OFFICIAL

How to... understand and measure impact

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Contents

The guide is intended to be of practical use to members of Health and Wellbeing Boards (HWBs) including: councils, clinical commissioning groups (CCGs), local Healthwatch and voluntary sector members, representatives of NHS England who sit on HWBs, and additional non-statutory members.

How to ... lead and manage Better Care
Click here to view publication.

How to ... bring budgets together and use them to develop coordinated care provision
Click here to view publication.

How to ... work together across health and social care
Click here to view publication.

How to ... understand and measure impact

Measuring integrated care

For health and care systems it is important to adopt and use a set of measures that align with the main elements of a national, regional or local strategy for person centred coordinated care. The complexity and the necessary variety in how integrated care strategies need to be developed, means that outcomes and measures need to be chosen to suit local and national priorities.

In order to choose the right measures through which to evaluate and judge performance and progress in integrated care, there needs to be a clear understanding of:

- the **core aims of integrated care** in terms of who and what the interventions involved are seeking to influence

- the **range of desired outcomes** that should result from the interventions, drawn primarily from the patient's / service user's perspective. Measures need to be relevant and focused on / aligned with outcomes

- the **timeframe over which such outcomes can reasonably be expected** to be achieved in order to understand which measurement categories actually have the potential to be improved

- **how impact can be measured** in a way that ensures attribution between the interventions developed and the outcomes observed

- the **robustness of measures,** so they can imply actions to be undertaken for quality improvement purposes by managers and professionals, and to avoid perverse incentives

- **simplicity and ease of measurement.** This is key. Consider the data that is already being collected, but be open to new and innovative approaches. The more measurements are in tune with what people do, the more they are seen as meaningful and the greater the drive for improvement; and

- **time series analysis.** Measuring data over time will enable you to understand trends, which will help you to understand changes in performance.

A reasonable range of outcomes and measures should be selected with the aim of delivering the following key impacts:

- People's experiences of care

- Care outcomes in terms of changes to people's health and wellbeing and

- Better use of resources.

Importantly, such data should be readily available through routine data sources – each with baseline measures to base progress over time.

By Dr. Nick Goodwin, CEO, The International Foundation for Integrated Care & Senior Associate, The King's Fund

Aim of this guide

This 'How to' guide aims to help local areas to understand and measure the impact of their efforts to integrate services across the provision of health and care. It is important to understand from the beginning what impact you want to make and how that impact is going to be measured. Keeping this in the forefront of your minds will mean it is much more likely that your project will not get lost in a welter of process. You need to be clear what you want to achieve and how you will measure it.

The scope of this document covers practical support when developing

- Outcomes that are appropriate to achieve the impacts

- Measures to help assess progress

- An evaluation framework to support ongoing monitoring and enable judgement

- A process for using feedback to promote continuous improvement and maintain creativity and innovation.

There is a need for health and care systems to understand the impact of the programmes and schemes they put in place to deliver better care. To enable this, there will need to be **joint ownership across all relevant stakeholders throughout the process.**

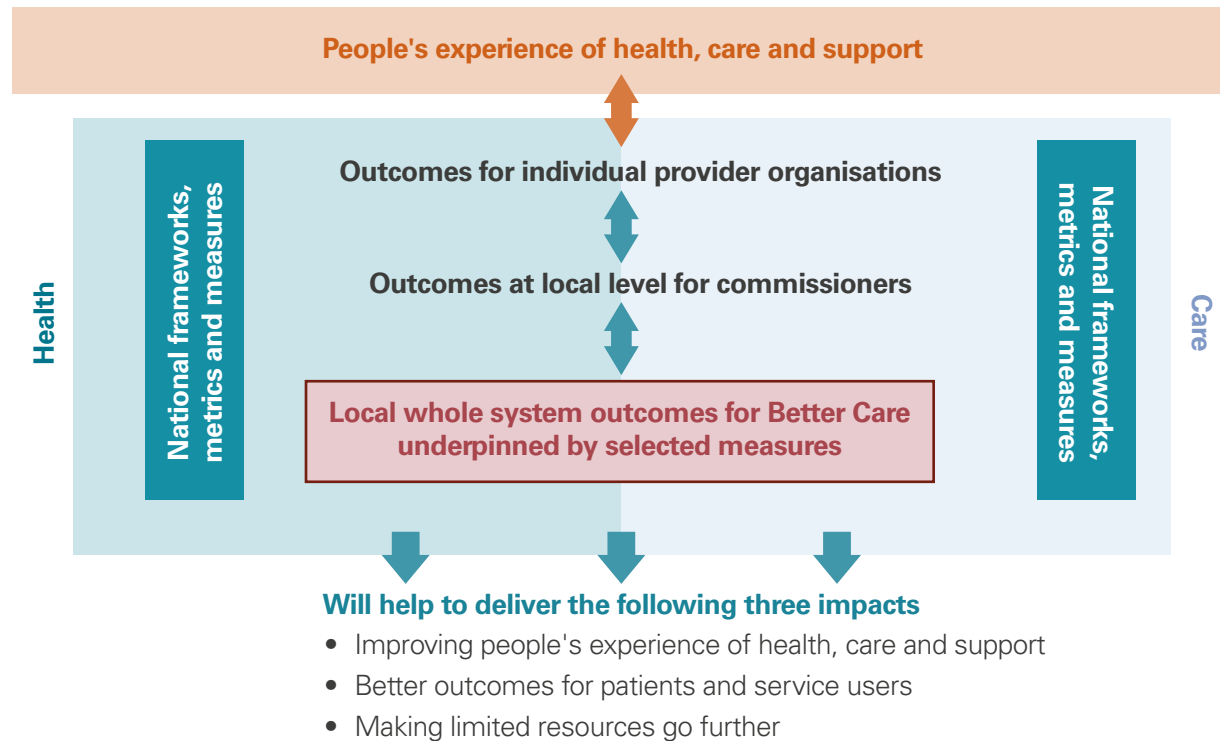| Ensure joint ownership across all stakeholders			
Define outcomes to be achieved	**Develop / select the right measures**	**Develop a monitoring and evaluation framework**	**Continuous improvement**
Outcomes are the benefits that are delivered as a result of a service.	*Measures* enable judgement on progress and need to be aligned to outcomes. Process measures assess how well or how reliably a service is being delivered. Outcome measures assess how close you are to achieving the intended goals.	*Monitoring* refers to observation of progress / quality of activites on an ongoing basis. *Evaluation* refers to the process of determining the worth or significance of an intervention. It is a systematic approach of gathering and analysing information to enable judgement regarding the impact in relation to measures.	*Continuous improvement* relies on data to inform and drive it and is important because it helps to enhance the effectiveness or efficiency of services.

Building local whole system outcomes for Better Care

Establishing person centred coordinated care offers very clear benefits yet presents a major challenge to health and care systems.

The diagram below demonstrates the range of different levels at which outcomes can be understood and measured (from individual to whole system) and the fact that you will want to draw on different national frameworks in understanding and constructing your own, local map of outcomes.

Please refer to the Appendix on what information is currently available regarding national frameworks, cross government resources and other useful material.

People's experience of health, care and support

Health

National frameworks, metrics and measures

Outcomes for individual provider organisations

Outcomes at local level for commissioners

Local whole system outcomes for Better Care underpinned by selected measures

National frameworks, metrics and measures

Care

Will help to deliver the following three impacts

- Improving people's experience of health, care and support
- Better outcomes for patients and service users
- Making limited resources go further

BCF metrics

The following metrics have been designated as the key performance metrics for the Better Care Fund. In putting together your plan you will have esitmated an impact against these metrics as a result of your BCF schemes. Therefore it would make sense for these metrics to feature in your understanding of local outcomes.

- Reduction in non-elective admissions (general and acute)
- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Delayed transfers of care from hospital per 100,000 population
- A locally chosen metric for patient/service user experience.

Click here to view publication.

Collaboration is the key to success

> *We are all interested in demonstrating the real impact of integrated care on people's individual and personal experiences of care and support, and on their lives more broadly. Demonstrating that impact will help to further strengthen the case for change nationally and locally, and also assist us to understand and learn what works in different contexts. Local schemes are encouraged to try out and find innovative ways of understanding and demonstrating their impact.*
>
> *- Ann Radmore, National Programme Director Better Care Fund*

> *There is no doubt that the pace of work across traditionally separate systems to improve care experiences and outcomes across the country is accelerating. The task now is to develop ways of measuring the difference integrated care and support is making to people's quality of life. This is far harder than measuring more traditional straight inputs or output measures. System leaders need to understand that they have the freedom to experiment, and be allowed the flexibility to try new approaches. These systems need be developed locally, alongside those who use services, an approach far more relevant and owned than top down approaches can ever be. If we can get this right, the prize is more and more people living the lives they want, supported by services that fully and properly reflect their ambitions and strengths.*
>
> *- Tony Hunter, Chief Executive, SCIE*

Build engagement through coproducing measures of quality across organisations

Local whole system outcomes will need to be aligned with national frameworks and other local outcomes (including those of individual providers and at commissioner level). Pre-existing lists of measures should be regarded more as a 'menu' of possible options than as a definitive list that has to be followed. The development or selection of measures in specific contexts needs to be locally negotiated to ensure that the outcomes and measures being focussed on are the most relevant and meaningful to commissioners as well as clinicians and care professionals seeking to improve quality.

This process provides an excellent opportunity for engagement with key actors across a local health system including patients and community groups, health and care professionals, care organisations from GP practices to large acute hospitals as well as the CCGs and local authorities tasked with planning and purchasing care.

It is important to remember that different partners have different traditions regarding information governance, data and what 'evidence' means to them. There are significant differences between health, care and the voluntary sector. But, even within health, systems are not joined up. Some stakeholders can only provide certain information or data which can prove a challenge when trying to aggregate results. It is therefore important to understand upfront what other organisations / sectors measure to be able to balance potentially competing needs. Challenges such as accountabilities between multiple stakeholders and historic relationships also need to be considered.

