now.

Data sharing for non-care purposes:
The most important example is for "risk stratification" – analysis of local population is assess risk of hospital admission, for example. This is done using health records, and there is already legal cover in place through something called a "section 251 application" that NHSE have sponsored.

Which sections of the BCF Planning template is this relevant to?
Part 1: Section 7) c) Data sharing

5. Guidance on Regulatory Frameworks

Complying with Information Governance requirements

Examples of care and non-care purposes

Use	Description	
A. Individual access to own medical record and history[1]	Allows people to view their own medical record and become more involved in their own care	Direct Care
B. Creating and sharing co-ordinated care plans	Co-ordinated care plans for people identified with high levels of specialised need for use across providers and setting	
C. Sharing of patient medical records and care history	Sharing patient medical records and care history for all patients to support their care	
D. Risk stratification	Risk stratification used to identify patients or patient cohorts that would benefit from proactive preventative care.	Not Direct Care
E. Identifying gaps in clinical data	For example data can be analysed to determine whether a patient is receiving the correct care for their diagnosis	
F. Piloting new care models and observing outcomes	Allows for the impact of care interventions to be measured in other settings of care, i.e. does an intervention in Primary Care reduce hospital admissions?	
G. Understanding current and future population needs and resource utilisation	For example, assessing where the highest areas of demand and cost are to assess where efficiency can be targeted.	
H. Tracking Outcomes, and meeting outcome targets	Linked data can be used for outcome tracking and outcome based payment across care settings	
I. Capacity planning	Through providing a picture of trends across settings of care to identify pressures across the whole locality	
J. Designing and implementing new payment models	Identifying the average spend associated with segments of population can be used as basis for population-based payments	

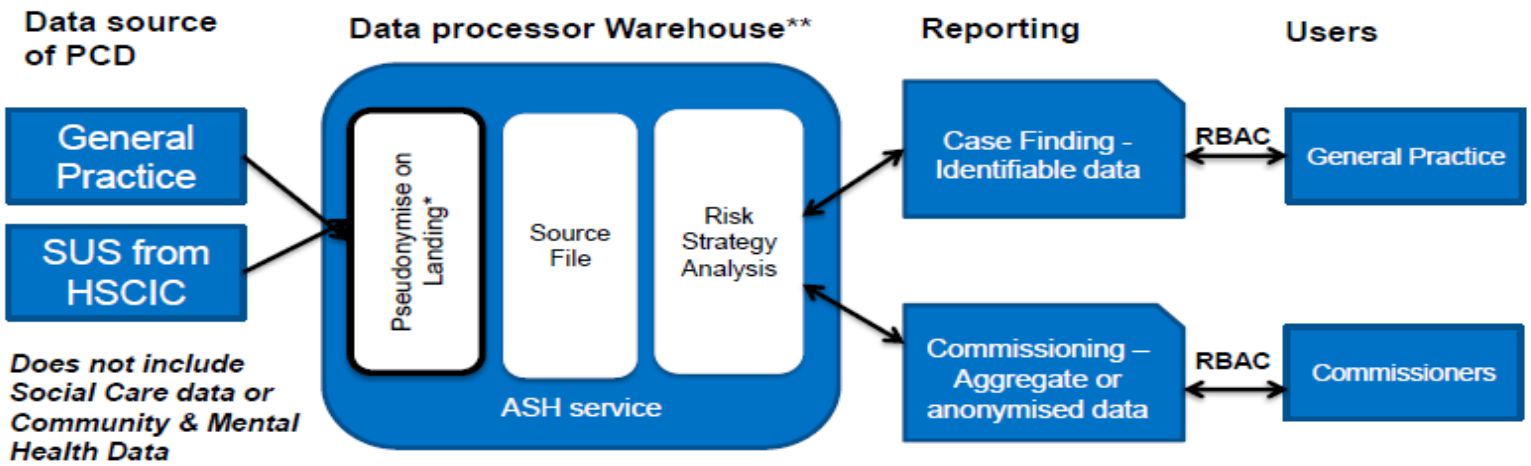
Source: Monitor
http://www.icase.org.uk/pg/cv_content/content/view/134253/83890?cindex=3&ctype=all&cflag=created&cdvault=83897&container=83890

