Lancashire Better Care Fund Plan 2015/16

Evaluation

1. Background

The Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care.

2015/16 was the first full year of the fund with each Health and Wellbeing Board being required to produce a plan on how the funds would be used and aims achieved

The Lancashire Better Care Fund Plan for 2015/16 was approved in February 2015. It comprised 21 “schemes” that were identified by the Lancashire Clinical Commissioning Groups and Lancashire County Council as supporting the overall vision for health and care services over the next 3 to 5 years of a system that took a person centred approach and had seamless integrated services and pathways. The Better Care Fund Plan would enable:

- People assuming greater responsibility for their health and wellbeing.
- Development of integrated out of hospital services
- Prevention of avoidable hospital admissions and attendances
- Creation of multi skilled health and social care workers
- Enhancement of the role of the voluntary sector in supporting mainstream services
- Remove barriers and demarcation lines between different health and social care services
- Establishment of joint system leadership across the entire health and social care environment.

The schemes focussed on

- Out of Hospital care with integrated neighbourhood teams
- Reablement services
- Intermediate Care Services
- Supporting Carers

Each individual scheme plan set out whether its delivery would impact upon the prescribed measures and gave an anticipated quantitative impact.

Nationally a set of metrics (measures) was defined, for all Better Care Fund plans, so as to give an indication of success against the primary aims of the fund.

In addition each Health and Wellbeing Board was asked to identify a local Patient Satisfaction measure and a further local priority measure.

The table gives the detail of those metrics along with, Lancashire 2015/16 target and actual and 2016/17 target.

Metric	Target 2015/16	Actual 2015/16	Better is
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population.	733.7	728.5	Lower
Proportion of elderly (65+) who were still at home 91 days after discharge from hospital into rehabilitation/ reablement services.	82%2%	83.2%	Higher
Average daily rate of delayed transfers of care from hospital.	4,212.7	4,685.5	Lower
Non-elective admissions	133,096	136,810	Lower
Patient experience	9.3%	9.1%	Lower
Estimated Diagnosis Rate for Dementia	67%	67.4%	Higher

A quarterly report is provided to NHS England, on behalf of the Lancashire Health and Wellbeing Board, on performance against the metrics.

2. Performance

All BCF metrics are reported through a BCF dashboard. The 2015/16 year end version is available at *Appendix 1.*

a. Non elective admissions

The target for this metric was set as a 3.9% reduction on a 2014/15 baseline that equated to an annual reduction of 5419 admissions across the county.

Actual performance was of a 1.2% reduction against baseline equating to an annual reduction of 1,662 admissions across the county. Nationally there was a 3.3% increase in emergency admissions during 2015/16 when compared against 2014/15.

Performance through the year had followed the profile of 2014/15 until the final quarter when emergency admissions continued to rise where they had fallen in the previous year. This saw a 5.8% increase, 1,937 emergency admissions, over baseline in Quarter 4. This was also evident nationally with a 7.6% increase over baseline seen during the period.

While the target plan was not achieved performance in Lancashire was better than baseline and national performance.

(Data source: http://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/monthly-hospital-activity/mar-data/)

b. Delayed Transfers of Care (DTOC)

A Lancashire wide target of a reduction of Delayed days of 5.1%, 2,143 days, was set for 2015/16 against the 2014/15 baseline. Actual performance saw an increase of 4,447 delayed days, 11.2% variance from target and 5.5% variance from the 2014/15 baseline.

The profile of performance through the year broadly followed the 2014/15 baseline until the final quarter when a sharp increase was seen significantly contributing to the annual total. This pattern was seen at all acute providers in the county.

Nationally there was a 10% increase in delayed transfers of care in 2015/16 compared to 2014/15 and an 11% increase in the last quarter of 2015/16 over the previous quarter.

Data source: https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2015-16/

The performance against the above two measures has to be seen against a background of high system demand that the national figures reflect.

The range of factors involved is likely to be many and requires further consideration.

Achieving better than baseline and national performance for non-elective admissions in such circumstances should be seen in a positive context.

The challenge around delayed transfers of care seems to be more entrenched with more volatility in the system. County wide improvement activity, including the 2016/17 BCF Delayed Transfers of Care (DTOC) planning programme should reduce this. The DTOC planning includes the requirement for "situational analysis" which will support evaluation.

c. Permanent admissions to residential and nursing home care

A target of 733.7 admissions per 100,000 population 65+ was set for 2015/16. The actual performance was 728.5 achieving target and further stretch from the 2014/15 actual of 774.9. This was based upon a total reduction of 113 admissions against the baseline.

At the time of writing national and comparator authority year end data was not available.

Success seen in achieving this target can be attributed to the level of cooperation and coordination to offer diversionary services and to promote independence. Lancashire has historically been a high user of residential and nursing care but the trajectory shows a move towards national performance. There is an as yet unsubstantiated view that this performance is also due, in some part, to the lack of sufficient and suitable residential and nursing home care in Lancashire.

