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Better Care Fund

A case study / step-by-step methodology using Greenwich's BCF plan as an example

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Contents and Introduction

This document provides a 'how to' guide in certain key areas for local areas who are developing their BCF plans.

Introduction

This document is designed to act as a 'how to' guide for local areas in developing their BCF plans, building on the experience of the exemplar BCF plans.

The exemplar BCF plans have been through a fast track process. In order to share the learning from these plans, a series of case studies have been developed to support local areas across the country with their revised BCF plans.

This case study focuses on six key areas as indicated in the contents on the left and provides advice and guidance in these key areas. This document is not a guide to inform filling in the whole BCF template but provides short, focused, practical examples of how to undertake certain elements of the planning required.

The document utilises examples from one of the BCF exemplar areas, Greenwich, to demonstrate good practice in each of the areas. Alongside the good practice, we provide advice and guidance, and in some cases a step by step method that explains how to produce similar good practice.

We hope it is helpful to local areas in developing their BCF plans.

Case for change (within Section 3 of the template): 1/3

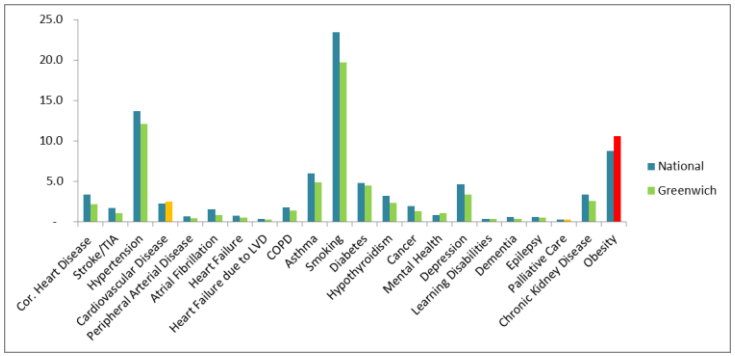
The case for change should tell a logical, flowing story that explains the problem and why integration is the answer.

Greenwich example

In this case for change we will present:

- The health and social care challenges facing Greenwich;
- The specific challenge presented by patients with long term conditions;
- Why in 2011 Greenwich decided that integration was the answer to these challenges, and the evidence base for this;
- The progress made since then, indicating that the approach taken works; and
- How the BCF schemes have been selected to improve further the standard of care in Greenwich through advancing integration.

Greenwich faces a significant problem in managing long term conditions, as demonstrated in the graph below.



Advice and guidance to local areas

It is worth laying out at the outset of the case for change a specific introduction that indicates exactly what this section will describe to signpost the reader, as in the example.

It is important that this case for change links the solution – integration – to the problem – prevalence of long term conditions and the rising burden of demography.

It is also worth including a patient story which shows the patient journey across different agencies to demonstrate the weaknesses in quality of the current system, indicating why the health and social care system needs to change.

Local areas should seek to demonstrate, using data on prevalence of disease types, that you understand the nature of the challenges facing your local area, and in particular the burden of long term conditions. This should help you to define the nature of the problem.

Case for change (within Section 3 of the template): 2/3

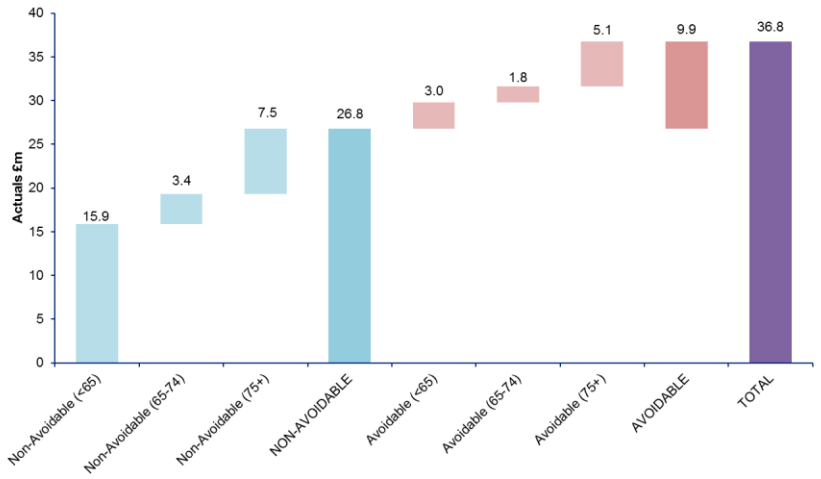
It is important to provide some examples of patient segmentation analysis to show you understand the nature of the challenges facing the local area and that you understand where you should target schemes.