Including key stakeholders in how care systems will be held to account, supports the inclusive process of developing a vision and driving change forward towards Better Care.

Remember, this is an evolutionary process

This is an ongoing process and not something that is 'ticked off' once

As person centred coordinated care is a new approach for many areas, it will be difficult to use the correct measures from the beginning, particularly when the end goal is evolving. It is therefore important to remain flexible and creative throughout. It is important to try to improve the approach to understanding and measuring impact and – if you fail to learn from mistakes. For many areas the development of outcomes and measures will be an iterative one and developing the correct outcomes and / or measures for whole system care will evolve over time. However, regular touch points can help to assess whether progress is being made and whether objectives and measures need to be adjusted.

Lessons learnt from Greenwich

"In Greenwich, we used an action learning approach (see chapter 5 for more detail) during the latest element of our pioneer integration work which helped us to think creatively around what we want to measure and evaluate".

Recognise that this process will require a lot of refinement before you get it right.

- *At the development stage, I really didn't know which features of the patient cohort would be the most useful to record in order to learn about, for example, unmet needs. On a number of occasions, I had to go back and refine what we were recording for the purposes of measuring outcomes.*

Once your measures become more refined, you will be able to gain further insight and act on it.

- *To understand the engagement levels of the Greenwich Coordinated Care Programme with the voluntary sector, I decided to capture which organisations were engaged and tracked that as a percentage of the total number of relevant voluntary sector organisations. We were doing so well, we could start to apply more granularity and look at which services are commonly used from those organisations. More recently, the voluntary service director has even expressed her desire of wanting to understand which types of services (e.g. gardening clubs, advocacy and befriending) are most in demand under the big umbrella organisations such as Age UK and MIND.*

Use qualitative information to support quantitative data. Don't get disheartened if an approach doesn't work and keep trying.

- *We applied a qualitative as well as quantitative approach, as we felt that relying on quantitative data alone would not provide a complete picture. We have trialled some methods such as a staff questionnaire (via survey monkey) to assess engagement and learning from our Greenwich coordinated care meetings, however this did not provide us with any clear conclusions. We are therefore now developing the next questionnaire in partnership with a core group of staff as part of our action learning meetings and hope this will provide us with useful insight.*

- Wendy McDermott, Integration Lead, Greenwich

A summary of the main challenges and key actions

Challenges

- Developing local 'whole system' outcomes is complex as it requires a multi-disciplinary approach
- Citizens should be fully involved in developing outcomes
- Using a logic model to identify outcomes is helpful but they can often be underdeveloped or flawed if not fully thought through

Key actions and top links

- Identify outcomes at an early stage of the process rather than retrospectively fitting them to a predetermined and funded set of activities or interventions.
- When developing whole system outcomes locally, consider their alignment with the Better Care impacts, including:
  - ✓ Improved experiences of care
  - ✓ Improved outcomes in terms of changes to people's health and wellbeing
  - ✓ Better use of resources
- Co-produce outcomes with citizens. The Social Care Institute for Excellence (SCIE) gives recommendations on how to develop co-productive approaches in organisations and projects based on a framework for change management. **Click here to view publication**
- Work together across stakeholders to develop a logic model, in order to enable shared understanding of any issues. Use a logic model to enable you to challenge assumptions and undertake a reality check about whether or not your programme's interventions are adequate enough to meet the intended outcomes. **Click here for more information.**

What are outcomes and why do we need them?

What do we mean by outcomes?

Outcomes are the benefits that are delivered as a result of a service. Outputs measure the levels of activity of a service or intervention. They are fundamentally different from each other and should not get confused.

Outcomes can range from broad lifestyle goals (e.g. number of days individuals spend at home / in their communities) to specific quality of care outcomes (e.g. permanent admissions to nursing homes).

Why do we need whole system outcomes?

- Failure to plan and co-ordinate services with and around people's needs, leads to fragmentations in care and suboptimal outcomes
- It is unlikely that any provider can deliver an outcome in isolation from other providers and patients / service users. Hence there must be joint accountability across stakeholders
- Redesigning care around the delivery of outcomes requires a multi-disciplinary approach across prevention, diagnosis, treatment, and follow-up. This needs to be supported by an environment of continuous learning, improvement, and innovation with ongoing and robust quality assessments.

How do whole system outcomes link to impacts?

When developing whole systems outcomes locally, it is important to consider that they are aligned with the following Better Care impacts as identified in the Foreword:

- **Improved experiences of care**

  Refer to the 'person centred coordinated care' definition of integration developed by National Voices **(Click here to view publication),** and an accompanying narrative of 'I statements' setting out a user based perspective of how integrated care should be experienced. **Click here to view publication.**

- **Improved outcomes in terms of changes to people's health and wellbeing**
  - Improved care outcomes for people in terms of their ability to manage their chronic illness, independence, quality of life, ability to die in a place of their choosing etc.
  - Proxy outcomes including reduced hospitalisations / nursing home placements and other avoidable utilisation of services that people would prefer not to happen to them.

- **Better use of resources**
  - Ensuring the best use of all resources in a local area, through joint approaches between the public, health and care as well as the voluntary sector.

The power of citizens

For care to be coordinated around citizens, we need to involve them much more fully in the development of how that coordination takes place.

As mentioned in the 'How to' guide on leading and managing Better Care **(Click here to view publication)**, any narrative on how person centred health and care should be improved, must come from the view of the citizens. The outcomes need to reflect the philosophy, overall aims and mission of that 'narrative'.

There are a **number of approaches** that can be used **to engage citizens** in the development of outcome measures, including focus groups, co-production techniques, surveys and workshops:

- North West London Toolkit - Outcome menu - working with service users identify meaningful outcomes.
  Click here to view publication

- Torbay 'Mrs Smith' - developed a narrative around a typical service user for the system.
  Click here to view publication

- SCIE co-production guide. **Click here to view publication**

- Making a difference: Measuring the outcomes of Independent Mental Health Advocacy. This SCIE report offers IMHA providers and commissioners an easy to understand introduction to measuring outcomes.
  Click here to view publication

- Care Quality Commission's expert by experience programme employs and trains service users to work alongside professional inspectors. They aim to develop this programme over the next 3 years so that every inspection will include experts by experience. **Click here to view publication**

- A model for developing outcome measures from the perspectives of mental health service users.
  Click here to view publication.

> *Engagement is not only a topic of academic interest; it has enormous practical significance.*
>
> *Put simply, organisations with more engaged clinicians and staff achieve better outcomes and experiences for the patients they serve.*
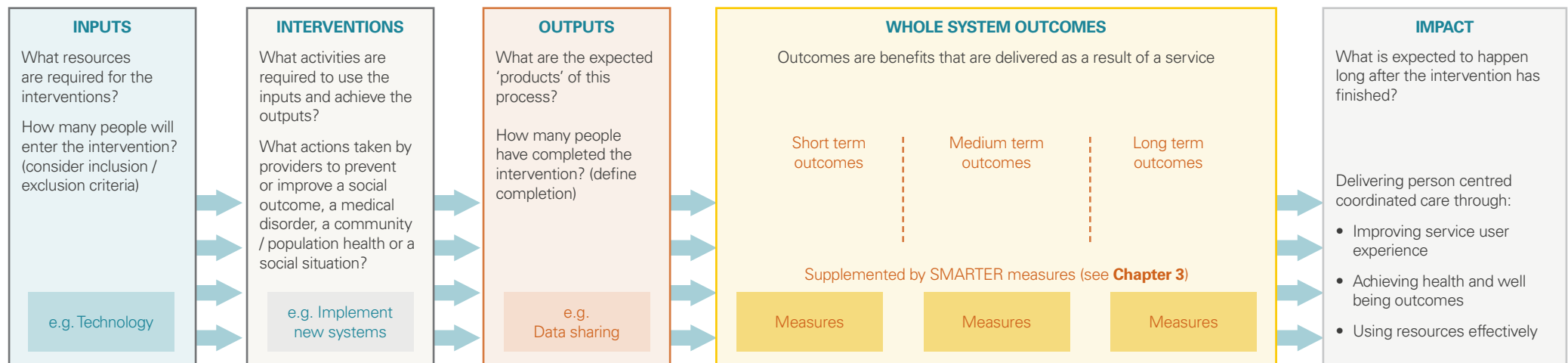>
> *- The King's Fund*

Using a logic model to identify outcomes and benefits

Logic modelling, or programme logic, is an approach for representing the way a programme's various components are expected to fit together to achieve its outcomes. Logic modelling has been one of the tools that has been used widely by localities, including by several Pioneers, for helping shape how they evaluate impact on outcomes.

A logic model creates a diagrammatic representation of the key components of a programme and the way that actions are intended to lead to outcomes. The underlying emphasis on logic underlines the potential for a model of this type to challenge assumptions and prompt a reality check about whether or not the programme's interventions are adequate to achieve its intended outcomes.

INPUTS	INTERVENTIONS	OUTPUTS	WHOLE SYSTEM OUTCOMES			IMPACT
What resources are required for the interventions? How many people will enter the intervention? (consider inclusion / exclusion criteria)	What activities are required to use the inputs and achieve the outputs? What actions taken by providers to prevent or improve a social outcome, a medical disorder, a community / population health or a social situation?	What are the expected 'products' of this process? How many people have completed the intervention? (define completion)	Outcomes are benefits that are delivered as a result of a service			What is expected to happen long after the intervention has finished? Delivering person centred coordinated care through:
			Short term outcomes	Medium term outcomes	Long term outcomes	• Improving service user experience
			Supplemented by SMARTER measures (see **Chapter 3**)			• Achieving health and well being outcomes
e.g. Technology	e.g. Implement new systems	e.g. Data sharing	Measures	Measures	Measures	• Using resources effectively

A completed example of the logic model can be found on the next page.

A logic model is designed to:

• Assess the strength of the assumptions being made about how your programme will achieve change

• Identify cause-effect relationships

• Build an indepth understanding of how a programme is intended to deliver results

• Raise awareness and build common understanding amongst stakeholders

Identification of outcomes should happen at an early stage of the process and ideally not be retrospectively fitted to a predetermined and funded set of activities or interventions. However, the latter might occur as part of the evolutionary learning process.

