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

Better Care Fund Task Force

Example charts to support BCF planning and submission

Better Care Fund Support Clinics

Draft document not official guidance
9 Sept 2014

About this document

- In the course of reviewing plans with HWBB during the first set of regional workshop clinics we have received questions about how to apply suggestions from the "how to guide" in the plan submissions

- In the clinics we have discussed with people how to consider the thought process, and also the specific outputs they might use to represent their thinking and planning. To support this we have developed and used a number of charts for people to use to clearly present key aspects of their plan.

- These may be helpful for people to either incorporate in their plans or use to support development of those plans with partners. We have provided these charts here electronically and are making them available to HWBB to make use of if they wish.

- Please note this is not new guidance and this is not a change to the template. We do, however, hope they may be helpful in the development and drafting of submissions.

Suggestion of how to use these example slides

	Item	Where to use
Impact	• Summary of impact goals for year 1 & 5 • Method for defining impact • Examples of defining impact	• 2b vision • Supporting document • Supporting document
Risk stratification / segmentation	• Example of risk stratification • Example of segmentation	• 3 case for change
Evidence based planning	• List of interventions/schemes • Mapping of schemes vs risk strata • Evidence for plans • Implications for delivery model	• 4 plan – replace list • Additional slide to use • Supporting document • Supporting document
Financial modeling	• Summary of impact by segment	• 4 plan

Example table to summarise impact

	Current level	Target next year	Target 5 years	Benchmark	Comment
Non elective admissions					
Care home admissions					
At home after 91 days					
Delayed transfers of care					
Patient experience					

This is simply an illustration and it is for each HWBB to decide how to present their data

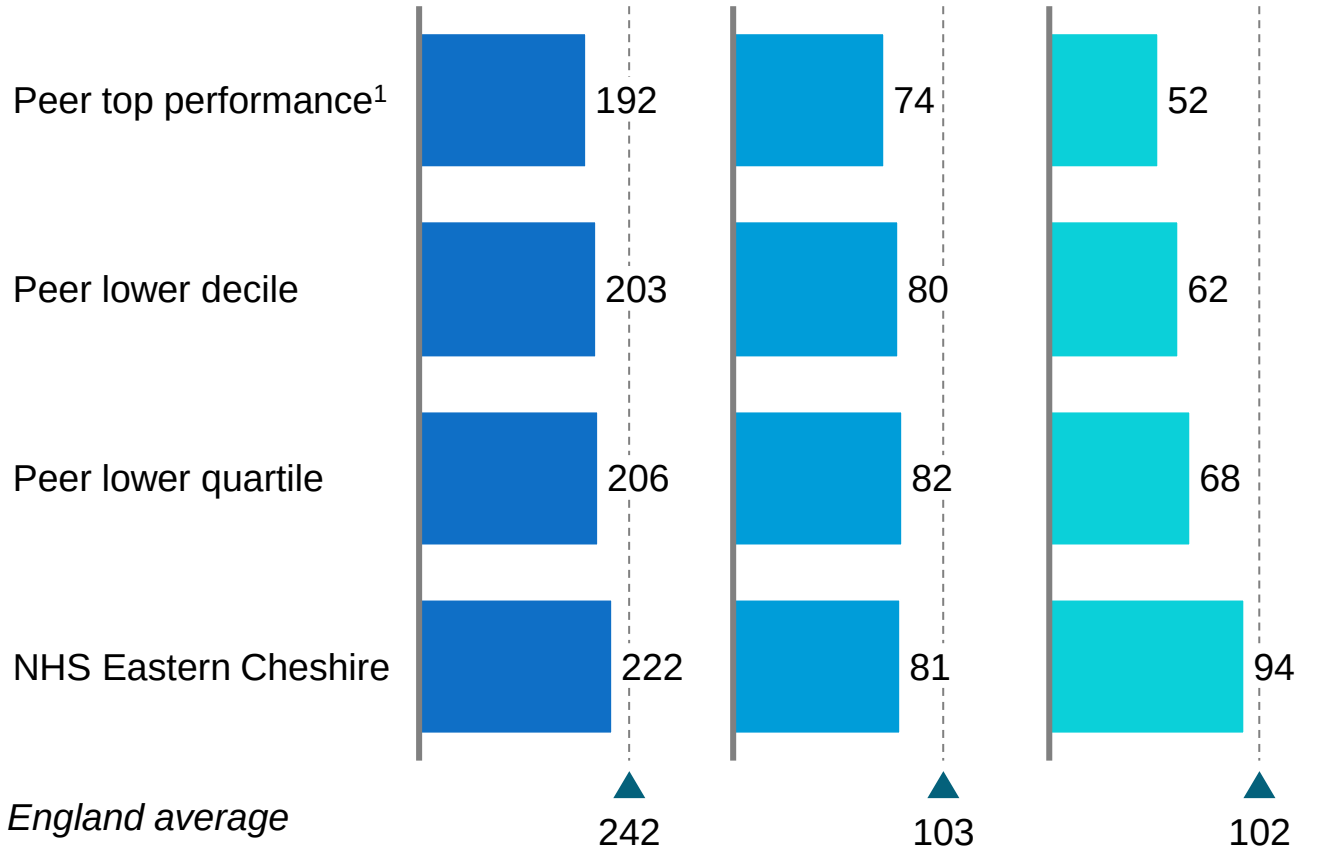
Example of methods used to arrive at goals

			How is impact calculated	NEL	EL	A&E	OP
Bench-marking	1	***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%***
	2	***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%***
Inter-national evidence	3	***Use international evidence base***	• 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	***19-40%***			
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%***

