Department of Health

Department for Communities and Local Government

Local Government Association

NHS England

Better Care Fund Task Force

‘How to’ Guide: The BCF Technical Toolkit

Section 3:
Outcomes and Impact Measurement

August 2014

The Better Care Fund

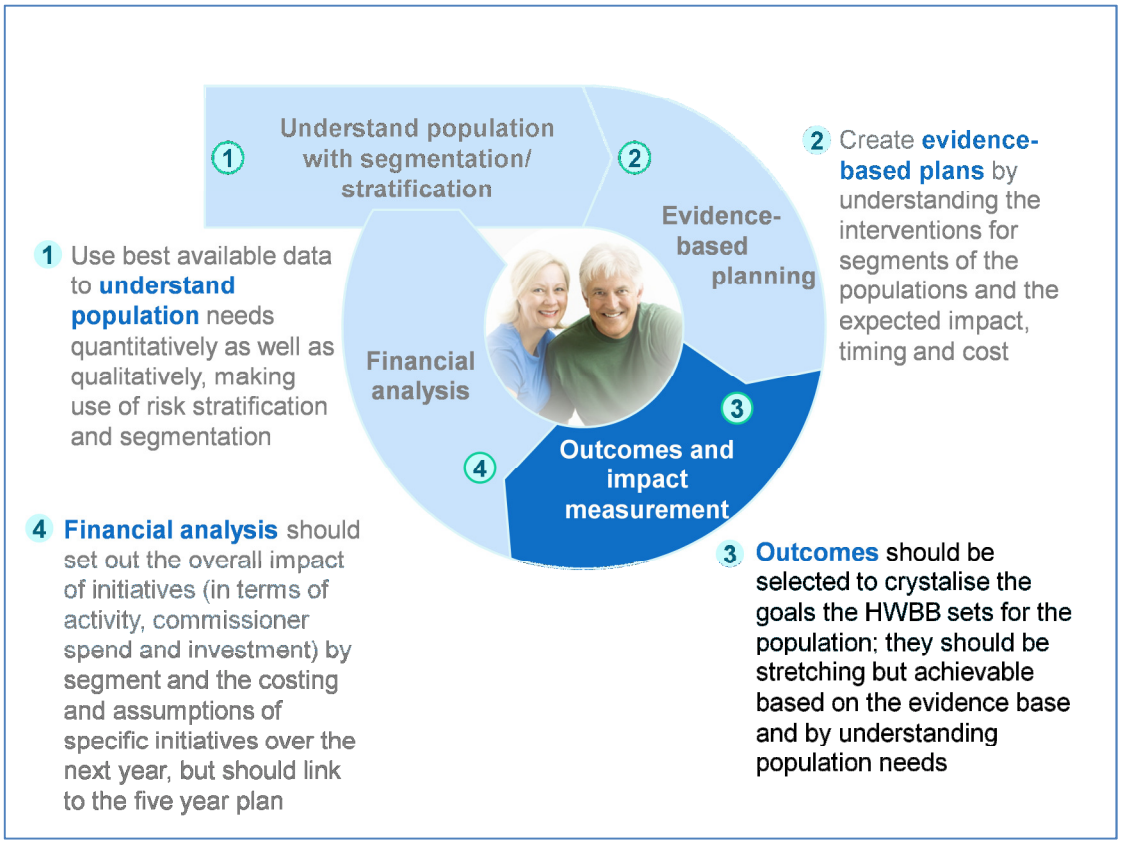
Contents

BACKGROUND

This document provides practical advice on how you can determine outcomes, targets and the measurement of impact. Also included in the following sections are hints and tips that will support the preparation of BCF plans as they pertain to these topics. This document is meant to be used in conjunction with the other documents that make-up the "how to guide." Please refer to the document entitled "Introduction to the How To Guide" to understand how to best use this document.

The financial analysis will build on the evidence based outcomes and targets explained in this section.