Using a logic model to identify outcomes and benefits (cont.)

> *The main problem I see in most BCF areas is that the logic models are often under-developed and or flawed, usually because system leaders have not done enough in the first instance of really thinking through the actual changes in service delivery and how these can actually change the way the system operates. Too often the initial focus is on funding and organisational issues.*
>
> *- Dr. Nick Goodwin, CEO, The International Foundation for Integrated Care & Senior Associate, The King's Fund*

To create a logic map – be clear about:

✓ Where you are starting from (context / baseline)

✓ What is required to deliver the work **(inputs)**

✓ What you expect / intend the **outputs** to be

✓ What **interventions** are required to achieve the outputs

✓ What you expect / intend the **outcomes** to be

✓ What **resources** are available

✓ What improvements result from and are enabled by the outcomes

By developing logic models through participation of stakeholders such as patients, services users and carers, localities can develop a better understanding of what they are trying to achieve. When stakeholders work together to develop a logic model, participants are able to identify and develop areas of shared understanding and expose issues that have yet to be clarified.

Impact ➜	PCT wide reduction in GP attendances (20% – Kings Fund) and hospital admissions – Sustained > 12 months post programme
Outcome ➜	Increase of 20% in function (SWT/6MWT), achieve a minimum of 1 patient set goal, Improvement in HAD score by 'X' points, improvement in understanding COPD (baseline BKCQ)
Outputs ➜	Number of patients with COPD completing PR programme (approx 70%) – (define completion!)
Intervention ➜	Pulmonary rehab programme based on CSP standards Focus on – Assessment of function (SWT/6MWT), patient set goals, Education (BKCQ), support to improve HAD score
Inputs ➜	Patients with COPD. Exclusion criteria – unstable CVD, recent MI/AECOPD, compliance issues etc.

Example from **Liverpool** PCT Health Outcomes Unit on Pulmonary Rehabilitation.
Click here to view publication.

Glossary:

COPD – Chronic Obstructive Pulmonary Disease

AECOPD – Acute Exacerbation of COPD

CVD – Cardiovascular Disease

CSP – Chartered Society of Physiotherapy

MI – Myocardial Infarction (heart attack)

SWT – Shuffle Walk Test

6MWT – Six Minute Walk Test

BKCQ – Bristol Knowledge COPD Questionnaire

PR – Pulmonary Rehabilitation

HAD – Hospital Anxiety and Depression Score

Healthwatch have developed an outcomes and impact development tool to assist local Healthwatch organisations in understanding what outcomes and impacts they can achieve through the delivery of their functions. The picture shows the draft template and how the sections relate to the logic model presented above. It also shows how outcomes have been split into short, medium and long term. **Click here to view publication.**

Local Healthwatch
Outcomes and Impact Development Tool

Blank grid for local Healthwatch to add outcomes based on local priorities

What do we want the OUTCOMES to be?	What could we do to achieve them?	How would we know we have succeeded?
Short term		
Short term Outcome	Inputs Interventions	Output
Medium term		
Med. term Outcome	Inputs Interventions	Output
Longer term IMPACT	How could we measure IMPACT?	
Long term Impact	Measures	Output

Wirral Council Public Health Research and Development Team developed an illustrative example for a simple teenage pregnancy prevention programme. This high level example is not directly relevant to Better Care, however it shows that a logic model doesn't need to follow a linear process and that inputs, outputs and outcomes can be interlinked. Those linkages need to be considered when developing the logic model. **Click here to view publication.**

A summary of the main challenges and key actions
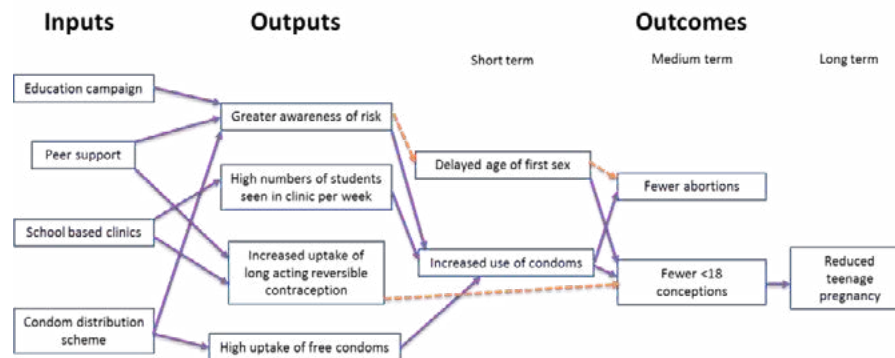
Challenges

- Integrating the outcomes and outputs from different services can be as difficult as integrating the services themselves
- It is difficult to know where to start without a clear baseline, or where particular measures are not pre-existing (e.g. local patient experience measures)
- Attribution of measures is difficult in the context of other factors influencing the outcomes

Key actions and top links

- Balance local measures with national requirements. **Click here to view national BCF metrics**
- Make use of the PIRU generic measures for integrated care: a set of 35 specific measures across 6 key domains reflecting elements of care coordination and integration. **Click here to view publication**
- Be aware where measures may be conflicting and proactively manage potential issues
- Use SMARTER criteria when selecting measures, and the good indicators guide on how to use and choose indicators. **Click here to view publication**
- Ensure that quantitative measures are supplemented with a qualitative approach. **Click here to view publication**
- Use the Picker Institute's 18 questions and the list of recommended proxy measures for patient experience of integrated care – outlined in the BCF planning guidance from August 2014. **Click here to view publication. Click here to view publication.**

Why do we need measures?

Collecting data can help organisations to make better decisions about how to improve services. More detail is required to ensure measures lead to positive change for patients / service users. Organisations need a mixture of measures that give them immediate and recent data that is sufficiently detailed and meaningful to influence their local populations, staff, managers and senior leadership.

Selecting and developing robust measures helps to:

- Provide measurable results to demonstrate progress towards outcomes

- Identify areas needing attention and opportunities for improvement

- Support continuous improvement. Measurement cannot be undertaken in isolation.

When developing or selecting measures it is important to acknowledge the following, and work closely together in identifying measures that work from a local and national perspective.

- Person centred coordinated care brings together care from a wide variety of different organisations. It is therefore important to **consider the whole system** and its different clusters (e.g. patients, service users, carers, professionals, NHS, social care, voluntary organisations etc.).

A "culture of evaluation" also needs to cut across the leadership level of all services and teams involved.

- **Integrating the outputs and outcomes from different organisations can be as difficult as integrating the services.** Different partners have different objectives as well as practices around information governance, data and what 'evidence' means to them. There are significant differences between health, care and the voluntary sector. But even within health, systems are not joined up. Some stakeholders can only provide certain information or data which can prove a challenge when trying to aggregate results. There can be instances where individual measures might even contradict one another. Accountabilities between multiple stakeholders and historic relationships need to be considered.

- **Local measures and KPIs need to be balanced with national requirements.** As an example, the BCF metric for reduction in non-elective admissions (general and acute) is required to determine payment for performance (P4P). The other core national BCF metrics are also required for monitoring. The Better Care Fund's Technical Guidance provides in depth explanation of the

required metrics (starting on page 20). **Click here to view publication.** However, you will inevitably require a more tailored set of measures locally to track and understand your progress.

- Certain measures (such as improvements in life expectancy, trends in hospital utilization, or changes in quality of life) may be legitimate long-term goals of integrated care, **yet attribution becomes conflicted due to a myriad of other factors influencing the outcome.** For this reason, measures of quality for integrated care should probably not include variables that are unlikely to be amenable to change within 3-5 years.

6 key domains to consider when assessing integrated care

Dr. Nick Goodwin conducted an analysis for the WHO on people centered and integrated health and came to the conclusion that there are **6 key domains** through which to assess integrated care. Consider using this framework as a basis when selecting your measures.

- **System-level measures of community wellbeing and population health** including reductions in avoidable deaths for treatable conditions, improved mental health and wellbeing, and the proportion of populations engaged in healthy lifestyle behavior

- **Service proxies for improved health outcomes** such as avoidable admissions to hospitals, lengths of hospital stay, and reductions in adverse events

- **Personal health outcomes** to people and communities, primarily relating to measures of improved quality of life, remaining independent, and reducing risk factors to better manage existing health conditions

- **Resource utilisation** that seeks to describe measures which demonstrate the reorientation of activities towards primary and community care, for example in terms of the balance of financial and human resources

- **Organisational processes** and characteristics that support evidence that systems to support high-quality people centred and integrated services are in place, for example in improving access to care, care planning, better care transitions, self-care support, care management and medications reconciliation

- **User and carer experiences** of, for example, shared decision-making, care planning, communication and information sharing, and care co-ordination.

Further Reading

PIRU have published a paper advising on indicators of integrated care. This features 35 specific measures across six key domains which Dr. Nick Goodwin used to develop his work (see above). The PIRU classification of measures is a pragmatic one, reflecting both the elements of care coordination and integration.

Click here to view publication.

What are the right measures?

> " *Measurement is the first step that leads to control and eventually to improvement. If you can't measure something, you can't understand it. If you can't understand it, you can't control it. If you can't control it, you can't improve it.* "
>
> *- H. James Harrington, International Author on Performance and Quality Improvement*

> " *There is a chronic lack of evaluation and measurement on which to judge the performance of care coordination programmes. This is a fundamental weakness; far greater attention is required to measure, evaluate, compare and reflect on performance.* "
>
> *- Report on Coordinated care for people with complex chronic conditions, The King's Fund*

The future of better care innovation is at a significantly increased risk of failure if evaluation and measurement is not addressed from the outset

As mentioned in the foreword to choose the right measures to understand performance and progress in integrated care, there needs to be a clear understanding of:

✓ the core aims of integrated care in terms of **who and what the interventions involved are seeking to influence**

✓ the **range of desired outcomes** that should result from the interventions, drawn primarily from the patient's / service user's perspective. Measures need to be relevant and focused on / aligned with outcomes

✓ the **timeframe over which such outcomes can reasonably be expected** to be achieved, in order to understand which measurement categories actually have the potential to be improved

✓ **how impact can be measured** in a way that ensures attribution between the interventions developed and the outcomes observed

✓ the **robustness of measures** so they can imply actions to be undertaken for quality improvement purpose by managers and professionals and to avoid perverse incentives

✓ **simplicity and ease of measurement.** This is key. Consider the data that is already being collected but be open to new and innovative approaches. The more the measurement is in tune with what people do, the more they are seen as meaningful and the greater the drive for improvement, and

✓ **time series analysis.** Measuring data over time will enable you to understand trends, which will help you to understand changes in performance.