5. Guidance on Regulatory Frameworks

Complying with Information Governance requirements

Generic Risk Stratification Process under s251 Regulations

Figure 1 **IG compliant approach – Legal basis provided by (CAG 7-04(a)/2013). Patient Consent is not required whilst this is valid.**



An additional CAG approval is being pursued to allow inclusion of Social Care PCD for Risk Stratification purposes for the Southend Pioneer

PCD – Personal Confidential Data,
ASH – Accredited Safe Haven,
RBAC – Role Based Access

**May also use weakly pseudonymised data, defined as the following data elements NHS Number as the single identifier and include age, partial postcode, presence of date of death and sensitive items of gender and ethnicity*

*** Processing of data for risk stratification takes place under the constraints set in place by the approval of the Section 251 by the Secretary of State. This means that processing can only be undertaken by accredited organisations, either already under contract to the NHS with a proven track record on managing data for risk stratification or by Commissioning Support Units, effectively part of NHS England, that have achieved (Stage 1) ASH status*." P16 http://www.england.nhs.uk/wp-content/uploads/2014/03/priv-imp-assess.pdf

Source: Monitor
http://www.icase.org.uk/pg/cv_content/content/view/134253/83890?cindex=3&ctype=all&cflag=created&cdvault=83897&container=83890

5. Guidance on Regulatory Frameworks

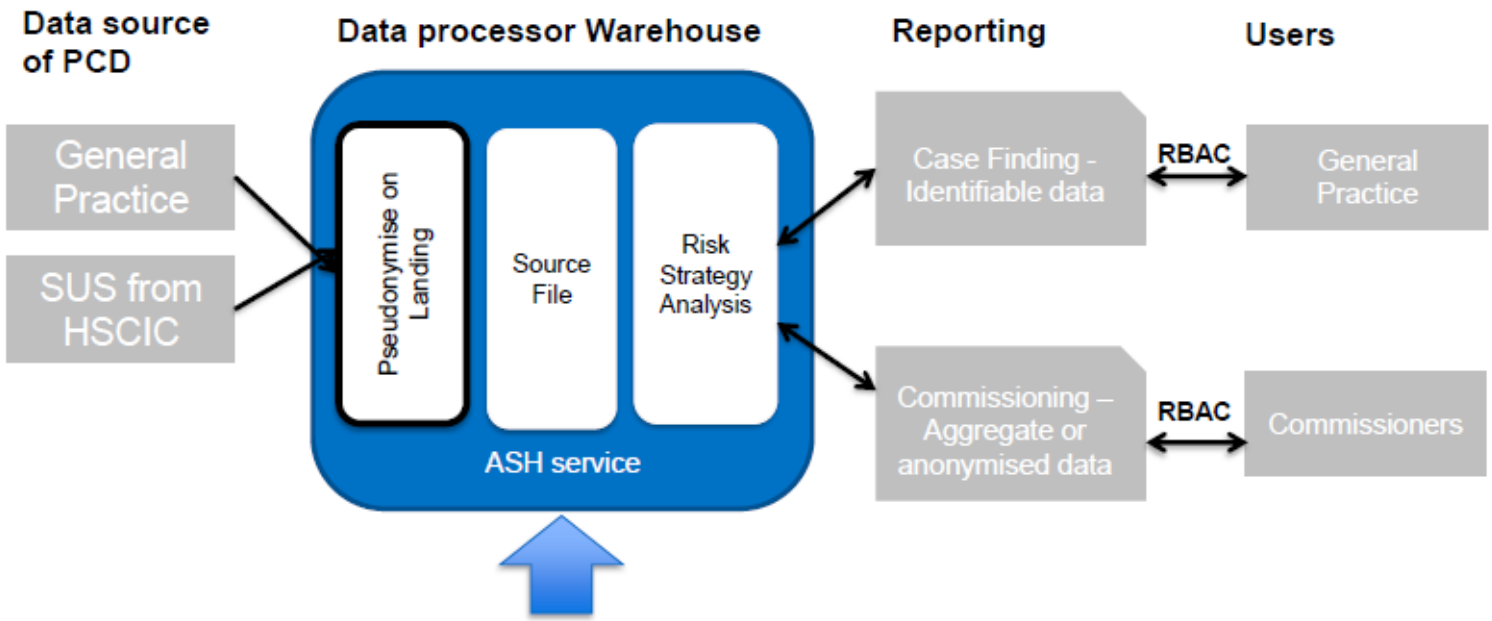
Complying with Information Governance requirements

See Appendix 2 of the NHS England Risk Stratification Assurance Statement for a list of approved suppliers

5. Guidance on Regulatory Frameworks

Complying with Information Governance requirements

Generic Risk Stratification Process under s251 Regulations – Further explained



What analysis can take place here for commissioning purposes?