Figure 1. Four steps for robust planning



OUTCOMES AND MODELLING IMPACT

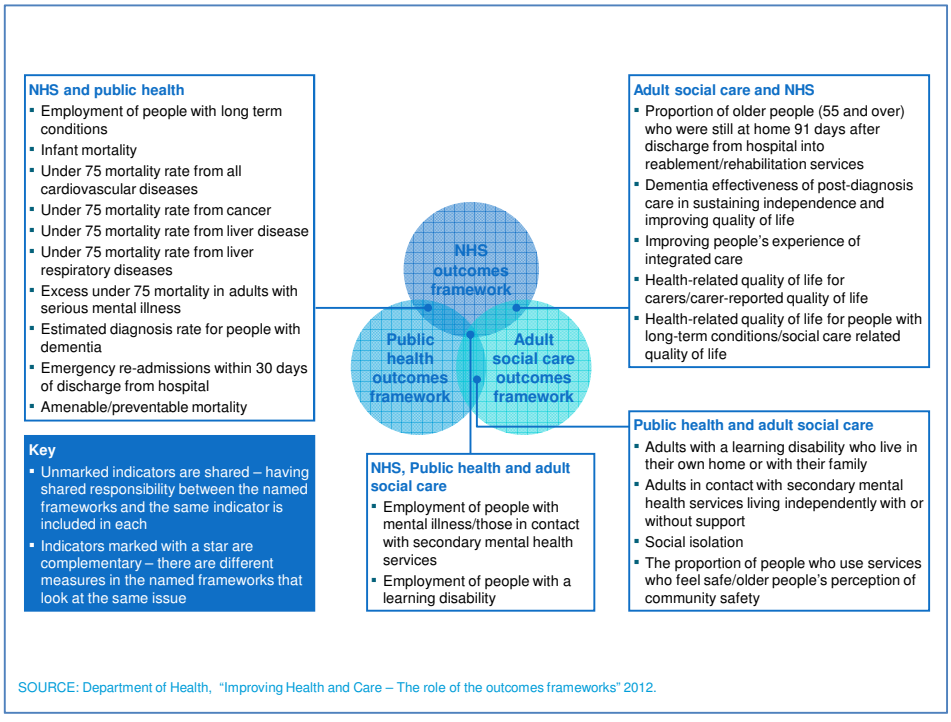
What is it?

Once the evidence base has been thoroughly reviewed and schemes selected that best meet the needs of the population, the next step is determining the most relevant outcome measures and identify target impact levels. Outcomes are the benefits that are expected once changes have been made. This might include changes in:

- Quality
- Experience
- Cost

Many frameworks across the health system exist to organise outcome measures. Examples of outcome measures from multiple frameworks have been aggregated in the figure below.

Figure 2. Examples of outcome measures
Various agencies have developed outcome frameworks that organise different types of outcome measures. The Department of Health published the below figure to demonstrate the overlap and complementary nature of several frameworks.



SOURCE: Department of Health, "Improving Health and Care – The role of the outcomes frameworks" 2012.

Alongside some of the outcome measures in figure 2 it is important to explicitly look at cost metrics which may be broken down into:

- Activity growth

- Total cost
- Per capital cost
- Cost growth

This will be essential for modelling the impact of integrated care schemes, some of which will be described in this section as well as in the financial analysis section.

Why is it important?

Defining outcome measures allows HWBBs to:

- Align commissioners and providers around the impact of planned schemes. This makes sure that everyone locally is aiming to deliver a common set of outcomes.
- Measure progress over time. Setting outcome measures at suitable time intervals allows initiatives to be tracked. Initiatives can be monitored to see whether they are delivering the expected outcomes and will highlight if changes to the scheme need to be made where they are not delivering.
- Provide a basis for aligning incentives. Schemes are most successfully implemented when all incentives (for example, payments) within the system are aligned with the agreed outcomes.

What is essential for your plan?

For the BCF submission, the measurements chosen should include the national BCF metrics:

A) Non-elective admissions (general and acute)
B) Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
C) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
D) Delayed transfers of care from hospital per 100,000 population
E) Patient/service user experience

Only the first measurement of reduction in non-elective admission (general and acute) will be linked to payment for performance, but all other metrics will still be monitored. The expected minimum target reduction is 3.5% (based on a baseline of the previous 12 months) for the period Q4 14/15 to Q3 15/16 unless the HWBB can make a credible case as to why it should be lower. HWBBs should focus on the population segments and schemes that will impact on this

metric as a priority and aim to identify schemes that will deliver the 3.5% reduction.

For supplementary guidance on the expectation of the 3.5% reduction in emergency admissions, please see: http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-supp-guidance-3-5.pdf

Additionally, the Better Care Fund's Technical Guidance provides in depth explanation of the required metrics (starting on page 20), it is available at: http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

Determining additional appropriate outcome measures, setting targets and modelling impact can be done in three steps:

1. Identify possible outcomes and targets based on lessons from the evidence base

   Expert interviews, international evidence, the clinical evidence base and internal and external benchmarking (described in section 2) will often explicitly identify the outcome measures and impact of schemes. It is important to consider these impact estimations in the local context and apply multiples or deflators on the potential impact based on well-formed assumptions (e.g., variation in starting point, differences in population characteristics).