Are you measures SMARTER?

Use the SMARTER criteria when selecting measures. It is effective in providing a structured approach to the development / selection process and helps people to focus on the practical implications of measurement.

Specific	Measures can be clearly articulated to people with a basic knowledge of Better Care
Measurebale	Criteria for measuring progress towards the attainment of the goal are concrete
Achievable	Measures are practical, achievable and realistic within operational constraints
Relevant	Measures offer insight into Better Care that matters
Time-bound	Clear timeframes have been set and are evident to stakeholders
Evaluated & **R**eviewed	Evaluation is happening on a consistent basis and regular review cycles are planned for

Key considerations

It can be difficult to get this right from the start. Remember to test your selected measures with stakeholders early on. If you don't seem to get sufficient insight or learning, don't hesitate to make changes.

- ✓ **Identify quick wins.** This will help to create momentum, engagement and enthusiasm. Use this as an opportunity to build a solid platform for continuous learning and improvement

- ✓ **Be practical when developing or selecting measures** and try not to create additional burden

- ✓ **Be creative and flexible** about what you want to measure and **do not be overly concerned if baseline figures don't exist.** When you start you may not know whether the chosen measures are the correct ones. Accept that measures may need to evolve over time and ensure that stakeholders are comfortable with this ambiguity. Consider that evolving measures will affect the timeline and baseline against which success is measured. A time lag regarding system data could mean that you are not able to report as quickly on new measures or that some data cannot be aggregated

- ✓ **Determine whether the information required to measure is covered by existing data sources.** Where no information is currently available, check whether primary research (collection of original primary data) is realistic within the constraints of available resources. **It may be more efficient and doable to use secondary data (existing information)** for quantitative measures and use scarce primary resources to look qualitatively at describing impacts identified as part of the secondary analysis

- ✓ **Take the phasing and timing of measures into account** (i.e. short term vs. long term)

- ✓ **Consider a balanced approach between measuring outcomes and process.** Process measures and proxy measures for the system are entirely legitimate and a time series analysis of those will minimise any disadvantages. The trend is what matters. For example if the whole system is working well, it could well be argued that readmission rate will reduce, or the number of people living in their own home will increase

- ✓ Check whether the geographical coverage of stakeholders (e.g. LAs and CCGs) is identical or whether adjustments to data need to be made in case areas don't match.

10 key questions	Answers and examples
1. What is being measured?	**Levels of diabetes**
2. Why is it being measured?	**It is a serious disease with serious consequences. Although it can be prevented and treated, it is still the leading cause of chronic disease globally and accounts for about 10 per cent of NHS costs**
3. How is this indicator actually defined?	**From recorded levels in general practice**
4. Who does it measure?	**All persons, all ages**
5. When does it measure it?	**Which day/month/year?**
6. Will it measure absolute numbers or proportions?	**Proportions: numbers of case per thousand resident population**
7. Where does the data actually come from?	**Collection and collation from Quality Outcome Framework (QOF) data in General Practice via the NHS Information Centre**
8. How accurate ands complete will the data be?	**The data cover more than 99 per cent of GP registered patients in England, although not everyone is registered with a GP (especially some groups with particular needs - see next box)**
9. Are there any caveats/ warnings/ problems?	**Potential for errors in collection, collation and interpretation (such as an under-sampling of ethnic populations, young people, homeless people, migrants, and travellers)**
10. Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	**E.g. when comparing small numbers, in small populations, or to distinguish inherent (common cause) variation, from special cause variation (See section 4 for more on variation).**

The good indicators guide: Understanding how to use and chose indicators (Page 10). **Click here to view publication.**

Using quantitative and qualitative information

To get a fuller picture, it is important to use quantitative <u>and</u> qualitative information

Qualitative and quantitative data can complement each other, with qualitative data giving meaning and richness to quantitative data. By combining both, a fuller picture can be produced.

How can we be sure that any one factor or service is directly responsible for any given effect or outcome? Although qualitative data cannot solve problems of causal connections, it is particularly relevant where there is ambiguity about terms and variables and can help improve understanding of different contributions towards outcomes, with several advantages. **Click here for more information.**

Quantitative information	**Qualitative information**
"What happened, where, when and who with"	*"Factors or reasons affecting behaviour or outcomes – the how or why"*

Example: Patient experience survey

Multiple choice questions that can be measured on a scale (e.g. 1 to 5 …)

| Dissatisfied | ① | ② | ③ | ④ | ⑤ | Satisfied |

Historically, the focus was on quantitative information as it is regarded as **reliable** and usually generalisable to a larger population.

However, quantitative **information may not help to identify potential levers and barriers.** Relying on this alone will not provide sufficient insight. Further qualitative information will be needed to understand the big picture.

Example: Patient experience survey

Free text answers

The use of carefully crafted outcome measures that assess the **person's experience** of care across organisations **will be critical** in demonstrating progress in improving person centred coordinated care.

Historically, collecting qualitative information in a consistent way has been **difficult and sometimes costly** (e.g. on patient experience).

Patient and service user experience of care and support

Measuring patient and service user experience is important. In the publication on "Measuring patient experience", the Health Foundation articulates the strong evidence base supporting this. **Click here to view publication.**

"Measuring patient experience is important not only to guide service improvement, but also because people's experiences of care may be linked to clinical outcomes and costs. A systematic review of 55 studies in primary care and hospitals found consistent positive associations between patient experience, patient safety and clinical effectiveness for a wide range of disease areas, settings, outcome measures and study designs."

Page 25 of the BCF – Technical Guidance provides further specification on the patient / service user experience metric. **Click here to view publication.**

The guidance highlights **six key benefits** for measuring patients/service user experience:

- Improves communication between communities, patients, service users, commissioners and providers
- Allows performance to be monitored over time and improvements demonstrated
- Gives patients, carers and their families a better understanding of their conditions and treatment plans to achieve better outcomes
- Increases understanding of patients and the public about health and social care services
- Empowers communities to have a say in the delivery of local services
- Encourages better decision-making and leads to more effective service delivery; by involving communities in the design/delivery of services they are more likely to be successful in terms of their relevance, usage levels and therefore, their impact.

To measure patient / service user experience HWBs may want to use:

- **An existing national measure** (e.g. Family and Friends Test). **Click here to view publication**
- **Or a newly developed local measure.** See the Tower Hamlet case study on the next page

If you are developing a new local measure, you might want to use Picker questions. **Please click here** to access the 18 questions developed by the Picker Institute and Oxford University.

Readers can also refer to the BCF Technical guidance for a full list of proxies for patient / service user experience as recommended by NHS England (page 36-41). If you are using this approach, you may want to review on a regular basis whether the data is giving you the insight that you need.

Case studies

Currently, there is no nationally agreed measure for patient and service user experience of integrated care. There are several projects ongoing in different areas to work collaboratively in developing new local approaches. The following examples provide insight on the approach, challenges faced and lessons learnt.

'Developing a patient reported measure of care coordination' – Tower Hamlets

Together with five other CCGs and local authorities, Tower Hamlets is participating in the piloting phase of the project 'Developing a patient reported measure of care coordination'. This project aims to develop a survey tool for measuring user reported experiences of integrated care for people over 65 with long term conditions. The Nuffield Trust, Picker Institute Europe, The King's Fund, the International Foundation for Integrated Care and National Voices have joint responsibility for the project which is funded by The Aetna Foundation.

Methodology

In each of the six participating CCGs and local authorities, a sample group of 600 participants (over 65s with at least one chronic condition) is sent a paper copy of the survey tool. This has been developed out of the 'I statements' and cognitively tested by the Picker Institute. Most of the questions in the survey are quantitative. Free text fields are available to add context and richness to the results. The findings will provide an understanding and comparison of the population based on demographic and location in the borough.

The pilot is due to end in late spring 2015 and the final validated tool will be available later in the year.

Challenges faced by Tower Hamlets

- Finding sufficient time to engage health and care networks and get buy in to support the pilot
- Identifying a sample size of 600 patients that meet the criteria and characteristics of the demographic
- Finding sufficient resources within GP practices to administer the process (as this is a locally driven pilot).

Lessons learnt by Tower Hamlets

- Take the opportunity to be involved in a reputable pilot
- Further tips will emerge in the report findings.

If any local commissioners, providers or local authorities are interested in contributing to the further development of this questionnaire which will assess care coordination and integration across health and care from the perspective of older people, **please contact** helen.crump@nuffieldtrust.org.uk or ruth.thorlby@nuffieldtrust.org.uk.

Case studies

Gloucestershire

Gloucestershire's Integrated Care Teams (ICT) realise patient and service user experience are central to achieving their BCF aspirations.

Approach

The approach to developing this new measure is to use survey / comment cards which include the national 'Friends and Family Test' and a set of 5 locally agreed questions.

- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did the staff caring for you introduce themselves?
- Did you have confidence and trust in the staff examining or treating you?
- Overall, did you feel you were treated with respect and dignity?
- How did you rate the care that you received? (The respondents mark a cross on a line between very poor and very good).

Response rate

In the services where the survey has been running for a while and is fully established, the teams are seeing high response rates. In February 2015 Minor Injury Units (MIUs) had a response rate of 32% and inpatients had a response rate of 52%.

In other areas where the survey has just started (end of 2014 or beginning of 2015) there is a big difference in the number of responses. These can vary between 0.5% and 35%.