(Data source: http://ascof.hscic.gov.uk/Outcome/323/2A(2))

d. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Lancashire outcome figures for 2015/16 show that 83.2% were still at home after 91 days. This exceeds the Lancashire target of 82%, the Lancashire 2014/15 baseline of 79.3% and the national average of 82.1%. This performance is in the context of a significant increase in the use of reablement and rehabilitation services. 860 people were referred into the services in Quarter 3 of 2015/16, 875 referred in in Quarter 4. The original target was a referral rate of 600 people per quarter. There is also some evidence, anecdotal at present that the increased use coincided with a greater level of complexity of needs of service users.

(Data: http://ascof.hscic.gov.uk/Outcome/323/2B(1))

e. Dementia Diagnosis rate

This locally selected measure had a target of 67% of the expected prevalence of dementia (number of people in Lancashire) receiving a diagnosis of dementia as recorded on QOF (Quality and Outcomes Framework) Dementia register.

This was against a 65.7% actual in 2014/15 and 2013/14 baseline of 55%.

2015/16 performance was 67.4%.

(Data source: http://www.hscic.gov.uk/catalogue/PUB15696)

f. Patient Satisfaction

The latest measure of this is the data from January 2016 that shows that 9.1% of people when asked: "*In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?"* answered "no". This then supported the assumption that the remainder i.e. 90.9% felt that they had received enough support. The target for this of 9.3% was exceeded. The next reporting date for this measure is July 2016.

3. Assessing progress

To give an insight into the overall progress of the BCF the individuals nearest to delivery of BCF schemes, the scheme leads, were asked to translate their overview and experience into an assessment of:

- scheme development
- delivery of scheme outputs
- and an estimate of impact on BCF metrics

This is expressed in a RAG…Red…Amber…Green rating as below.

Scheme development

- **Green = Advanced development**
- **Amber = Good progress**
- **Red = Early in development**

Delivery of outputs

- **Green = Good delivery**
- **Amber = Moderate delivery**
- **Red = low level of delivery**

Impact on BCF metrics

- **Green = High impact**
- **Amber = Moderate impact**
- **Red = low level of impact**