1. Benchmark CCG level performance with ONS and peer group

Non-elective hospital admission rate by age group, 2012/13

Rate per 1,000 population in age group



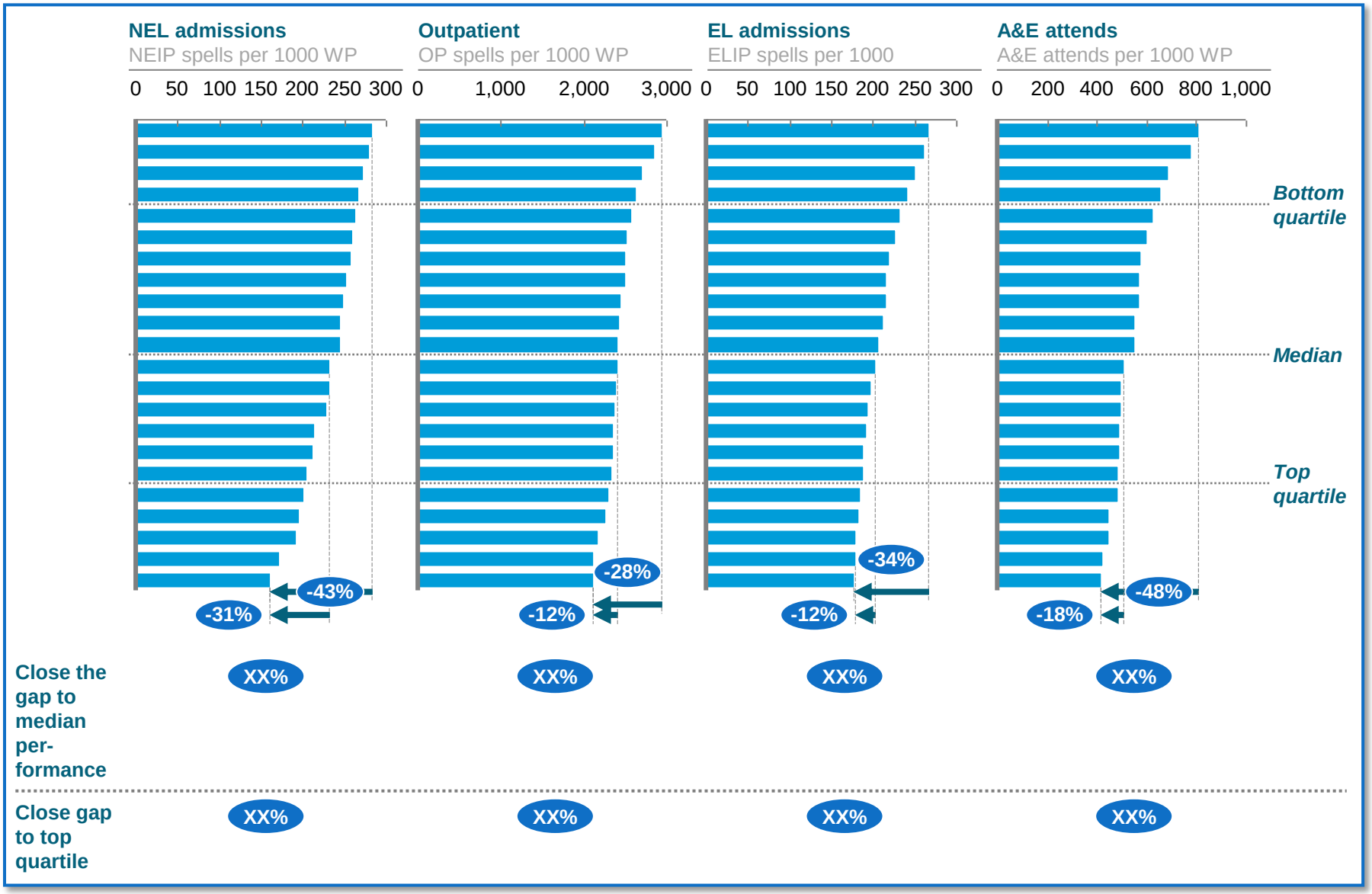
Overall impact

- Benchmarking against the median would get us a 5-10% savings
- Benchmarking against the peer top performance would mean a 10-15% savings