The ICTs are committed on concentrating their efforts on finding ways to integrate the surveys as part of service delivery.

Gloucestershire (cont.)

Reporting

Monthly reports are produced to monitor feedback on an ongoing basis. The local team has seen that by providing frequent reports the feedback becomes a powerful tool to demonstrate to staff how the services are perceived by service users. The reports have made it easier to follow trends and to continually update staff on specific performance measures. Service leads are able to identify areas that require action and implement these in a more timely manner. In the community hospitals there are now feedback boards that display survey results, comments and actions based on feedback, within the 'You Said, We Did' framework.

As well as the monthly reports, all service leads now receive a weekly update on any free text comments received during the previous week. This has been very well received as it highlights any issues straight away and an opportunity to solve problems within a timely manner. The teams often find that the free text comments are much more specific than the answers to the survey questions. A system is in place where respondents have an opportunity to leave their contact details if they wish to be contacted by the Service Experience Team to discuss a concern. Again, this is something that has enabled the local trust to respond in a more timely manner to any issues raised.

Lessons learnt

1. Keep it simple

2. Use existing techniques and methodologies wherever possible

3. Make sure the feedback is used and reported back e.g. 'You said we did', 'We took action and are letting you know that…'

Contact: Mary Morgan, Interim Joint Commissioner (Older People and Better Care Fund)

Email: mary.morgan2@nhs.net

Checklist

- ☐ Identify the **key stakeholders that need to be involved** in the process (health, public health, social care, private sector, voluntary sector, self funders etc.)

- ☐ **Engage stakeholders** to understand the vision of future care and the impact of the Better Care interventions in terms of expected Better Care outcomes – experiences to people, care outcomes and better use of resources

- ☐ Understand individual / local / national priorities and **identify common ground and any potential conflicts** across stakeholders

- ☐ **Coproduce a set of measures** that reflect these care outcomes in order to judge performance and self-reflection. Ensure this is an inclusive process

- ☐ Ensure that quantitative measures are **supplemented with a qualitative approach** and agree how data analysis should be conducted. All key partner organisations need to be actively engaged in this process

- ☐ Be aware where measures may be conflicting and proactively manage potential issues

- ☐ Understand **existing funding flows** so that financial flows can be mapped back to activities

- ☐ Bear organisational / staff **capability and capacity** in mind

- ☐ Map what **information / data flows** are available (including timelines and systems). Identify whether **new systems / processes need to be developed**

- ☐ **Agree accountabilities** about how the measures are being managed (especially across several stakeholders) and which board they will be reported to

- ☐ **Communicate widely and clearly** so that everyone understands the 'shared measures' and it filters down to trigger culture change (leadership, champions, trail blazers, evaluation networks)

- ☐ Consider how people can be **brought together to understand each others priorities / measurements / outcomes** and to start a potential cultural shift. Consider various options from regular face to face meetings (short term) to co-location (medium / long term)

- ☐ Consider **how findings will be fed back** to staff, patients, service users and the public

- ☐ Build on **existing work or the experience of others** doing similar things. Identify what works, action it and share learnings across boundaries. **Don't reinvent the wheel.**

- ☐ Identify what works, action it and share learnings across boundaries.

A summary of the main challenges and key actions

Challenges

- Developing a monitoring / evaluation framework for whole systems care is challenging and is a new process for many localities
- Constructing analysis of the counterfactual to demonstrate the impact of interventions can take time to develop, implement and analyse

Key actions and top links

- Be clear on why developing a monitoring / evaluation framework is important to stakeholders and the benefits it will deliver to your programme so you can articulate this to stakeholders. The Magenta Book for Evaluation Guidance provides a good starting point to understand an evaluation framework and the benefits it can bring. **Click here to view publication**
- The Public Sector Transformation Network (PSTN) has developed an introductory guide on evaluation, a section of which is dedicated to understanding the counterfactual. **Click here to view publication.**

Building an evaluation framework

Why do we need an evaluation framework?

A well thought out monitoring and evaluation framework can assist greatly with thinking through programme strategies, objectives, planned activities, and whether they are indeed the most appropriate ones to implement.

The starting point is to build a framework to capture key information about how the outcomes will be evaluated. There are different types of evaluation, but the one that most areas will use will be a formative evaluation – one that is intended to improve performance and is conducted during the implementation of programmes or projects. Each area will have its own challenges and so this chapter covers the essential elements of an monitoring / evaluation framework.

Example structure

| Specific aim	Outcomes	Measure	Data collection	Analysis and reporting
What are you trying to evaluate? e.g. was the programme effective?	What outcome is this regarding?	- What is the measure that you are basing this evaluation on? - Is there an evaluation norm (i.e. standard to be met) e.g. 80% of those accessing services	- Is the data that is being collected relevant to stakeholders? - What source will be used? - Is the data already available? What approach will you take if it is not? e.g. primary / secondary research - Is baseline data available? What is your approach if baseline data isn't available? - What timeframes is the data collection based on (e.g. weekly / monthly)? Is it consistent across all stakeholders? - What method are you going to chose to collect data (e.g. survey) - Who will be accountable? - Have you taken equal opportunities and ethical issues into account? - Do you have permission to use the collected data? - Is the collected data kept safe and confidential?	- How will the data be analysed (e.g. annual evaluation)? - Are the selected methods manageable regarding resource requirements? - Who will scrutinise the data? - Which meetings / boards will this be reported to (including timeframe / frequency)? - What changes will be made as a results?

Approach and examples

The template below can be used as a outline monitoring and evaluation framework. It has been populated with a health and social care example, looking at improving parenting skills through interactions at a family centre. **Click here for more information.**

Specific aims	Outcomes	Measures	Data collection		Analysis and reporting
To improve the parenting skills of the parents using the family centre	Parents are more knowledgeable about their children's health	90% of parents score 80% or higher on a basic questionnaire on child health within 6 months of attending the programme	Questionnaire	By trainer at start of workshop and 3 months later	6 monthly management report
		95% of parents participating in this programme whose child has previously not been registered with a GP, have registered them within three months	Questionnaire	Responses from parents	Quarterly management report
		80% of parents are following the nutritional guidelines as provided by the programme and their GP within three months of starting the programme	Questionnaire	Responses from parents	Quarterly management report

Specific aims	Outputs	Measures	Data collection		Analysis and reporting
To provide workshops, information and advice on parenting skills	Workshops on managing children's behaviour and children's health	Number of workshops scheduled within 6 months are designed to reach 75% of the target parent population (geographically, demographically, etc.)	Programme Plan	Programme Management	6 monthly management report
		60% of parents invited have attended at least one workshop within 6 months of launch of the first workshop	Register	On day by trainer	Quarterly reporting to management

Impact evaluation: counterfactual analysis

Counterfactual analysis involves a comparison between what actually happened and what would have happened in the absence of the intervention.

What would have happened in the absence of your integration programme or project?

What would have happened had you done nothing?
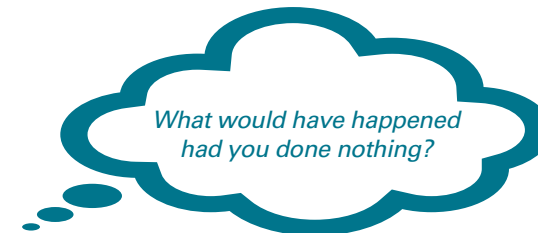
By constructing some analysis of the counterfactual you can establish which changes in outcomes are directly attributable to a project or a programme, versus those which would have occurred anyway. An analysis of the counterfactual takes your evaluation beyond just understanding whether outcomes have been achieved to understanding whether these outcomes are a result of your intervention and therefore whether there is value in continuing / extending the intervention.

How can you begin to understand the counterfactual? The Public Sector Transformation Network (PSTN) has developed an introductory guide on evaluation, a section of which is dedicated to understanding the counterfactual. It highlights the following approaches: **Click here to view publication.**

Experimental approaches…

This can be a very effective method, free from bias and may not be as expensive to implement as some other methodologies. It does however require careful planning and appropriate analytical capability.

Undertake a randomised control trial

A number of people are randomly assigned to two or more groups to test a specific change. One group (the experimental group) receives the change being tested while the other, the control group, receives an alternative service or the existing service.

There may be instances where matched comparison groups occur naturally. In this instance it is important to select similar groups or cohorts of patients or service users. Consider carefully how this method is implemented and ensure that areas or groups are not intentionally disadvantaged.

See Cornwall Case Study

Quasi-Experimental approaches…

It looks like an experimental design but lacks the key ingredient of random assignment. This may be easier to implement initially.

Intervention group versus well matched counterfactual

Outcomes are compared between the intervention group and the comparison group on factors known to be relevant to the intervention. This process will require analytical support.

Strong difference-in-difference methodology

There is no direct matching. This involves a before and after study comparing two groups where there is strong evidence that outcomes for the two groups have shown similar traits in the past. This is similar to the matched-comparison group design but there is no literal matching. Instead, the trends over time for the two groups are compared to provide an estimate of the overall impact.

South Tyneside – An evaluation framework for the self-care programme

South Tyneside is undertaking a programme of fundamental **cultural and behaviour change for staff and residents,** based on promoting self care through all health, care and community services. Central to this is the 'Changing Conversations' programme to shift conversations from "How can I help you?" to "How can I help you to help yourself?". The initial focus is on the area of Hebburn of South Tyneside where the self-care programme is being trialled.

The 'Changing Conversations' programme has **two aims:**

- Health and care staff and volunteers in all sectors have conversations that enable people to be active members of their 'care team'
- The environment of South Tyneside supports people's contribution to their health and wellbeing.

Four key measures (from the National Outcomes Framework) have been selected to provide a focus for measuring the impact of the self care programme:

- Proportion of people who use services who have control over their daily life
- Proportion of people feeling supported to manage their condition
- Proportion of pregnant women smoking at time of delivery
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (broken down by conditions).

Where possible, the data has been drilled down to locality level rather than just CCG level on the measures. This allows South Tyneside to understand its localities' relative performance.