Greenwich example

When we analyse the CCG's emergency admissions in 2013/14 in the chart below, we see that in total emergency admissions in Greenwich cost £36.8m.

£9.9m of spend (27%) on emergency admissions could be considered avoidable. Of this, £6.9m of spend (70%) related to the over 65s.

This suggests that the single major challenge Greenwich faces in terms of patient groups is tackling the frail elderly pathway and those patients with long term conditions. The integrated care programme has been designed accordingly.



Advice and guidance to local areas

In the case for change section of the BCF plan, it is important to demonstrate that the local area understands its patient population and those groups which integration may impact. Understanding this allows the local area to make an estimate of financial savings from integration.

One example of a simple exercise that can be undertaken to segment emergency admissions is provided on the left:

1. Acquire a download of a year of emergency admission data for the CCG from SUS.
2. Undertake data cleansing to remove duplicates.
3. Filter by age at time of admission.
4. Filter by a list of HRG codes that could be considered 'avoidable', predominantly those codes that relate to patients with long term conditions such as diabetes who could be managed more effectively in the community.
5. Establish the total cost of these admissions; an average cost of these admissions can also be established by dividing the total cost by the number.

This avoidable over 65 emergency admissions segment can then be targeted as a patient cohort by the integration schemes that focus on the frail elderly and LTC pathways. Further filtering and segmentation can support subsequent, more granular financial analysis.

Case for change (within Section 3 of the template): 3/3

The case for change should tell a logical, flowing story that explains why integration is the answer to the problems identified.

Greenwich example

Integration is the answer to these problems. Greenwich Integrated Care was launched in April 2011.

Experience from Greenwich since 2011 suggests that the results of integration are that the elderly population maintain their independence longer, with fewer people entering full social care, fewer people requiring services after the completion of the pathway, fewer delayed discharges and reduced length of stay in intermediate care, as well as preventing A&E attendances and emergency admissions.

Furthermore, integration has received widespread support from organisations such as The King's Fund as it has been shown to improve clinical outcomes and reduce unscheduled hospital admissions. The benefits of integration have been summarised and published in the LGA Integrated Care Value Case Toolkit.

All the evidence therefore shows that Greenwich is already seeing the benefits of integration and is following a tried and tested model which we can build on through the Better Care Fund. We therefore have a strong evidence base for our model both in theoretical, best practice terms, and in practical terms: we have proved that it works over the past three years.

Advice and guidance to local areas

Having identified the nature of the problem, the case for change must then outline why integration is the solution.

In the case of Greenwich the heart of this case has focused on the fact that integration has been in place since 2011 and has already delivered measurable results.

In a local area where there is no history of integration to prove that it works, the evidence base for integration must be used to indicate why integration is the answer to these problems. This can use a range of sources as demonstrated in the text to the left.

There should be a clear narrative that outlines why integration is the answer at a macro level, before the case for change moves onto demonstrating the selection of individual schemes.

Using the evidence base to select appropriate interventions (Section 3)

It is important to indicate why you have selected your schemes, and use the evidence base to do this.

Greenwich example

In Greenwich we wish to build on what has worked in our integrated programme over the past three years and use the BCF to advance integration significantly, improving the quality of care across the borough.

We went through a rigorous process to select our schemes.

Two workshops were held in May and June 2013 bringing together nominated representatives across the social care and health system to hear about the preferred model of integrated care and work through the detail of the schemes.