   Impact can also be calculated based on:

   - Benchmarking: What is the relative performance of your locality compared to peers (e.g., those with similar populations)? Would it be feasible to move to quartile? To the median? Once there is an agreed end-state target, it is possible to calculate impact of reaching this target (e.g., as a simple example, assume that moving to the median will result in 200 fewer bed days, at £200 per bed day, savings could imply £40k)
   - Reducing variation: Calculate the impact of reducing variation between providers and/or between geographies. For example, what would be the impact if all providers met the median in terms of ALOS for conditions of interest?
   - Aspiring to a historical "personal best": What could be achieved if your performance on relevant outcome metrics met the HWBBs historical best?

Using a combination of these methods will triangulate your calculations and identify a suitable best-case and conservative range of impact.

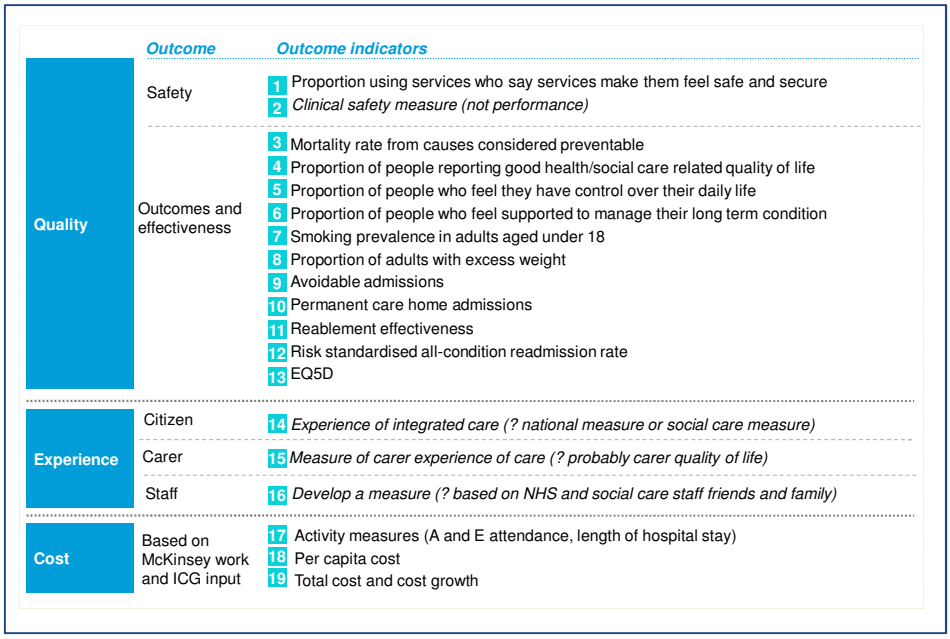
BetterCareTown HWBB case study Exhibit: Calculating gross savings

BetterCareTown HWBB used their findings from the evidence, along with clinical input and an understanding of benchmarks versus peers to calculate the range of potential impact on NEL admissions, EL admissions, A&E attendances and OP attendances. In some cases, it will be difficult to attribute impact to any one specific scheme. In these instancs, it is acceptable to include a package of schemes that will create impact. This will be called out in the evidence base.

		How is impact calculated	NEL	EL	A&E	OP
Bench-marking	1 ***Close gap in practice level variation controlled for IMD***	• Close emergency admission rates gap to median or top quartile performance across various GP practices	***12-19%***	***9-13%***	***19-23%***	***5-13%***
	2 ***Benchmark CCG level performance with ONS and peer group***	• Reduce emergency admission rates to median and top quartile performance of various peer sets (ONS, peer group, national)	***5-15%***	***7-12%***	***7-17%***	***5-13%***
Inter-national evidence	3 ***Use international case examples adjusted to local population***	• Use international case examples to understand the impact of integrated care on different parts of the population • Adjust these to the local population and demographics	***25-40%***			
Interviews	4 ***Assess avoidable A&E and inpatient admissions***	• Determine number of admissions that could have been avoided in a defined period. This will be achieved through interviewing GPs	***38%***		***50%***	
Number used	***Range actually used in the financial modelling***		***25-35%***	***7-12%***	***7-17%***	***5-13%***

2. Define a relatively small number of outcome goals for the whole population that are agreed across all commissioners, and that will be impacted by the schemes being implemented. Examples of outcome measures and outcome indicators are shown in Figure 3.

Figure 3. Examples of outcome indicators
Following the common Quality/Experience/Cost framework, the figure below lays out example indicators that are often tracked.