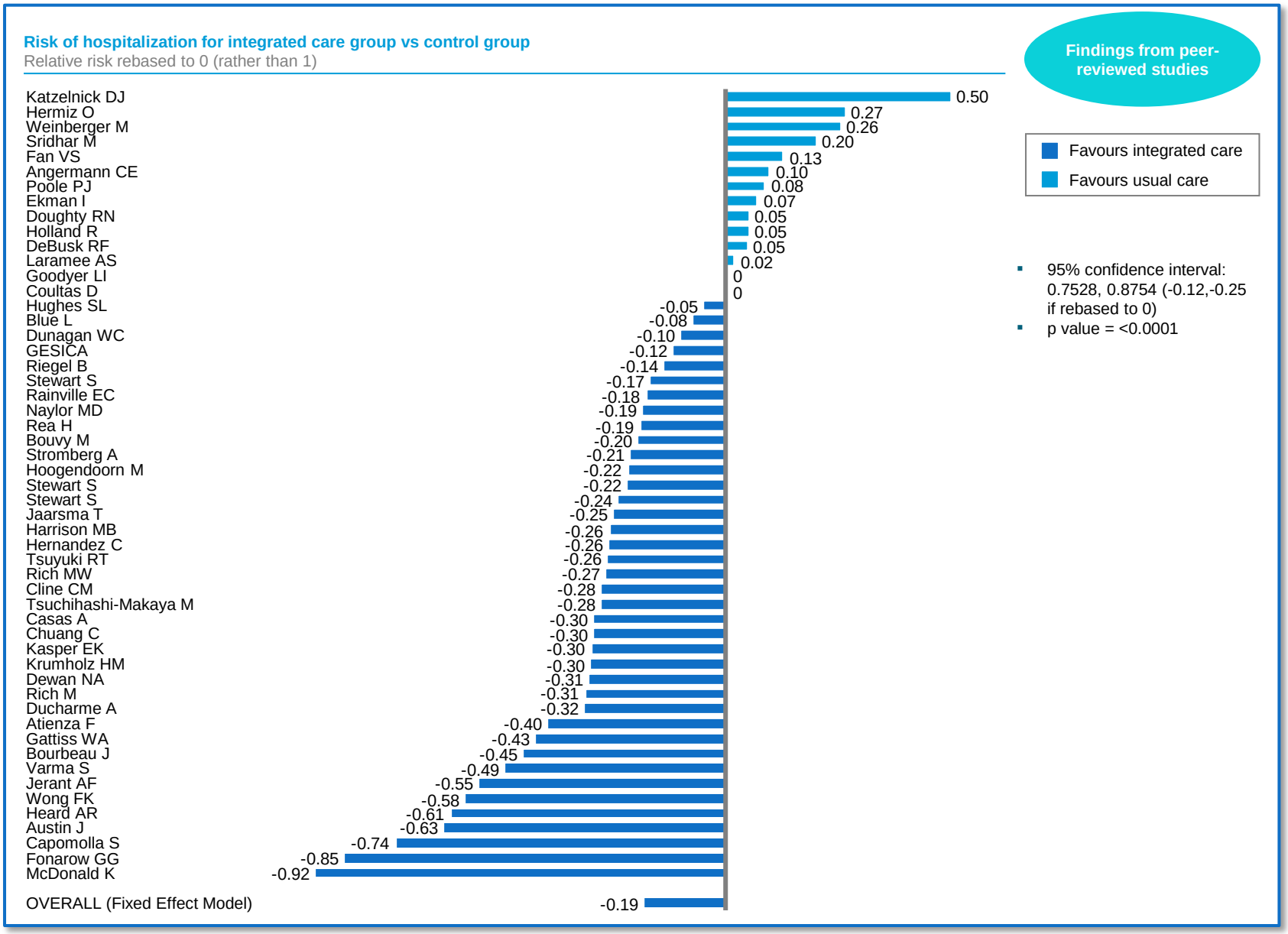
Range used

5-15%

2. Close gap in practice level variation controlled for IMD



3. Use international evidence base



SOURCE: Ricahrdson & Dorling, Evidence base for integrated care (2014 forthcoming)

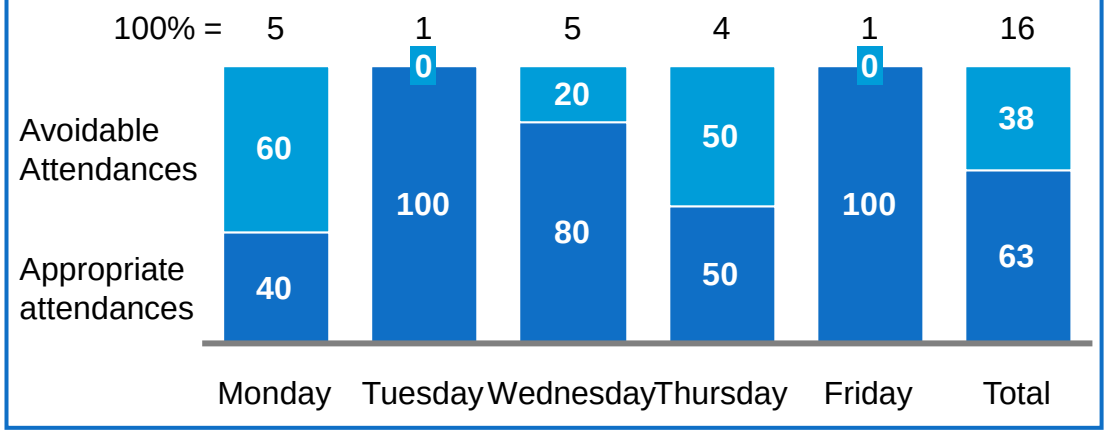
4. Assess avoidable A&E and inpatient admissions

PRELIMINARY

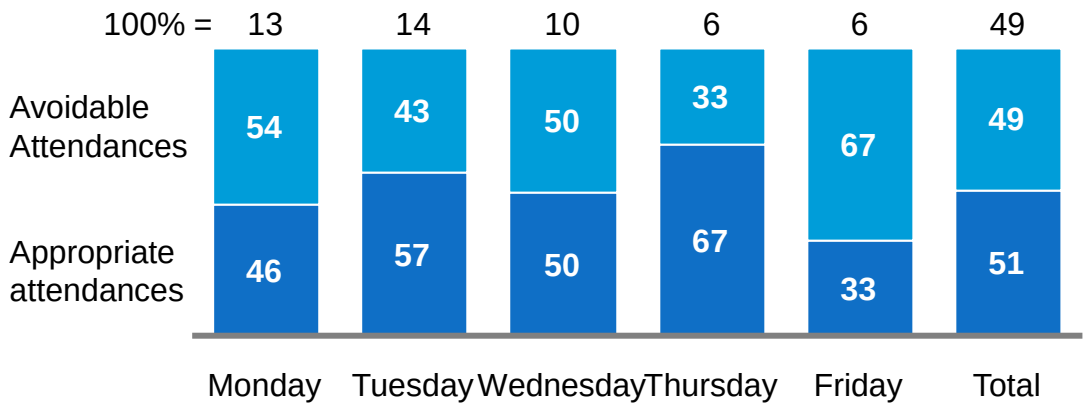
Methodology

- ***Interviewed 2 GPs and 2 mental health professionals from XX*** to understand the details of ***avoidable A&E attendances and non-elective admissions***
- Obtained a sample size of ***~50 A&E attendances*** and ***~16 inpatient admissions*** from GP practice populations of ~3,000 each, over a period of 3 weeks
- Each A&E attendance and inpatient admittance was assessed by the GP to determine whether it was ***appropriate or avoidable***
- Each attendance and admission was also explained in detail to determine ***how integrated care initiatives could have helped*** to avoid it