As a result of this process, we have identified 14 schemes based on the existing integration evidence base both nationally and locally, a sample of which are demonstrated in the table below:

Scheme	Case study / Evidence base
Pioneer	North West London pilot
Virtual Patient Record	Integrated care for patients and populations: Improving outcomes by working together, The Kings Fund and Nuffield Trust, January 2012
Care Homes	Care Quality Commission review of health care in care homes

Advice and guidance to local areas

The last element of the case for change should identify why local areas have selected the integration schemes they have, using the evidence base. This evidence base should then feature in the individual annex one business case templates as well to make the case for each individual scheme.

Initially the local area should explain the process by which you selected the schemes. This may have involved workshops across the whole health economy, or consultation with patients, providers and the third sector. Demonstrating an inclusive process with appropriate governance is important here.

Subsequently it is important to outline the evidence base for each of the schemes. The table to the left does this by indicating the most relevant case study example from the literature for a selection of schemes. This explains how the evidence base has been used to select certain interventions. Local areas should consider using published materials such as the LGA Integrated Care Value Case Toolkit to undertake a similar exercise.

Modelling the impact of the interventions on activity (Annex One schemes): 1/2

Selecting the right evidence base to support your scheme modelling is very important.

Greenwich example

Greenwich scheme: The Pioneer scheme will involve the implementation and rollout of the extended community integrated service across the whole of Greenwich. The service model is designed to address the needs of adults with complex care needs and long term conditions by developing a team around the person consisting of health and social care professionals. These community integrated teams will work in a person-centred way to reduce the need for patients to attend hospital.

To support the delivery of the scheme above, Greenwich selected the following case study from the evidence base:

Case study: North West London implemented multi-disciplinary groups (MDGs) involving professionals from community health, mental health, primary care, secondary care, social care, community pharmacy and specialist nursing coming together with patients and carers to realise a shared vision of high quality services. The scheme has seen the following outcomes:

- **Reduction in emergency admissions by up to 15%**
- Reduction in A&E attendances by up to 30%
- Reduction in emergency inpatient days
- Reduction in poly-pharmacy and prescribing costs

Advice and guidance to local areas

The key part of any modelling exercise is to select carefully the appropriate assumptions about the impact your scheme can have on activity. To do this you need to have some evidence which supports the assumptions you make.

Two of the potential options for acquiring this evidence are:

1. Base any assumptions on upscaling or rolling out an existing model in the area, making suitable assumptions based on the impacts that have already been seen.
2. Select evidence from the evidence base that indicates that this scheme has worked elsewhere and delivered a measurable impact.

In the example to the left, Greenwich have selected the North West London community integrated team example to support their own scheme around expanding their community integrated teams.

Choose the model closest to your own proposal. In some cases this can be difficult as the scheme may, for example, be in an urban context whereas you are a rural area, or vice versa. In this case tailoring the assumptions made in the case study becomes very important.

The key thing is that the case study contains specific evidence of impact that you can apply to your own data.

Modelling the impact of the interventions on activity (Annex One schemes): 2/2

When you have the right evidence base, you must identify and segment the correct patient cohort, so that you can apply the activity impacts from the case study to the right patient cohort.

Greenwich example

Case study selected by Greenwich: North West London implemented multi-disciplinary groups (MDGs) involving professionals from community health, mental health, primary care, secondary care, social care, community pharmacy and specialist nursing coming together with patients and carers to realise a shared vision of high quality services. The scheme has seen the following outcomes:

- **Reduction in emergency admissions by up to 15%**
- Reduction in A&E attendances by up to 30%
- Reduction in emergency inpatient days
- Reduction in poly-pharmacy and prescribing costs

Advice and guidance to local areas

1. The case study gives you the activity impact figures. Then you need to define in your own data the patient cohort.
2. Define the patient cohort you are targeting, and then select the activity that best matches that patient cohort e.g. filter the activity by emergency admission, age, diagnosis, HRG code.
3. Apply the case study percentage to the activity to calculate an expected reduction in admissions as a result of the scheme.
4. Tailor for local circumstances

Application to the Greenwich context:

The overall activity for acute hospital admissions in 2013/14 was 61,653 spells (49,390 with a tariff attached)