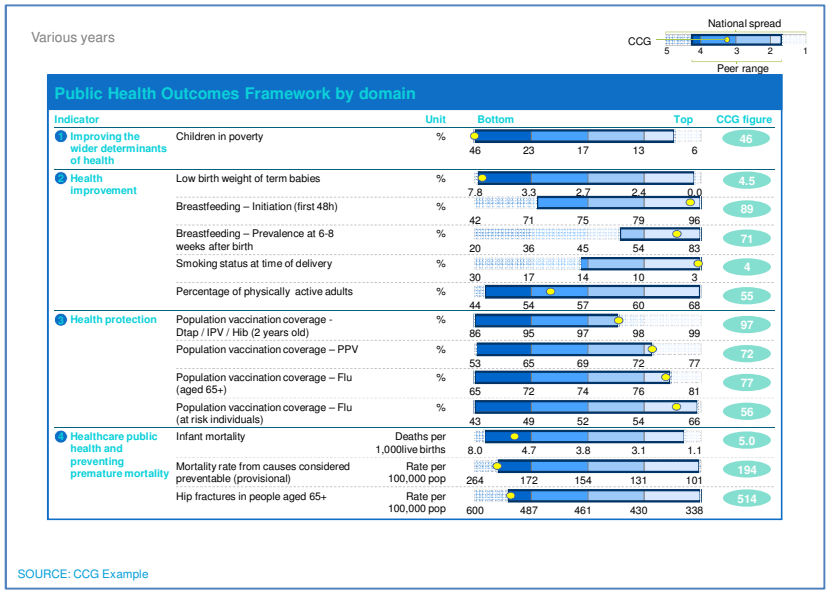


Other local metrics that have already been agreed, for example from the NHS Outcomes Framework, the Adult Social-care Framework and the Public Health Outcomes Framework[1] could be also be included, if they are relevant to the schemes being proposed. In fact, overlap in metrics with pre-existing frameworks will demonstrate strong alignment in local strategy.

3. Plan to routinely collect data which can be used in measuring progress against goals. This data needs to be reviewed at suitable intervals with a more in-depth review where progress is not as planned. Implementation of schemes may need to be accelerated, schemes may need to be changed or, in extreme cercumstances, stopped. Figure 4 shows an example of a dashboard that might be used to measure outcomes.

[1] North West London – Whole systems integrated care toolkit, 2014

Figure 4. Example outcomes dashboard from NHS England SAFE 2 project The below figure provides an example of how metrics can be displayed. This example not only tracks performance of the metrics, but also versus peers and a target range.



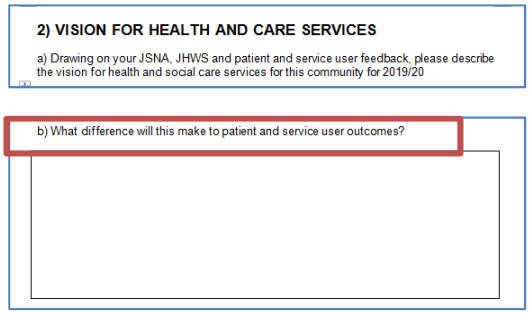
A practical outcomes selector tool for commissioners and providers to use to help them decide which outcomes they want to achieve, and which metrics they will use to measure their success can be found in Chapter 5 of the North West London Whole Systems Integrated CareToolkit http://integration.healthiernorthwestlondon.nhs.uk/chapter/what-are-the-outcomes-to-be-delivered-

Again, you should refer to the Technical Guidance issued by the Better Care Fund. It also includes guidance on planning appropriate levels of ambition for targets. It is available here: http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

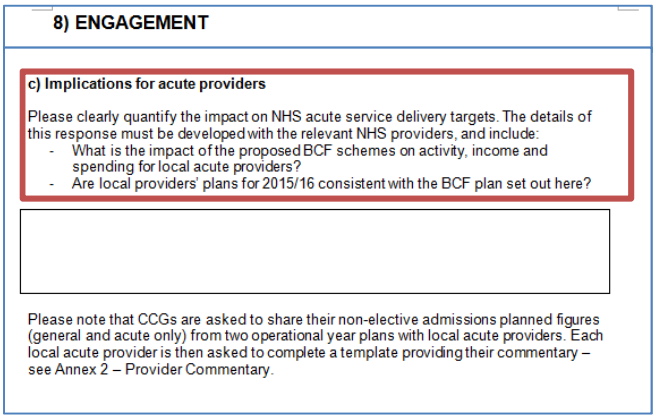
What is recommended for your plan?