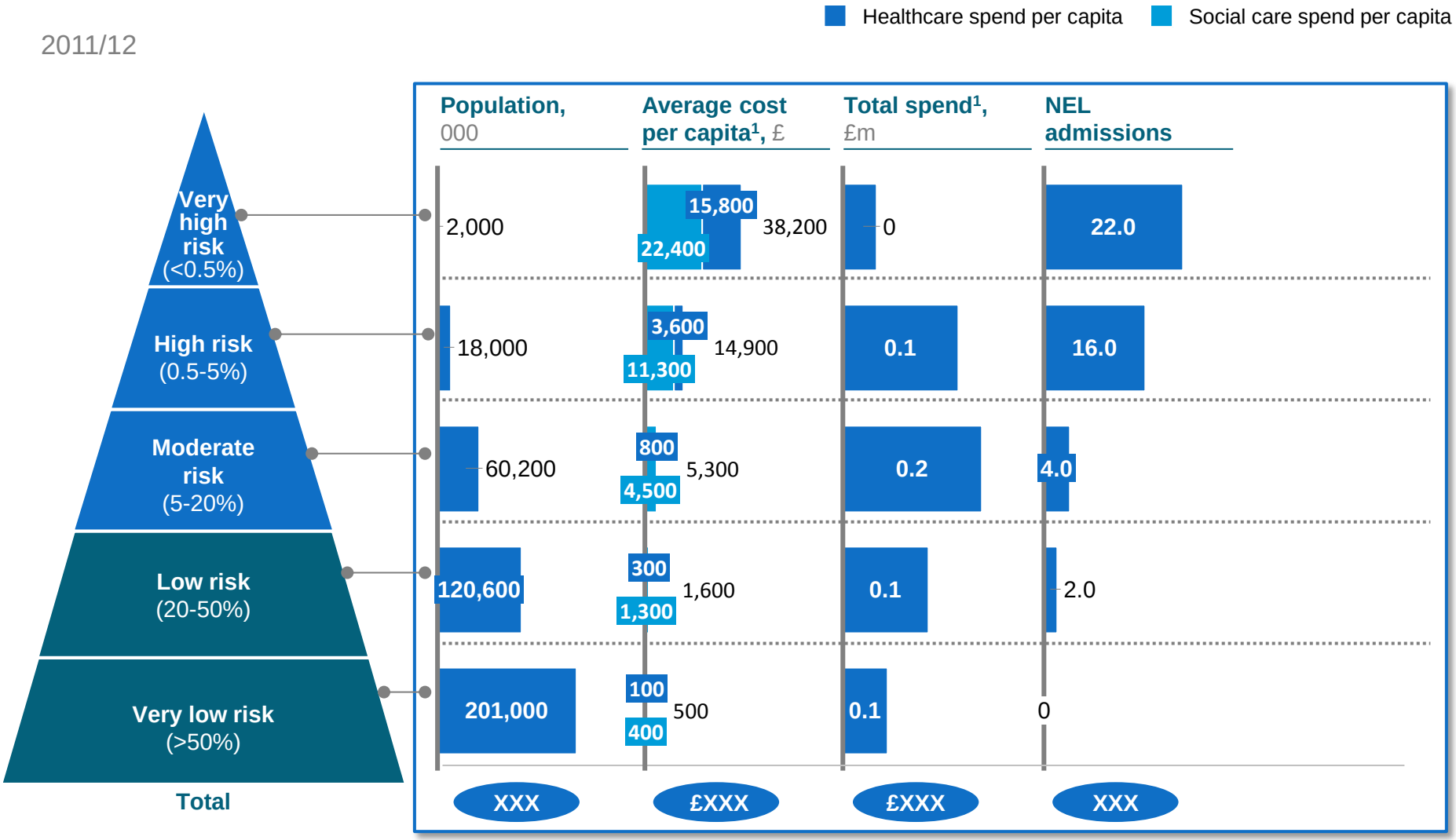
Percentage of inpatient admissions that were avoidable