The Pioneer Operating Group (POG), the oversight body for the programme, has developed a **local evaluation framework** to support the evaluation of South Tyneside's HWB BCF programme and its plans. This will include both quantitative and qualitative measures which will allow the POG to:

- Measure, monitor and evaluate whether the programme is achieving the desired outcomes and objectives
- Facilitate discussions with stakeholders
- Develop a shared plan for action.

South Tyneside **Partnership**

Please take a few moments to complete this postcard or alternatively go to www.surveymonkey.com/s/5KMKPGW and complete online.

Please rate how strongly you agree or disagree with the following statements:

1. Taking an active role in my own health and social care is the most important thing that affects my health.
   Strongly disagree 1 2 3 4 5 6 7 8 9 10 *Strongly agree*

2. When all is said and done, I am the person who is responsible for taking care of my health.
   Strongly disagree 1 2 3 4 5 6 7 8 9 10 *Strongly agree*

Can you tell us one thing that you would like to change so that services work better together and support you to live independently and get on with your life: _____

_____

South Tyneside (cont.)

Selecting a control group

A control comparison group is being developed. This will enable comparison against the outcomes for the target population in Hebburn. Currently the idea is that the control group will be identified through the use of MOSAIC to identify a ward with similar demographics to Hebburn. This approach is currently being developed by the Pioneer Evaluation Group.

Approaches	Key Findings
1. Postcard survey	
A postcard (see previous page) has been designed and issued through a mail out, on the street, through focus groups (with incentives to attend), GP practices, other centres and online.	1,077 postcards were returned. Results showed a very high level of agreement about the importance of personal responsibility.
2. Interviews and focus groups	
Street interviews and focus groups were held with nearly 600 recipients.	Feedback identified barriers to self care such as lack of confidence, lack of information, financial worries, fear of crime on the streets and isolation. Assets included free bus passes, community groups and affordable activities.
	Staff were committed to helping people take control over their own care and to motivate them to do so. Over 30% however, were sceptical as to whether what they did would make a difference to people's behaviour.

Key learnings to date

A Public Health consultant played a vital role in helping South Tyneside to identify areas of learning and further opportunities by providing expertise on different evaluation frameworks.

For further reading

Case study: South Tyneside - An evaluation programme for self-care. **Click here to view publication.**

Case study: South Tyneside – Engaging the local population to 'change the conversation'. **Click here to view publication.**

Contact: Phil Taylor, Integration Support Officer, South Tyneside CCG and South Tyneside Local Authority
Email: phil.taylor4@nhs.net

Cornwall Evaluation Framework

This case study is a good example for cross system collaboration when selecting and developing measures and using a counterfactual analysis.

Fifteen organisations across Cornwall and the Isles of Scilly have joined together as one of the Pioneer pilot sites.

Cornwall's Living Well is an approach that brings a fragmented system together under a shared vision and commitment and provides a framework for the future engagement of local communities and the delivery of services. The triple aims of the Cornwall Living Well project is improved health and wellbeing, improved experience of care and reduced cost of care.

The Living Well team believes that one of the programme's strength's is the robustness of its measures and evaluations: "We want to have a debate about what the numbers are telling us, not whether they're accurate". It was acknowledged that this could not be achieved in isolation and that it would be difficult to achieve a balance between using an academic approach and being pragmatic to create something that works for Cornwall.

The team have already started their work in Newquay and are now rolling out in Penwith. The aim is to spread this work the Living Well approach across the rest of Cornwall and the Isles of Scilly.

Lesson Learnt to date

- Performance teams from relevant organisations have been brought together to develop an **outcomes framework**, linked to the three key aims.

- **Measures** were built on existing HWB outcomes. Additionally, new measures were introduced e.g. the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). **Click here to view publication.** The WEMWBS was tested with all relevant stakeholders to ensure that it would be owned by the whole system. **A key learning was that finance and activity measures generally tend to get more attention than other measures.**

- An **evaluation framework** linked to the outcomes has been agreed by all the partners involved in the project. The evaluation framework includes a quality of life tool, practitioner survey and financial modelling to understand the cost impact. **Click here to view publication.**

- To understand what would have happened in the absence of the project and demonstrate the effect of the interventions, the Living Well team conducted a counterfactual analysis. The comparison group was established by selecting patients in a neighbouring geographical area who were not receiving the Living Well service, but who also had long term conditions.

- Some additional learning occurred when trying to conduct the matching for the cohort comparisons. The team found the more granular their matching approach using clinical descriptors, the less similarities there were between patients. **This highlighted that 'no one patient is identical to anyone else'.**

- There were issues regarding information governance and sharing data. This was identified as a major barrier but will be resolved in the near future.

Contact: Tracey Roose, Chief Executive Age UK Cornwall and the Isles of Scilly, Director of Integration
Email: Tracey@ageukcornwall.org.uk

A summary of the main challenges and key actions

Challenges

- Developing a whole system dashboard is difficult and it will take time to get agreement from various stakeholders on what should be included

- It is challenging to create a learning culture that supports and underpins Better Care aspirations when faced with on-going operational pressures

Key actions and top links

- Use your networks to understand where whole system dashboards have been created and implemented already and learn from them. If you have created a dashboard, ask yourself about how accessible it is for your stakeholders. Does it clearly present information on the performance of schemes / projects? What insight does it bring to your programme?

- Develop and facilitate a learning culture within teams across the the whole system. Understand the power of bringing people together from different organisations and tools to aid you (Action Learning sets). How to... work together across health, care and beyond provides excellent reading on joint working. **Click here to view publication.**

Using whole system dashboards

By bringing together quality, performance and finance measures, systems can produce an integrated dashboard which can replace some of the current reporting arrangements. Consider aligning measures to the 6 domains to assess integrated care.

A integrated dashboard should:

✓ Provide relevant and up-to-date information on a page

✓ Be engaging – with infographics and data bridges

✓ Reflect the range of services provided across the pathway with an increasing focus on health outcomes

✓ Include the range of measures, standards to be achieved and monthly / year to date performance and forecasting information

✓ Use a data quality 'kite mark' system to help provide a good sense of the quality of the data being used

✓ Include further measures as it develops.

Better Care Fund Dashboard
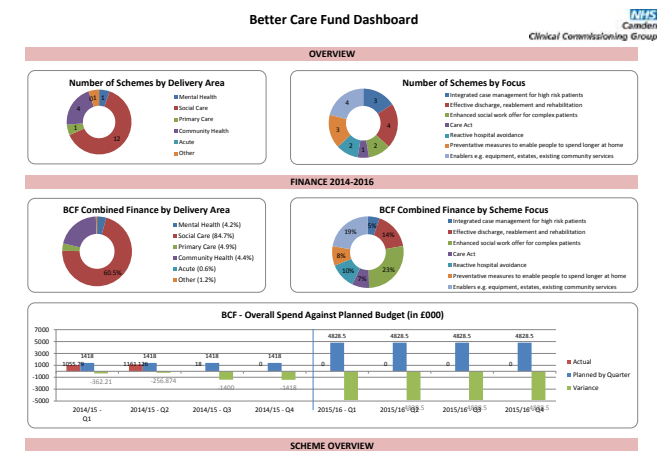
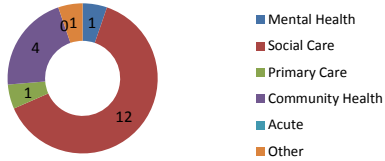## Joint Performance and Electronic Dashboard – Lanarkshire (NHS Scotland)

The Lanarkshire partnerships' joint performance framework and electronic dashboard was developed initially to measure progress and impact in Reshaping Care across both the North and South Lanarkshire Partnerships. This dashboard system of key measures is now being rolled out to support the improvement of wider outcomes for health and care integration across all adult groups. The system tracks progress overtime against significant measures.

Dashboard example

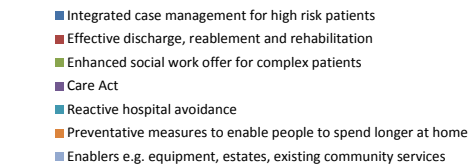1 2 3 4 5

Better Care Fund Dashboard

NHS Camden
Clinical Commissioning Group

OVERVIEW

Number of Schemes by Delivery Area

- Mental Health
- Social Care
- Primary Care
- Community Health
- Acute
- Other

(values shown: 1, 1, 0, 1, 4, 1, 12)

Number of Schemes by Focus

- Integrated case management for high risk patients
- Effective discharge, reablement and rehabilitation
- Enhanced social work offer for complex patients
- Care Act
- Reactive hospital avoidance
- Preventative measures to enable people to spend longer at home
- Enablers e.g. equipment, estates, existing community services

(values shown: 3, 4, 4, 3, 2, 1, 2)

FINANCE 2014–2016

BCF Combined Finance by Delivery Area

- Mental Health (4.2%)
- Social Care (84.7%)
- Primary Care (4.9%)
- Community Health (4.4%)
- Acute (0.6%)
- Other (1.2%)

(value shown: 60.5%)
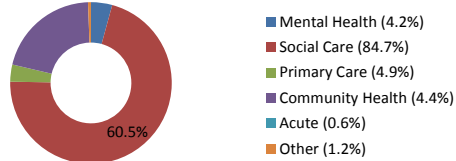
BCF Combined Finance by Scheme Focus

- Integrated case management for high risk patients
- Effective discharge, reablement and rehabilitation
- Enhanced social work offer for complex patients
- Care Act
- Reactive hospital avoidance
- Preventative measures to enable people to spend longer at home
- Enablers e.g. equipment, estates, existing community services