In addition to the guidance provided above, a best practice submission will be able to demonstrate high levels of stakeholder engagement across commissioners and providers in defining outcome measures and targets. This will inform a key set of metrics which are specific, measurable, actionable, realistic and time bound (SMART). As there are many outcome frameworks, some of them shown in figure 2, the chosen outcomes should aim to align across relevant frameworks, whilst ensuring adequate diversity of metrics. As well, outcome measures should link to relevant public health measures, CCG plans, local authority plans and other sources like JSNA and winter planning.

How do you use this information in the planning templates?



The written template has various boxes where outcomes and impacts will be required. *Part 1 Section 2b* asks for the difference the proposed changes will make to patient and service user outcomes. This can be a high level description of the overall improvements once the schemes are in place.



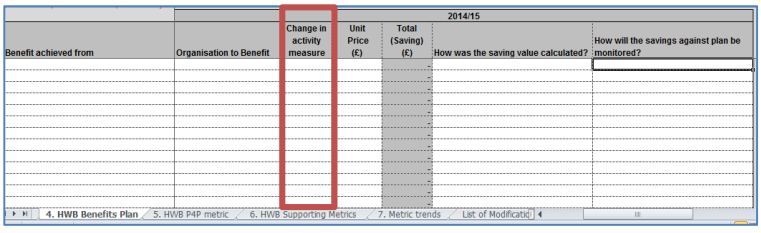
Part 1 Section 8c asks for a quantification of the impact of the proposals on acute providers. This will require analysis to show the impact of proposed schemes on acute activity, such as non-elective admissions and A&E attendances, using the evidence around impact of each scheme. It is important to make sure that there is no double-counting between schemes if some people within the population are being impacted on by more than one scheme.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
What is the strategic objective of this scheme?
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

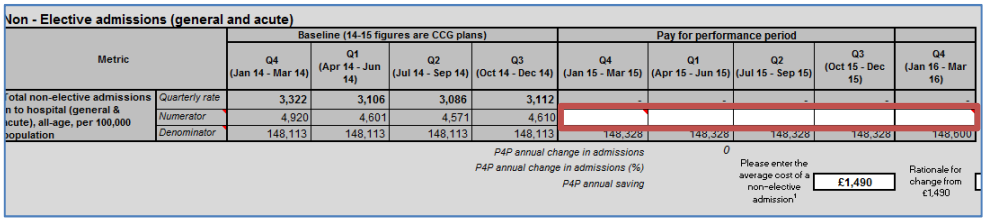
Part 1 Annex 1 asks for information on the impact of each scheme that is not captured in the headline metrics. This might include impact on e.g. patient experience or carers.



Part 2 Tab 4 asks for the impact of the schemes in terms of changes in activity. This will need to be calculated using the baseline activity and the percentage reduction that is anticipated for each scheme according to the evidence base. Again, it is important to make sure that there is no double-counting between schemes if some people within the population are being impacted on by more than one scheme.

Finally, *Part 2 Tabs 5 and 6* contain the required BCF plan metrics. You will be required to outline how the impact of your schemes will affect these metrics.

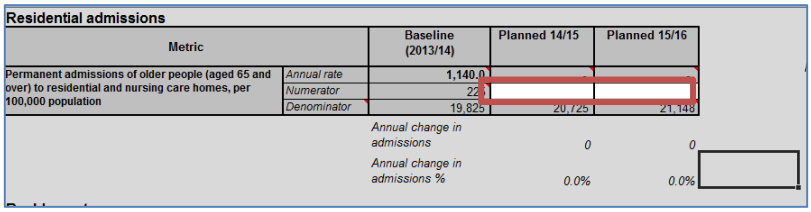
Tab 5:



Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans) Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Pay for performance period Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	3,322	3,106	3,086	3,112	-	-	-	-	-
	Numerator	4,920	4,601	4,571	4,610					
	Denominator	148,113	148,113	148,113	148,113	148,328	148,328	148,328	148,328	148,600
	P4P annual change in admissions						0			
	P4P annual change in admissions (%)									
	P4P annual saving									
	Please enter the average cost of a non-elective admission[1]								£1,490	
	Rationale for change from £1,490									

Tab 6:



Residential admissions

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	1,140.0	-	-
	Numerator	22		
	Denominator	19,825	20,725	21,148
	Annual change in admissions		0	0
	Annual change in admissions %		0.0%	0.0%

Further reading

- Chapter 3 of the North West London Integrated Systems Tool Kit maps example outcomes across 5 NHS / Social care outcomes domains : 'How do we define outcomes and metrics?'
- CCG and LG outcomes benchmarking support packs
- 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' , http://www.piru.ac.uk/assets/files/IC%20and%20support%20Pioneers-Indicators.pdf