Percentage of A&E attendances that were avoidable



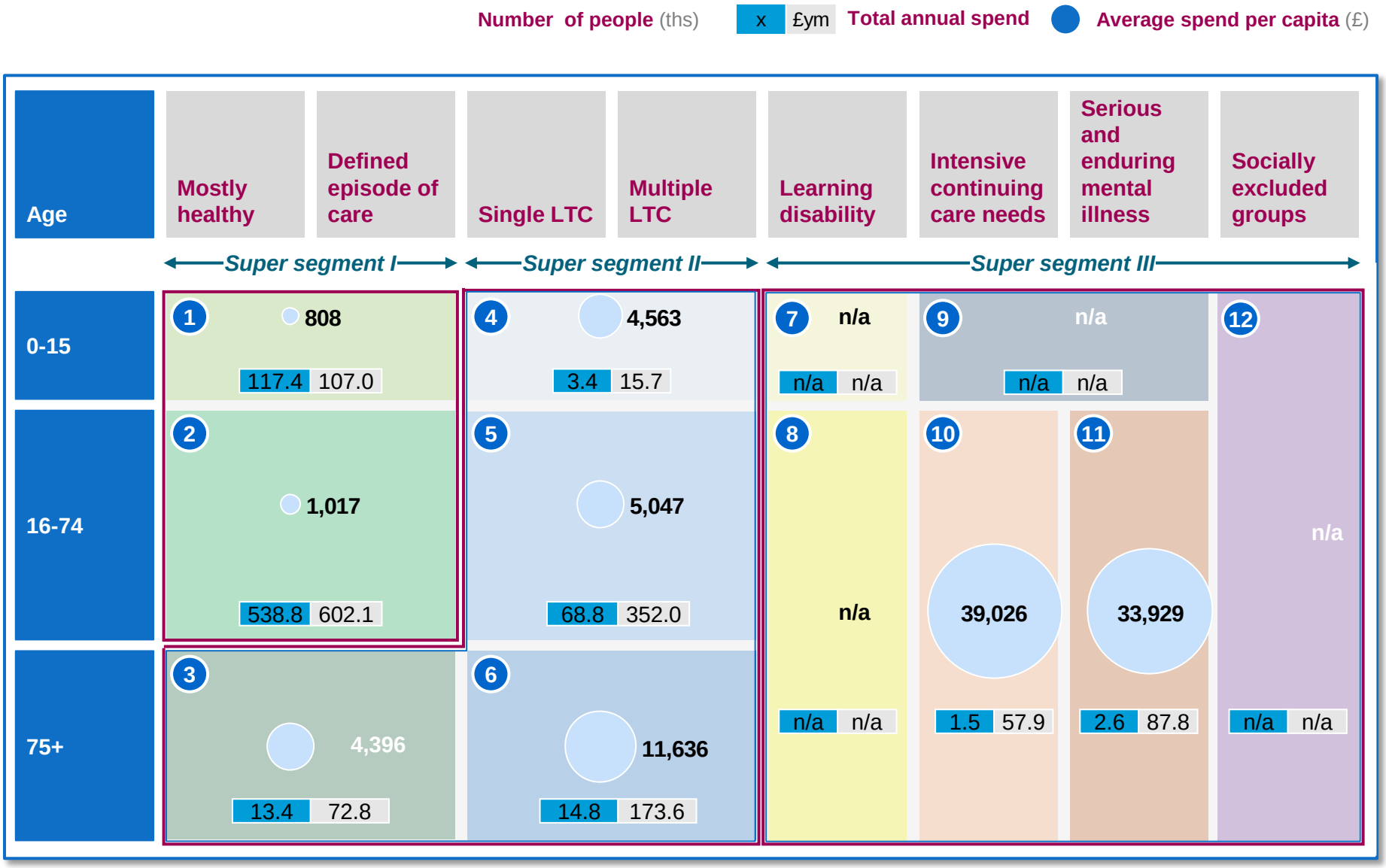
Example of risk stratification output



1 Includes primary care, acute PbR tariff and community care; Mental Health and Social Care spend allocated to risk groups based on CHS distribution, Social Care calculated based on weighted population from EC LA

This is simply an illustration and it is for each HWBB to decide how to present their data

Example of segmentation output



SOURCE: NWL Whole Systems work; SLIC Sponsor Board discussion July 2013; ICG discussions January-March, 2014

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Example list of interventions (1/2)

		Estimated cost, £m	Cost per person, £	People covered	WTEs (before productivity)
1 Short term care	• Ensuring that the relevant providers are able to put in care packages quickly to support the person at home. Requires joint commissioning/personal budgets and access to specialist opinion and diagnostics.	xxx	xxx	xxx	xxx
2 Care coordination	• Care co-ordinator can act as the first point of contact for people with complex needs • Support from the most appropriate care professional to work with each person to oversee their care and assist in organising care when required, e.g. planning appointments and follow-ups, reviewing the care plan, and assisting in management whilst in hospital and planning discharge home.	xxx	xxx	xxx	xxx
3 Rapid response	• Provide an alternative to unnecessary acute and care home admissions by responding to person's need in situations of crisis	xxx	xxx	xxx	xxx
4 Single contact point (including early assessment)	• People have a single point of contact with health and social care that makes things easy and convenient and is available 24 hours a day. • This provides people with direct access to their GP practice, or access a health or social care professional, e.g. nurse, doctor or social worker,. • Early assessment by a senior clinician is key to make sure that people receive an appropriate response as soon as possible.	xxx	xxx	xxx	xxx
5 Discharge support	• Ensure discharge planning starts from day 1, that people are assessed regularly during their stay, and that all required care packages are in place for when the person returns home. This will also aim to ensure that post-acute care can happen at home as much as possible, e.g. rehabilitation, or within alternative community settings and that it can be put in place in time for a person's discharge	xxx	xxx	xxx	xxx

1 The number of NEL admissions that will need to be avoided in order to pay for this service, per contact

Note: All numbers included on this page assume a mean level of productivity improvement for each type of person, based on the ranges of productivity improvements used in the latter half of the document

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Example list of interventions (2/2)

		Estimated cost, £m	Cost per person, £	People affected	WTEs
6 **Specialist input in the community**	• Ensure specialists are able to provide support in the community for GPs or to provide input for people. Where people are appropriately seen in specialist services, contact to be maintained with the community team and person to be discharged back into the same team.	xxx	xxx	xxx	xxx
7 Care planning[2]	• Jointly create a care plan with person focussed on their goals, required interventions, provider details, and a crisis plan with information on what to do and who to contact in case of change or crisis. This should also trigger a request for specific services e.g. falls assessment. Complexity of the plan is matched to each person's needs.	xxx	xxx	xxx	xxx
8 **Needs assessment**	• Single holistic assessment focused on people's lifestyle, goals and care needs using a joint assessment tool. Home assessment for those at the highest risk/needs, assessment outside the home (e.g. in GP practice) where appropriate. Identify care co-ordinator from within multi-disciplinary team, if required. To include advanced End of Life discussion and plan, including carers and families	xxx	xxx	xxx	xxx
9 **Self care, self management support, and signposting**	• Support for people to provide self-care including the use of web-based resources. People are enabled to self-care with patient education and public health programmes. • Appropriate signposting to support people to self-care, for example, to community pharmacists or the voluntary sector. Potential integration with other Cheshire East Council services. Directory of services available to professionals and people.	xxx	xxx	xxx	xxx

1 The number of NEL admissions that will need to be avoided in order to pay for this service, per contact
2 Care planning WTEs are subsumed under Care Coordination, as the WTEs are fully overlapping
Note: All numbers included on this page assume a mean level of productivity improvement for each type of person, based on the ranges of productivity improvements used in the latter half of the document