- Making data less identifiable
- Data linkage
- audit, monitoring, & analysis of healthcare provision

For what purpose?

The aim supported was to target vulnerable patient groups and offer them appropriate services. The aim of risk stratification is to reduce hospital readmissions and target clinical interventions to high risk patients.

5. Guidance on Regulatory Frameworks

Complying with Information Governance requirements

Summary: Linking Data for Risk Stratification Purposes under the NHS England sponsored s251 application (CAG 7-04(a)/2013)

CAG 7-04(a)/2013 provides a legal basis for sharing of GP data and SUS (secondary uses services) data for the purpose of risk stratification*.

The CAG approval grants temporary permission for data processors working on behalf of GP Practices. To be compliant they must complete an Assurance Statement; available at: Risk stratification assurance statement - CAG7-04(a)/2013 compliance for CCGs

"The existing approval applies only to GP data and SUS data. Social care data needs a separate legal basis at the present time – either consent, a separate s251 application of techniques which don't breach confidentiality."[1]

A further CAG request has been submitted for the Southend Pioneer site for Risk Stratification with the inclusion of Social Care Data.

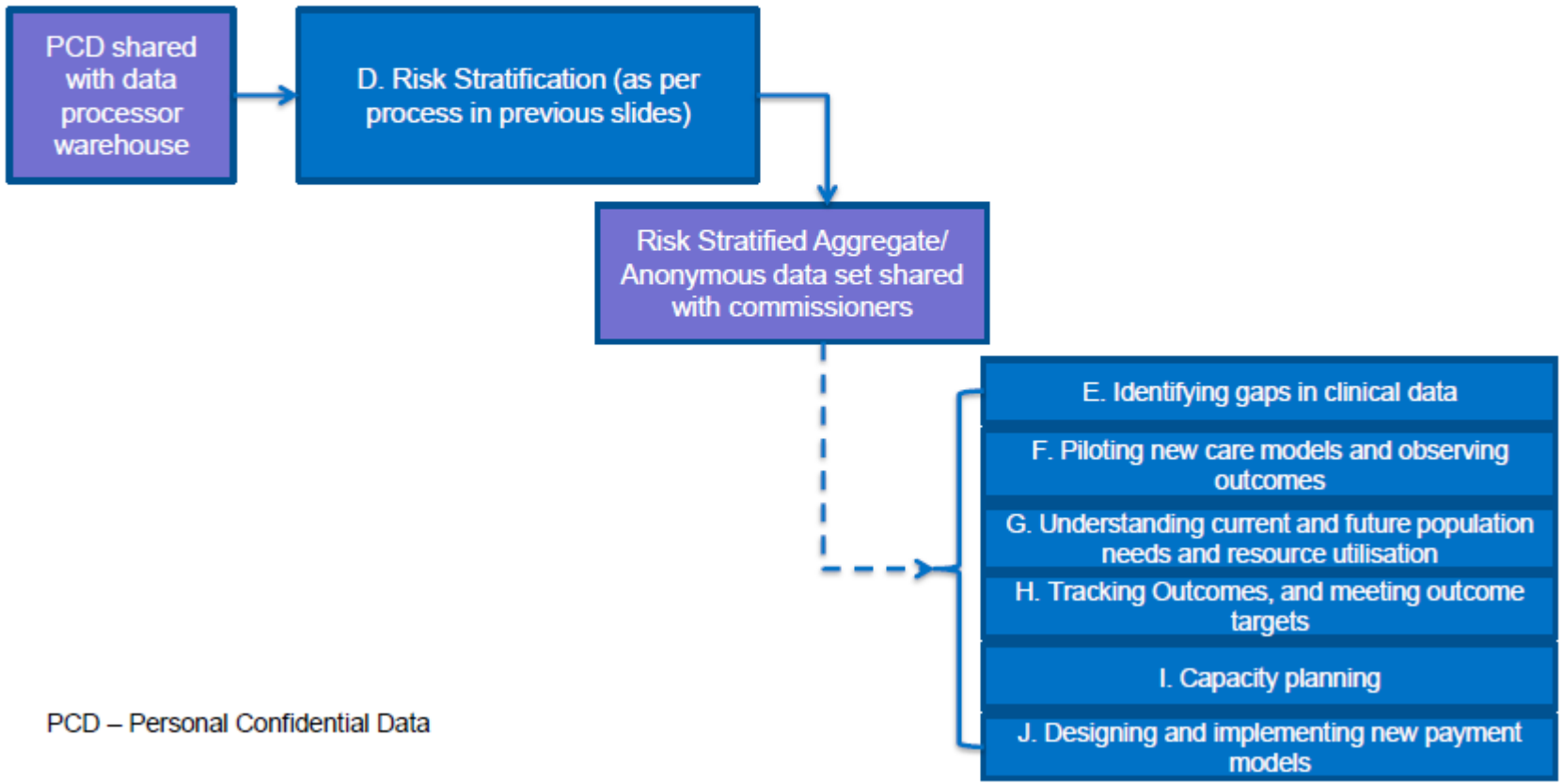
1 NHS England, Risk Stratification Assurance Statement, CAG 7-04(a)/2013 compliance for CCGs; http://www.england.nhs.uk/wp-content/uploads/2014/02/rsa-state-02-141.pdf