By filtering the data to reflect only the emergency admissions, we are left with 19,990 (17,210 tariff)

If we remove the unavoidable admissions from this total, we are left with 4,119 (3,943 tariff)

Of these, the over 65 age group equates to 2,474 (2,396 tariff)

A specific locality must also be removed as there is a pilot scheme there already, leaving 1,673 for the other localities (1,623 tariff)

Apply the 15% reduction in emergency admissions from the case study to the patient cohort identified

Assessing the costs of schemes (Annex One schemes)

It is important to consider a range of potential costs for all parts of the health and social care economy and include the relevant costs for the right time period.

Greenwich examples

Please find below four examples of the cost analysis Greenwich has undertaken for individual schemes:

- Greenwich's telehealth programme is a brand new initiative and will require initial investment for equipment in the first year on top of the recurrent cost needed for patient monitoring in subsequent years.
- The Pioneer scheme rolls out an existing pilot and therefore Greenwich have a reliable figure for the current staffing costs to apply to the next phase. This figure can then be extrapolated over a full year over two further localities.
- The Long Term Conditions scheme includes increased levels of screening for patients at risk of developing COPD to try and identify new cases.
- Greenwich's virtual patient record project is joint funded with other organisations over a long term timescale. It was important to identify Greenwich CCG's share of the project costs for 2015/16 only to include in the Better Care Fund plan. A detailed breakdown enabled the relevant costs to be identified.

Advice and guidance to local areas

The investment needed should reflect the combined cost of setting up and delivering the scheme.

If this is a new scheme, there may be set up costs for things like training, installation of new technology, and procurement of additional equipment.

For both new and existing schemes there will be ongoing, recurrent costs. These may be staffing costs or the costs of commissioning a service. Consider whether the service can be delivered by the existing staff base or if additional WTEs will be needed – this requires careful analysis. Many integration schemes can be delivered by the existing workforce working differently.

You might also need to consider incentives for GPs, e.g. for a long term condition screening / early diagnosis scheme, will there be extra payments per patient for new services provided by primary care?

The costs should only be those that relate to 2015-16 and any schemes that start mid-year should be pro-rated appropriately.

Any joint-funded schemes with other CCGs or providers should be apportioned appropriately.

Translating the impact into financial benefit (Annex One schemes)

Average emergency admission costs can be used to translate activity impacts into financial benefits, although if possible using average costs for groups of admissions is more accurate.

Greenwich example

The North West Case study, as discussed, demonstrates a 15% reduction in emergency admissions to apply to the Pioneer scheme.

13/14 data filter	Total spend	Tariff activity	Avg Cost (incl. MFF)
All admissions	£80,066,315	49,390	£1,621
Emergencies	£36,752,397	17,210	£2,136
Avoidable	£9,945,698	3,943	£2,525
Over 65s	£7,021,590.	2,396	£2,931
- exclude locality	**£4,595,861**	**1,623**	**£2,832**
Over 75s	£4,739,881	1,591	£2,979
- exclude locality	**£3,295,001**	**1,101**	**£2,993**

By applying this reduction to the activity and costs in our data set, NHS Greenwich CCG could achieve the following savings:

Over 75 age group – 15% of 1,101 spells at an average cost of £2,993 gives a saving of £494k.

Gross Saving: £494k
Costs: Salary cost of running the service: £348k
Net saving: £146k

Advice and guidance to local areas

Take the potential activity reduction from the previous page

Consider using the average emergency admission cost in the local area (including the market forces factor) to cost the activity reduction

Be as specific as you can be to achieve amore accurate estimate: e.g. can you use an average emergency admission cost for the specific condition or patient group being targeted? Certain targeted groups may cost more (or less) than the average.

Apply the most applicable average emergency admission cost to the activity reduction to calculate a financial saving

Finally, local areas must assess the costs of the proposed new schemes which will be an additional cost to the local area, as indicated on the previous page. The savings minus the costs will demonstrate a net saving figure.