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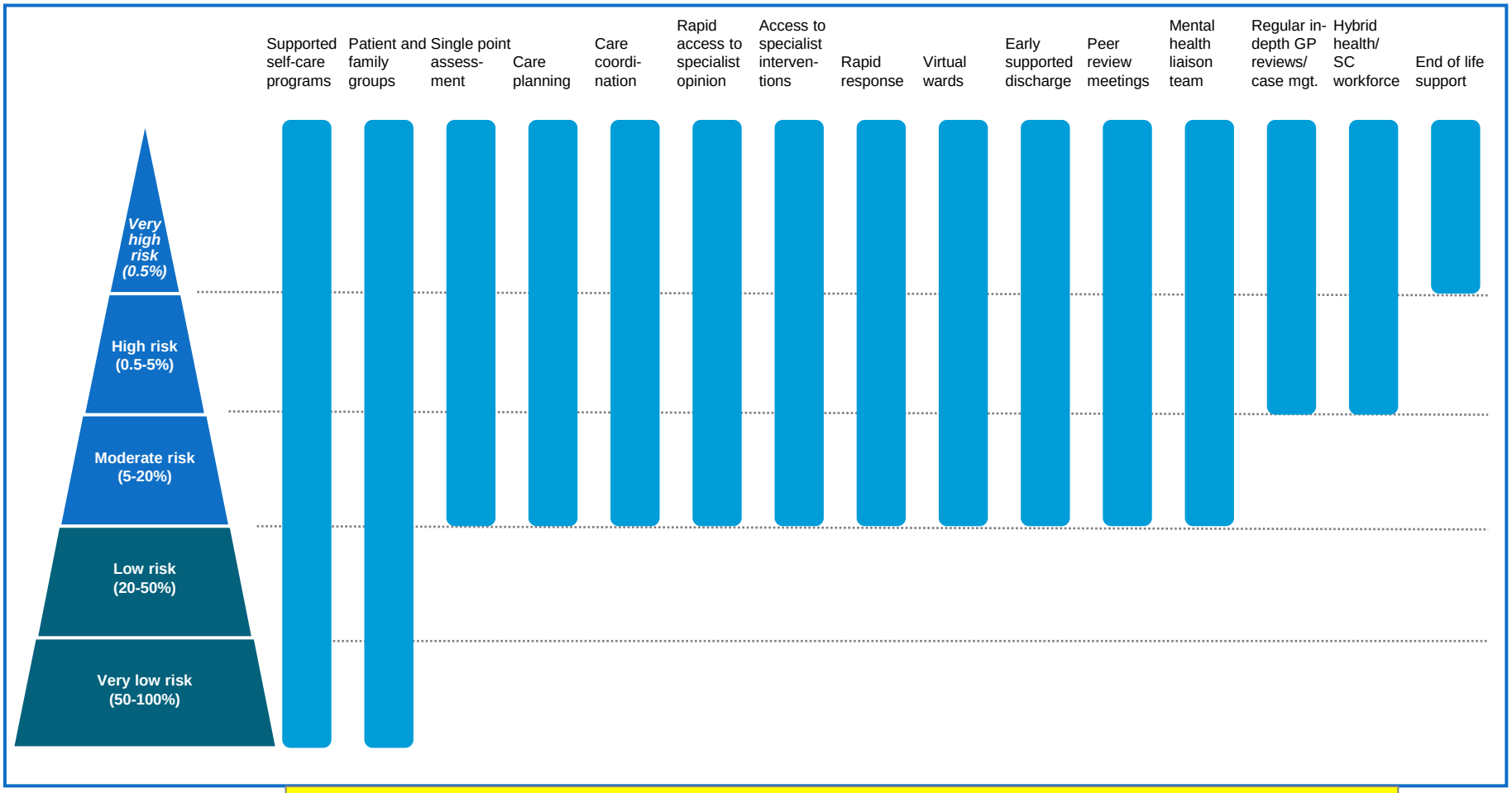
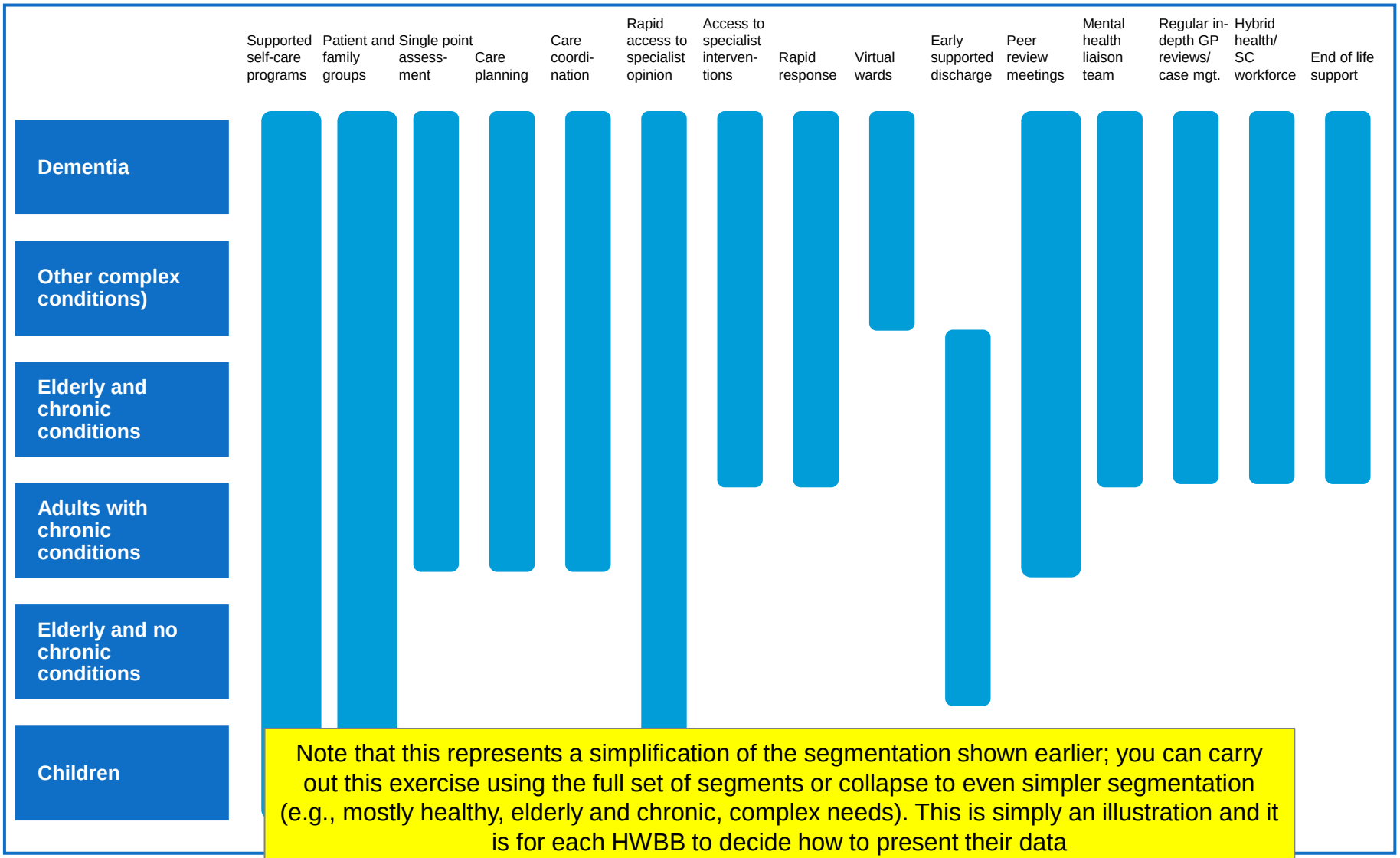
Example of showing how different interventions target different segments of the population