*The s251 application covers SUS commissioning data sets approved under including NHS number, local hospital number, date of birth, postcode, gender and ethnicity, and to GP data including patient data, event data, referral data, prescriptions, conditions / diagnosis groups, health groups, interventions group, exclusions group, and practice data (practice ID and registered patient list)

5. Guidance on Regulatory Frameworks

Complying with Information Governance requirements

Effectively anonymised/aggregate output of the risk stratification process can be used for other commissioning purposes (E-J) either within the data processor if kept separate or by commissioners



PCD – Personal Confidential Data

Guidance on regulatory frameworks - Additional support available

Tier 1- Resources available to all areas:

- We have a now published a "How To" Guide, which provides tips and advice for completing the technical sections of the BCF planning templates and includes specific chapters on "Outcomes and Impact measurement".
- A Risk Stratification and Information Governance webinar was run on 28th August and is available to download. The same webinar will be re-run on 3rd September 1400- 15:30

Tier 3- Bespoke consultancy support:

- Where possible, bespoke consulting support will be available to areas who require more 'hands on' support with issues around regulatory frameworks.

Additional, useful resources on planning and delivering integrated care

1. **Case studies developed from BCF "Fast Track areas":** These case studies walk you through step by step how BCF plans were developed in the 5 Fast Track areas: http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/fast-track/
2. **The Integrated Care and Support Learning Exchange, ICASE,** is a learning community focussed on integrated care and support, where you can make connections and find solutions to issues that you are facing. On the site you will find a broad range of resources to assist you with integrated care planning. http://www.icase.org.uk/pg/dashboard
3. **LGA Integrated Care Value Case Toolkit -** The toolkit should enable Health and Wellbeing Boards and local partners to understand the evidence and impact of different integrated care models on service users, as well as the associated impact on activity and cost to different parts of the health and care system http://www.local.gov.uk/web/guest/health/-/journal_content/56/10180/4060433/ARTICLE
4. **The Longer Lives project from PHE** quantifies premature deaths from the four most common causes of mortality in England – heart disease and stroke, lung disease, liver disease, and cancer, highlights inequalities in premature mortality across the country and provides examples of effective local interventions. http://longerlives.phe.org.uk/about-projectetc
5. **The National Voices and TLAP Narrative for Person Centred Co-ordinated Care** - http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf
6. **LGA Care and Support Reform Implementation –** For information about broader support on implementing the Care Act: http://www.local.gov.uk/care-support-reform
7. **SCIE step by step toolkit on planning for Integration** - http://www.scie.org.uk/publications/integratedworking/index.asp
8. **Skills for Care** case studies containing valuable lessons and outcomes in workforce development for organisations focussing on integrated care: http://www.skillsforhealth.org.uk/service-area/integrating-health-and-social-care/