Sensitivity analysis / downside planning (Annex One schemes)

Case study outcomes are only indicative and local areas should perform sensitivity analysis to calculate a range of savings if possible.

Greenwich example

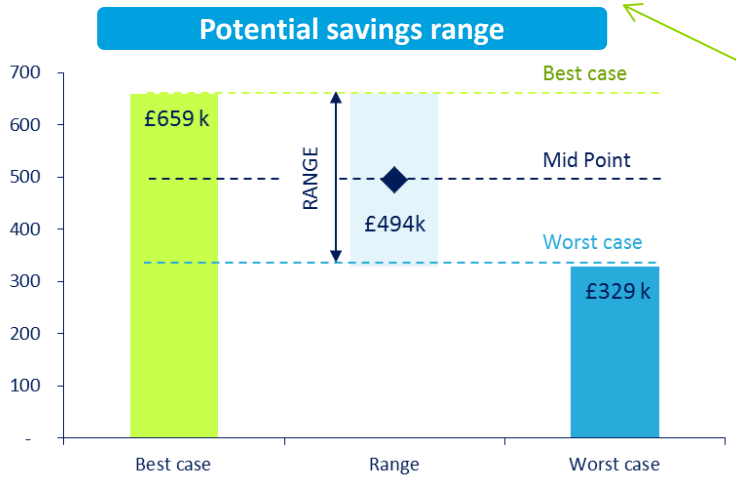
In Greenwich, a 15% reduction based on the North West London case study has been assumed.

However, if we apply sensitivity analysis, the outcome could be anywhere in the range 10%-20%.

This would result in a range of savings as follows:

- Best case scenario (20%) - £659k
- Mid-point (15%) - £494k
- Worse-case scenario (10%) - £329k

Final savings range: £329k to £659k



Advice and guidance to local areas

The approach used to calculate the high level savings from integration assumes that the schemes proposed locally will achieve the same impact as in the case studies used. However, this is theoretical and only produces an indicative saving; the actual local outcome will not perfectly match the outcome in the case study.

To allow for variation from the percentage reduction used, apply a scale of the potential savings should the scheme achieve an impact that is 5% lower or higher than that in the case study, providing a best and worst case scenario.

Use the highest and lowest figures to generate a range of savings that the scheme could achieve.

Consider whether your schemes will have an effect for the full year or whether there will be only a part year effect, and adjust the savings figures accordingly.

Risk stratification (within Section 3 of the template: Case for Change)

It is important to tell the story about the local area's approach to risk stratification, making clear what the plan for completion is, and outlining any barriers.

Greenwich example

Greenwich narrative on risk stratification:
As the legal basis of population level risk stratification has been in doubt since April 2013, and in the absence of legal authorisation to undertake such risk stratification, efforts in Greenwich have focused upon using case finding tools within health and social care to identify those most at risk, and also by publicising the services and the single point of access to maximise the appropriate uptake. Greenwich CCG has applied, along with other integration pioneers (notably Southend), for s251 approval to undertake risk stratification, and is awaiting the outcome of the Confidentiality Advisory Group's deliberations on this.

Local example of case finding:
Our existing integrated teams bring together health and social care managers and front line staff into joint teams, delivering coordinated care with a clear focus on roles and responsibilities. The GCC model of integrated care based around GP Local Area Networks will operate in the same way to identify a lead professional with the additional function of care navigators to coordinate multi-disciplinary care planning meetings and develop a care plan. All patients moving through the Eltham test and learn pilot have joint care plans in place. A total of 73 since May 2014.

Advice and guidance to local areas

It is important to make clear in the BCF plan how the local area has sought to implement risk stratification.

If progress has not been made directly, local areas should explain why, including what alternative approaches have been used. Local areas should also explain their plan for how they are going to implement risk stratification.

It is important that this plan identifies the potential legal barriers and problems to implementing risk stratification, and how these will be overcome, including acquiring the necessary approvals.

If no formal risk stratification process has been undertaken, it will be useful to indicate what local examples of case finding have been undertaken.

Contact details

If you have any queries about the methodologies or information contained within this case study, please contact the following people:

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