Note that the list of interventions is not prescribed and is purely for illustration as is the mapping of them to different segments. The point is simply that interventions can be identified and these can be mapped to different segments

Example of showing how different interventions target different segments of the population



Note that this represents a simplification of the segmentation shown earlier; you can carry out this exercise using the full set of segments or collapse to even simpler segmentation (e.g., mostly healthy, elderly and chronic, complex needs). This is simply an illustration and it is for each HWBB to decide how to present their data
Similarly, the list of interventions are purely illustrative as is their mapping to segments.

Research suggests that 4 components of integrated care are especially important, with impact being a reduction of up to 37% in hospitalisation

Review of findings from 34 systematic reviews of integrated care[1] published in the last 10 years

Intervention	Number of reviews showing positive evidence[2]	Additional insight from evidence base	Average impact[3]
1 Self-empowerment and education	83% (20 of 24 reviews) assessed support for self-care and found a positive impact	Supported self-management has the strongest effect on clinical outcomes of all IC components when estimated at component-level *Tsai et al, Am J Manag Care, 2005 (August), 11(8), 478-88 (Table 4)*	Hospitalisations reduced by 25-30% (inter-quartile range)
2 Multi-disciplinary teams	81% (13 of 16 reviews) assessed MDTs and found a positive impact	All reviews have concluded that specialised follow up of patients by a multidisciplinary team can reduce hospitalisation *Holland et al, Heart, 2005, 91, 899-906*	Hospitalisations reduced by 15-30% (inter-quartile range)
3 Care coordination	57% (8 of 13 reviews) assessed care coordination and found a positive impact	Interventions involving case management reduce HbA1c [in patients with diabetes] by 22% more than interventions without case management. *Shojana et al, JAMA, 2006, 296(4), 427-440*	Hospitalisations reduced by ~37% (average from 2 reviews analysing hospitalisations)
4 Individualised care plans[4]	64% (7 of 11) reviews) assessed care plans and found a positive impact	Personalised approaches using tailored information influence health behaviour more than uniform approaches *Graffy et al, Primary Health Care Research & Development, 2009, 10(3), 210-222*	Hospitalisations reduced by ~23% (average from 2 reviews analysing hospitalisations)

These elements also observed in the vast majority of the 13 case studies

Overall impact of integrated care

Method: meta-analysis of all individual RCTs identified in 34 systematic reviews where impact on hospitalization reported for integrated care vs usual care at sufficient level of detail for analysis

Results:

- **19% reduction in admissions**
- Relative risk: 0.8141
- 95% Confidence Interval: 0.7528, 0.8754
- P-value: <0.0001

1 Search strategy used a range of terminology (including coordinated or collaborative care, case management, disease management etc) then results were filtered to exclude interventions not meeting the criteria for integrated care (e.g. single component interventions). See next pages for further details and references.
2 Positive impact (i.e. in favour of integrated vs usual care) on whatever outcomes measures selected by review authors (e.g. disease severity or clinical marker, mortality, hospitalisations)
3 Impact measured from systematic reviews including relevant interventions and containing meta-analysis of hospitalisation rate (intervention vs controls)
4 Cochrane review of the evidence for personalised care planning (Coulter et al.) currently in preparation (results not yet available)

SOURCE: Richardson, Dorling – Review of systematic reviews of integrated care (McKinsey)

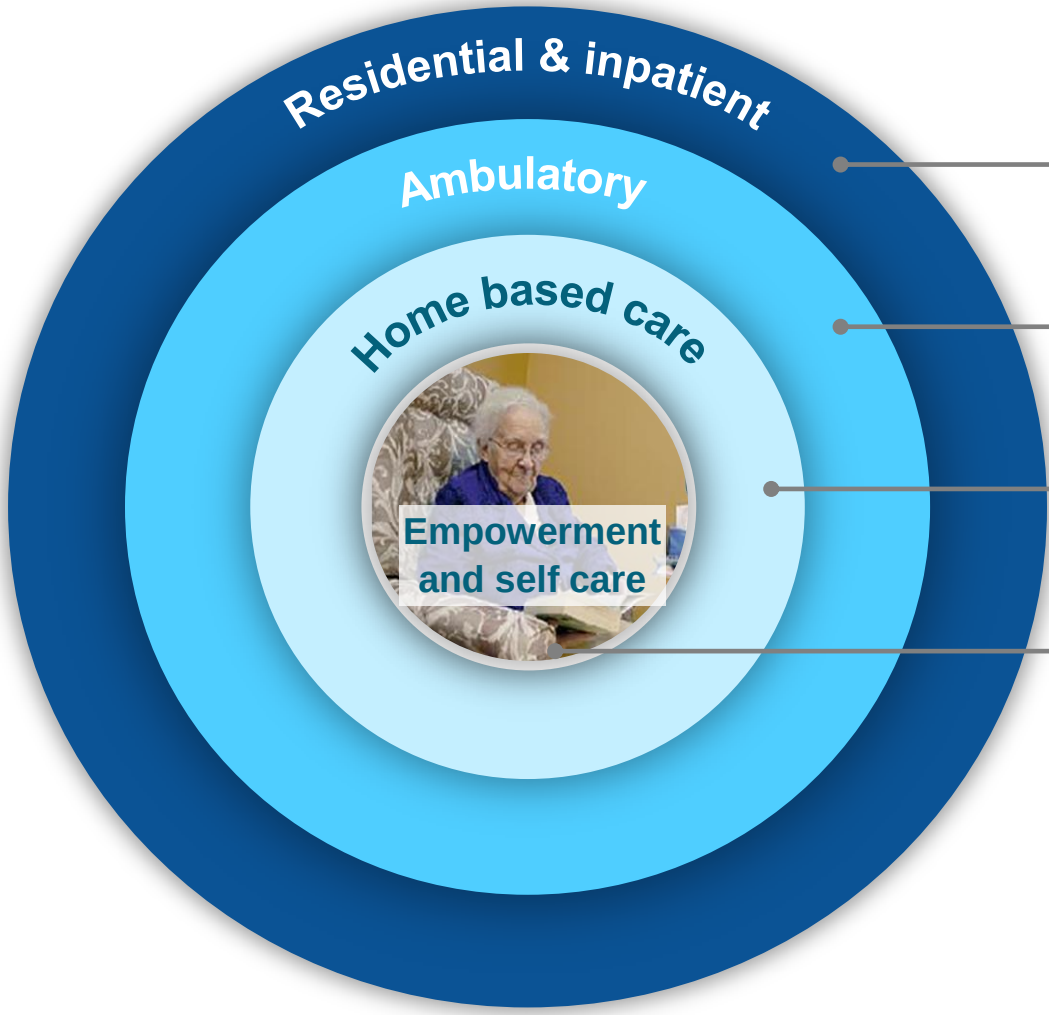
Interventions present in successful integrated care programmes