(values shown: 5%, 14%, 23%, 7%, 10%, 8%, 19%)
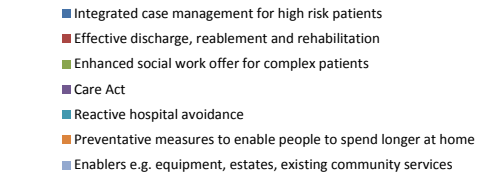
BCF - Overall Spend Against Planned Budget (in £000)
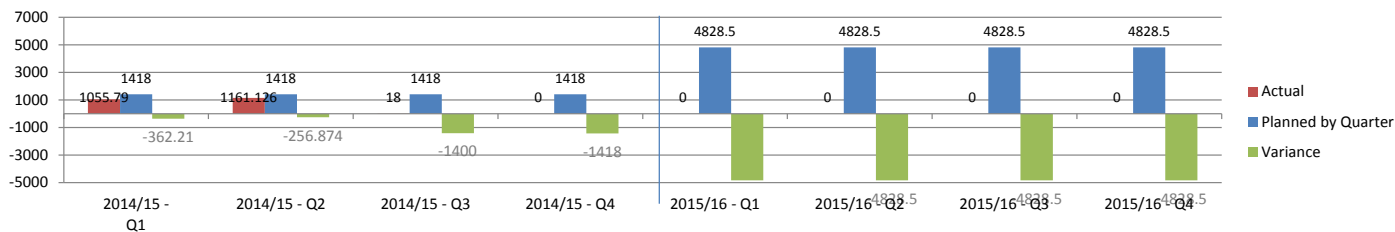
Quarter	Actual	Planned by Quarter	Variance
2014/15 - Q1	1055.79	1418	-362.21
2014/15 - Q2	1161.126	1418	-256.874
2014/15 - Q3	18	1418	-1400
2014/15 - Q4	0	1418	-1418
2015/16 - Q1	0	4828.5	-4828.5
2015/16 - Q2	0	4828.5	-4828.5
2015/16 - Q3	0	4828.5	-4828.5
2015/16 - Q4	0	4828.5	-4828.5

- Actual
- Planned by Quarter
- Variance

SCHEME OVERVIEW

Learning culture - A framework based on improvement theory, local research and growing evidence based practice should be used to support learning, training, evaluation and development.

The NHS and Local Authorities have a long tradition of improvement discipline. This approach should be used to continue to learn.

Develop and facilitate a learning culture within teams. Consider that in some organisations it will require a culture shift to achieve this (See 'How to' guide on working together across health, care and beyond. **Click here to view publication.**)

✓ Ask individuals for their reflection at every stage of the journey

✓ Encourage frontline staff to share feedback and capture results

✓ Act on what you have learnt

✓ Identify best practice and share it widely

> ### Note
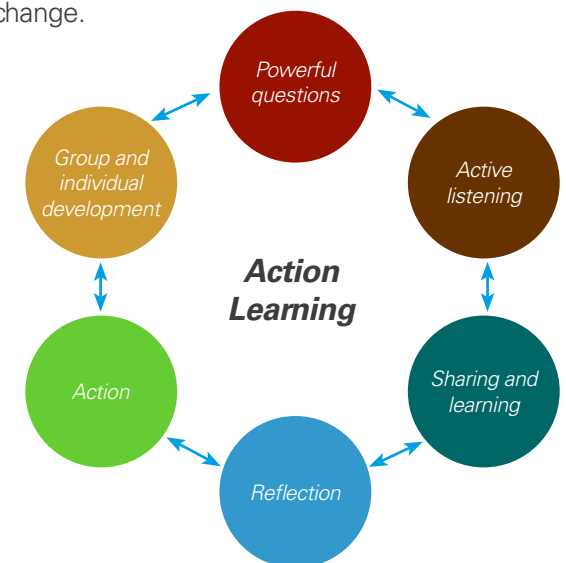> Remember to share your learnings across your network

An Action Learning Set is defined as a "continuous process of learning and reflection, supported by colleagues, with an intention of getting things done" (McGill and Beaty, 2001, p.11). Individuals work on real work issues and openly reflect on their experiences with a view to taking subsequent action. One of the fundamental aims of action learning is to help participants develop the skills and make time for active reflection in order to solve their own problems.

Action Learning Sets are a core feature of all development programmes, which can also be linked with coaching/ mentoring or added impact. The set should meet regularly (every 6-8 weeks) to sustain momentum and commitment. Less often than this and a group can often repeat the cycle of trust formation and not get further.

Three benefits for Action Learning Sets are:

- **Learning from others** - because the focus of action learning is work-based issues, shared with others, one of the most important benefits is being able to learn from others' experiences of dealing with similar issues

- Action Learning focuses on changing this way of **interacting with others**, by working on asking questions; open, probing, and challenging questions – all of which help to draw out what Revan's refers to as "exploratory insight" (Revans, 1998:6) which leads to taking action

- One of the main benefits of action learning is that it **facilitates people to both reflect on a work based issue and share that with others,** and as a result, **formulate actions and decisions** that they then take back to their workplaces, which results in change.


Powerful questions
Active listening
Group and individual development
Action Learning
Action
Sharing and learning
Reflection

Using results to continuously improve
Establishing a learning culture (cont.)

1 2 3 4 5

Better Care Atlas

As part of the Better Care Fund, NHS England have developed a tool which allows HWBs to monitor and benchmark their performance against key measures and national performance. This tool also provides an opportunity to see how peers are performing which should enable HWBs to proactively reach out to other areas for good practice.

Click here to access the Better Care Atlas.
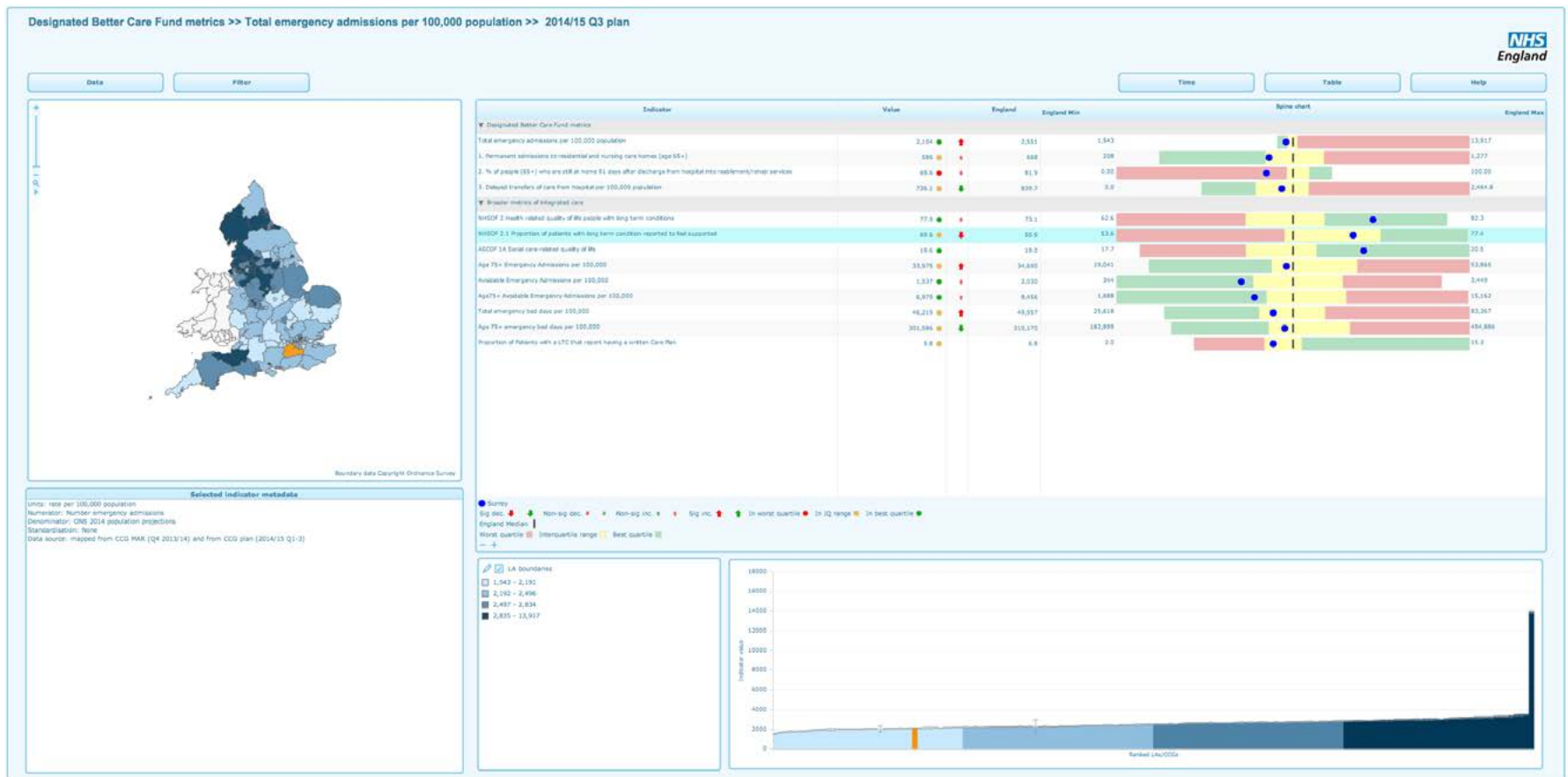
Conclusion
After reading this 'How to' guide, we hope you come away with 5 key messages

This guide will help people to understand and prepare for developing Better Care and the wider goals of person centred coordinated care.

1. To build meaningful local whole system outcomes and measures for Better Care **there needs to be joint ownership and a sense of accountability**

2. You need to **actively engage and listen to your local populations.** They are the key to your success and together you can develop meaningful outcomes

3. Quantitative information on its own is not enough to understand if systems are delivering patient centred care. You are strongly encouraged to **consider qualitative data to support quantitative information**. It is important to use local patient / service user experience measures to support the ongoing development of integrated care models

4. This process will be hard. It is accepted that developing the right outcomes, measures, evaluation frameworks and reports will be an evolutionary process – **you may have to find local solutions in addition to the ongoing national approach**

5. Embed a culture of learning and see this as a journey of discovery.

What guidance and material is currently available?

National frameworks

There are three outcomes frameworks, one each for public health, adult social care, and the NHS. They set out high level areas for improvement, alongside supporting measures, to help track progress without overshadowing local priorities. They are intended to provide a focus for improvement and action across the system and will be a helpful reference for you in shaping your local outcomes framework.