Review of case study evidence

Intervention	Torbay	Greenwich	Tower Hamlets	Dementia	Midlands	Australia	Knappschaft	Valencia	ChenMed	Geisinger	CareMore	Kaiser	New York Coordinated Care
	Case study												
1 Self-empowerment and education		✓	✓	✓	✓	✓				✓		✓	✓
2 Multi-disciplinary teams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3 Care coordination	✓	✓	✓	✓			✓		✓	✓	✓	✓	✓
4 Individualised care plans	✓		✓	✓	✓	✓			✓	✓	✓		✓
5 Rapid response	✓	✓		✓						✓	✓		✓
6 Training for care professionals	✓	✓	✓	✓	✓	✓			✓		✓	✓	✓
7 Co-location of services	✓	✓	✓					✓	✓	✓	✓	✓	
8 Shared electronic care records		✓					✓	✓	✓	✓	✓	✓	
9 Frequent primary-care appointments		✓			✓				✓		✓		
10 Risk stratification	✓		✓			✓			✓	✓	✓	✓	✓
11 Case management	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓
12 Discharge support	✓	✓		✓							✓		✓
13 Service user registries	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
14 Scheduled service user follow-ups		✓	✓	✓	✓	✓			✓		✓		✓
15 Co-located pharmacies							✓	✓	✓		✓	✓	

SOURCE: Richardson, Dorling – Global Integrated Care Case Compendium (McKinsey)

Example of implications for delivery system



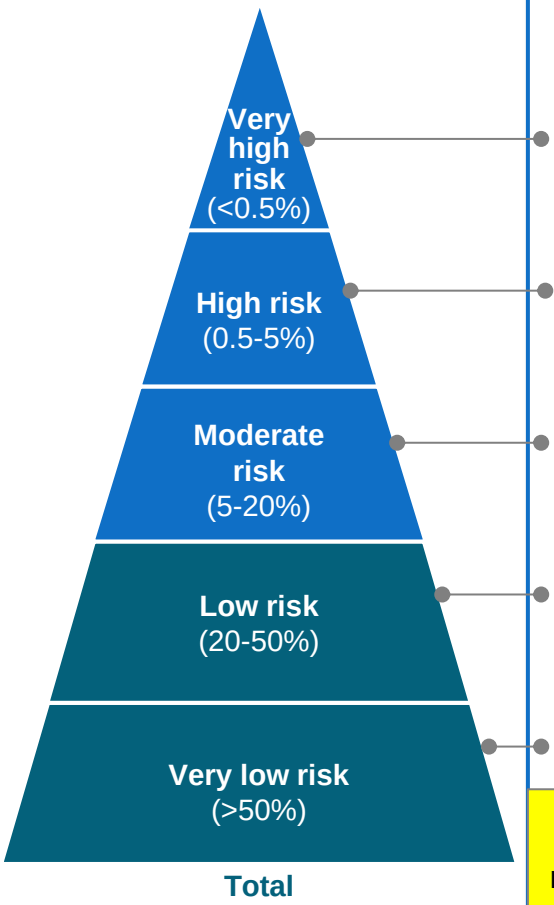
Accessed in acute provider, mental health inpatient or residential care

Accessed in practice, hub, health centre or local hospital

Single integrated teams working in partnerships with individuals & carers

Initiatives that empower the individuals to maintain and improve personal well-being

Example chart summarising impact for risk stratified approach



Population, 000	NEL adm	Impact NEL adm	Savings £m	Initiative	Cost £m	Net impact £m

Note that the idea of this chart is to simplify how consider impact as opposed to make it more complicated. HWBBs may find it easier to identify impact for a specific segment based on the spend and number of admissions in that segment and overall impact expect as opposed to define impact scheme by scheme. Costing of initiatives or schemes can be done scheme by scheme and could be shown along side the impact expected

Example chart summarising impact for segmentation approach

	Pop. 000	%	Spend per Person (£)	NEL adm	Impact NEL adm	Savings £m	Initiative	Cost £m	Net impact £m
Elderly and chronic conditions									
Adults with chronic conditions									
Elderly and no chronic conditions									
Dementia									
Other complex conditions)									
Children									

Note that this represents a simplification of the segmentation shown earlier; you can carry out this exercise using the full set of segments or collapse to even simpler segmentation (e.g., mostly healthy, elderly and chronic, complex needs). This is simply an illustration and it is for each HWBB to decide how to present their data