- NHS National Outcomes Framework. **Click here to view publication**
- Public Health Outcomes Framework. **Click here to view publication**
- Adult Social Care Outcomes Framework (ASCOF). **Click here to view publication.**

Additionally, there is

- Technical Guidance on Better Care Fund Metrics. **Click here to view publication**
- Health Education Outcomes Framework. **Click here to view publication.**

Cross government resources

- The HM Treasury Green Book: Appraisal and Evaluation in Central Government. This provides a substantial overview of approaches to appraisal and evaluation. **Click here to view publication**
- The HM Treasury Magenta Book for evaluators: The recommended central government guidance on evaluation that sets out best practice for departments to follow. **Click here to view publication**
- Government Social Research Unit: Rapid Evidence Assessment Toolkit. Information about REA and other secondary research methodologies. **Click here to view publication.**

International examples

In many countries, the introduction of policy reforms to support approaches to integrated health and social care delivery have also seen attention placed on how to develop a set of quality measures through which to monitor system performance. For example:

- In New Zealand, the Integrated Performance and Incentive Framework was drafted in 2013 containing an inventory of measures intended to support District Health Boards identify and use locally relevant system-level measurements indicating progress towards care integration and improved health and equity for all population groups. **Click here to view publication**
- In the USA, the National Quality Forum (NQF) identified 38 preferred practices of patient centered care for palliative and hospice care quality, including the domains of care coordination, patient and family engagement, and disparities. National Quality Forum (2014) NQF – Endorsed Measures for Care Coordination: Phase 3, April 29, 2014. Draft report for comment. **Click here to view publication**
- In the USA, the Agency for Healthcare Research and Quality (AHRQ) have related a framework through which to assess care co-ordination, including a range of measurement domains (McDonald et al, 2010). **Click here to view publication.**

Additional information

- The Policy Innovation Research Unit (PIRU) provides advice on measures of integrated care for individual and collective progress monitoring using routine data. **Click here to view publication**
- The Nuffield Trust undertook a series of evaluations looking at case studies of integrated and community based care. The report summarises a series of 'key points' that can help systems when developing their integrated care models. A key aspect to consider is to develop robust methods to provide interim reporting of service changes and feedback on observations about process in a way that informs decision-making, enables learning, informs the next stage of service change, and can itself be tracked within the evaluation. **Click here to view publication**

Appendix
What guidance and material is currently available? (cont.)

1 2 3 4 5

- Logic Model. Templates and examples. **Click here to view publication**

- Frechtling, Joy A: Logic Modelling, Methods in Program Evaluation. John Wiley & Sons, Inc., 2007

- Reason from the National Foundation for Educational Research. **Click here to view publication**

- Research in Practice. **Click here to view publication**

- New Philanthropy Capital (more for the third sector) but key health partners. **Click here to view publication**

- Charity Evaluation Services (more for the third sector). **Click here to view publication**

- Picker Institute Europe: Developing measures of people's self-reported experiences of integrated care. **Click here to view publication**

- Publication by the Health Foundation on measuring patient experience. **Click here to view publication**

- North West London Toolkit. How do we define outcomes and metrics? **Click here to view publication**

- BMC Health Services Research: Selecting process quality indicators for the integrated care of vulnerable older adults affected by cognitive impairment or dementia. **Click here to view publication**

- Public sector Transformation Network document on evaluation approach. **Click here to view publication**

- The good indicators guide: Understanding how to use and chose indicators (Page 10). **Click here to view publication**

- Evaluating outcomes in health and social care by Helen Dickinson. Policy Press. 2008

- The National Institute for Health Research **(click here)** provides free and confidential advice and provides support for health and social care researchers on all aspects of developing a grant application including research design, research methods, identifying funding sources and involving patients and the public. **Click here to view publication**

- The NPC have published clear and practical guidance on developing an impact measurement framework as a way for charities and funders to increase their effectiveness. Their guide provides clear and practical guidance and is based around a four pillar approach. **Click here to view publication.**

- **Collaborations for Leadership in Applied Health Research and Care (CLAHRCs)** are collaborative partnerships between universities and surrounding NHS organisations, focused on improving patient outcomes through the conduct and application of applied health research.

  Each CLAHRC aims to improve patient outcomes across the geographic area covered by the Collaboration through three key interlinked functions:

  - Conducting high quality applied health research;
  - Implementing the findings from research in clinical practice; and
  - Increasing the capacity of NHS organisations to engage with and apply research

  There would be value in contacting your local CLAHRC to understand what work may already be underway on integration. For more information on the CLAHRC Partnership Programme **click here.**

Dr. Nick Goodwin's research was based on the following (in addition to the international examples)

- OECD (no date) Health Care Quality Indicators. **Click here to view publication**

- Strandberg-Larsen M, Krasnik A. (2009). Measurement of integrated healthcare delivery: a systematic review of methods and future research directions. Int J Integr Care 9: e01.

- National Voices (2012) A narrative for person-centred coordinated ('integrated') care. **Click here to view publication**

- WHO – Global Reference List of Core Indicators

Introduction

http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

http://www.nationalvoices.org.uk/defining-integrated-care

Identifying the outcomes you want to achieve

http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf

http://www.healthiernorthwestlondon.nhs.uk/integrated-care

http://www.kingsfund.org.uk/publications/integrating-health-and-social-care-torbay

http://www.scie.org.uk/publications/guides/guide51/how-to-do-coproduction/index.asp

http://www.scie.org.uk/independent-mental-health-advocacy/\

http://www.cqc.org.uk/content/involving-people-who-use-services#inspections

http://www.ncbi.nlm.nih.gov/pubmed/21338297

http://www.fadelibrary.org.uk/wp/wp-content/uploads/downloads/2011/11/Commissioning-For-Outcomes.pdf

http://www.local.gov.uk/documents/10180/11463/Local+Healthwatch+outcomes+and+impact+development+tool/

http://info.wirral.nhs.uk/document_uploads/evidence-factsheets/12%20Logic%20Modelling%20factsheet%20Feb%202014.pdf

Developing / selecting the right measures

http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

http://www.piru.ac.uk/assets/files/IC%20and%20support%20Pioneers-Indicators.pdf

http://www.apho.org.uk/resource/item.aspx?RID=44584

http://www.iriss.org.uk/sites/default/files/understanding_and_measuring_outcomes_-_the_role_of_qualitative_data_.pdf

http://www.health.org.uk/public/cms/75/76/313/4300/Measuring%20patient%20experience.pdf?realName=7qM8Wm.pdf

http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

http://www.kingsfund.org.uk/sites/files/kf/media/Dan%20Wellings.pdf

Developing a monitoring and evaluation framework

http://www.ces-vol.org.uk/Resources/CharitiesEvaluationServices/Documents/Monitoring%20and%20evaluation%20framework.pdf

http://publicservicetransformation.org/resources/evaluation-and-analysis/139-evaluation-guide

http://www.local.gov.uk/documents/10180/6927502/Case+study+South+Tyneside++An+evaluation+framework+for+the+self-care+programme/f8d99d46-6f30-4254-b8ea-e29e6b257cfe

http://www.local.gov.uk/documents/10180/6927502/Case+study+South+Tyneside++Engaging+the+local+community+to+change+the+conversation/25fc9a50-b36f-47f0-a240-5bc9ce309d9f

http://www.healthscotland.com/documents/1467.aspx

http://www.local.gov.uk/documents/10180/6927502/Case+study+Cornwall+-+An+evaluation+framework+linked+to+outcomes.pdf/e14ed2be-f28b-4aea-872e-c35b5590f48d

http://www.clahrcpp.co.uk

Using results to continuously improve

http://www.scie.org.uk/about/partnerships-better-care.asp

http://ccgtools.england.nhs.uk/bettercare/flash/atlas.html

Appendix

National Frameworks

https://www.gov.uk/government/publications/nhs-outcomes-framework-2015-to-2016

https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-ascof-2015-to-2016

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220542/magenta_book_combined.pdf

http://www.civilservice.gov.uk/networks/gsr/resources-and-guidance/rapid-evidence-assessment

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf

International examples

http://www.hiirc.org.nz/page/42610/draft-integrated-performance-and-incentive/;jsessionid=B22A87CCE567BAD0F49D0032EE8B7E92?show=popular&contentType=251&section=8959

http://www.apic.org/Resource_/TinyMceFileManager/Advocacy-PDFs/care_coordination_draft_report.pdf

http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/index.html

Additional information

http://www.piru.ac.uk/assets/files/IC%20and%20support%20Pioneers-Indicators.pdf

http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/evaluation_summary_final.pdf

http://www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html

http://www.nfer.ac.uk/local-government/reason.cfm

https://www.rip.org.uk

http://www.thinknpc.org/our-work/

http://www.ces-vol.org.uk/Homepage

http://www.pickereurope.org/wp-content/uploads/2014/10/Developing-measures-of-IC-report_final_SMALL.pdf

http://www.health.org.uk/public/cms/75/76/313/4300/Measuring%20patient%20experience.pdf?realName=7qM8Wm.pdf

http://integration.healthiernorthwestlondon.nhs.uk/section/how-do-we-define-outcomes-and-metrics-

http://www.biomedcentral.com/1472-6963/7/195/

http://publicservicetransformation.org/resources/evaluation-and-analysis/139-evaluation-guide

http://www.apho.org.uk/resource/item.aspx?RID=44584

http://www.nihr.ac.uk

http://www.nihr.ac.uk/documents/about-NIHR/RDS-National-Leaflet-FINAL.pdf

http://www.thinknpc.org/publications/npcs-four-pillar-approach/?utm_source=New+Philanthropy+Capital&utm_medium=email&utm_campaign=5444675_measurement+for+charities&dm_i=UL9,38P4Z,C59OFE,BLR9B,1

Dr. Nick Goodwin's research was based on the following (in addition to the international examples)

http://www.oecd.org/els/health-systems/health-care-quality-indicators.htm

http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/narrative-coordinated-care.pdf

The Better Care Fund