The chart below set out the overall position

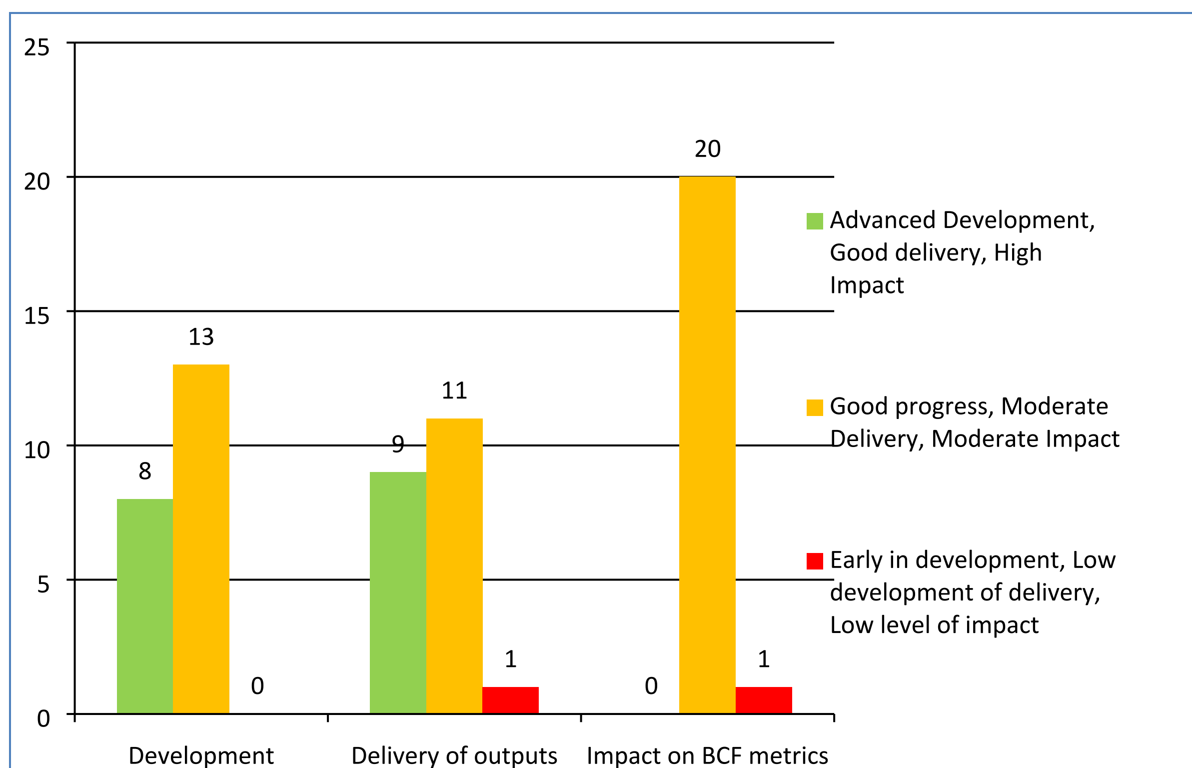


Table 1

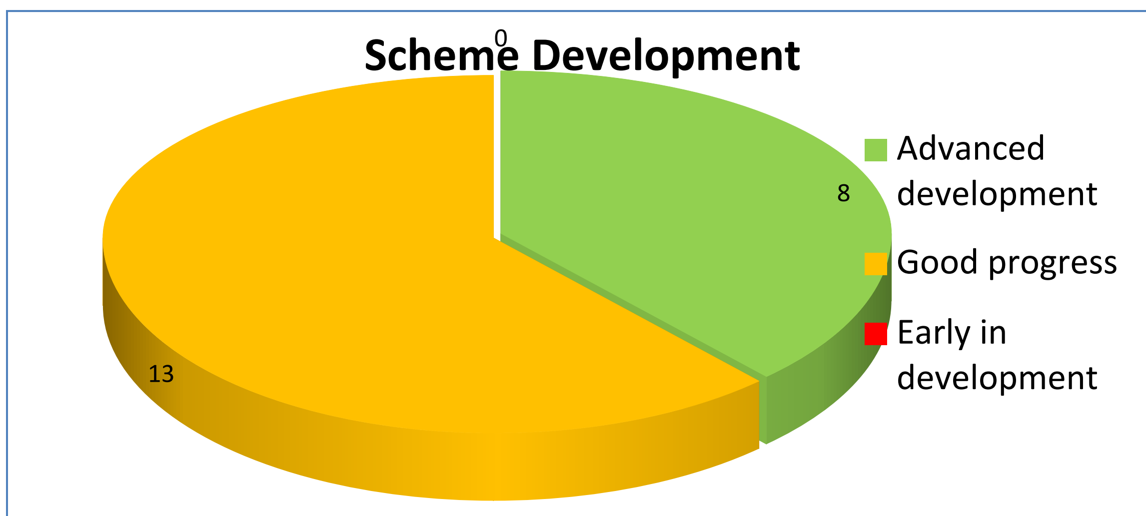


Chart 2

All schemes have developed during 2015/16 with over a 1/3rd in advanced development. The split between advanced and good progress, 38% to 62% shows the differing pace of development across the BCF and can be linked to the starting point of the scheme development, the complexity of planned service and external local factors such as availability of suitable providers.

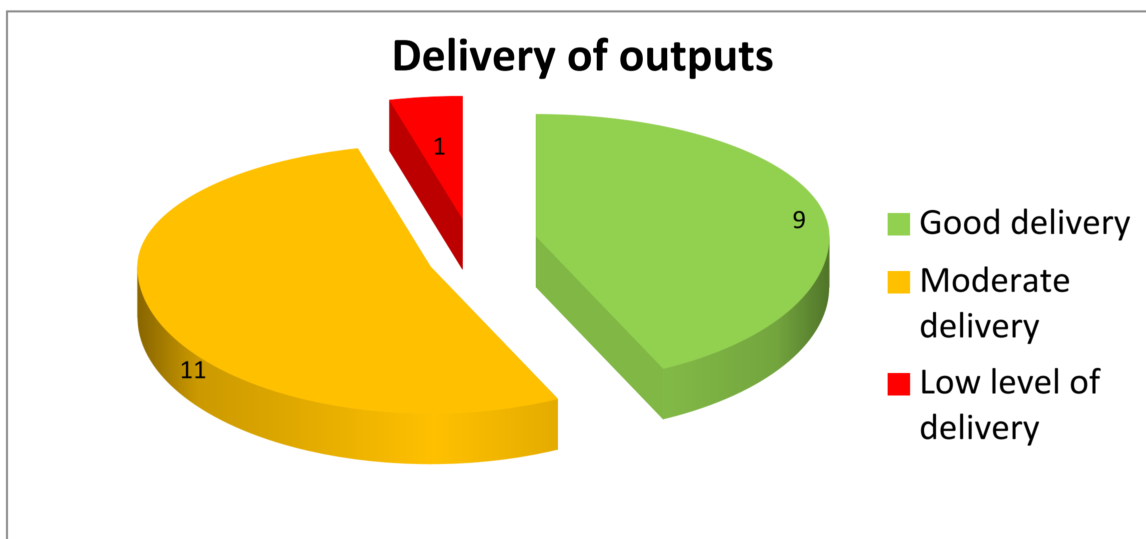


Chart 3

The level of delivery of outputs for the schemes activity to deliver their core services, has grown during the year with good delivery approaching 50% and only one scheme showing a low level of delivery. The delivery of this scheme, Extra Care Housing, has been compromised by changes in national funding arrangements rather than any BCF or organisational related inertia. Except for that one scheme all others are delivering some degree of planned outputs at moderate level or above.

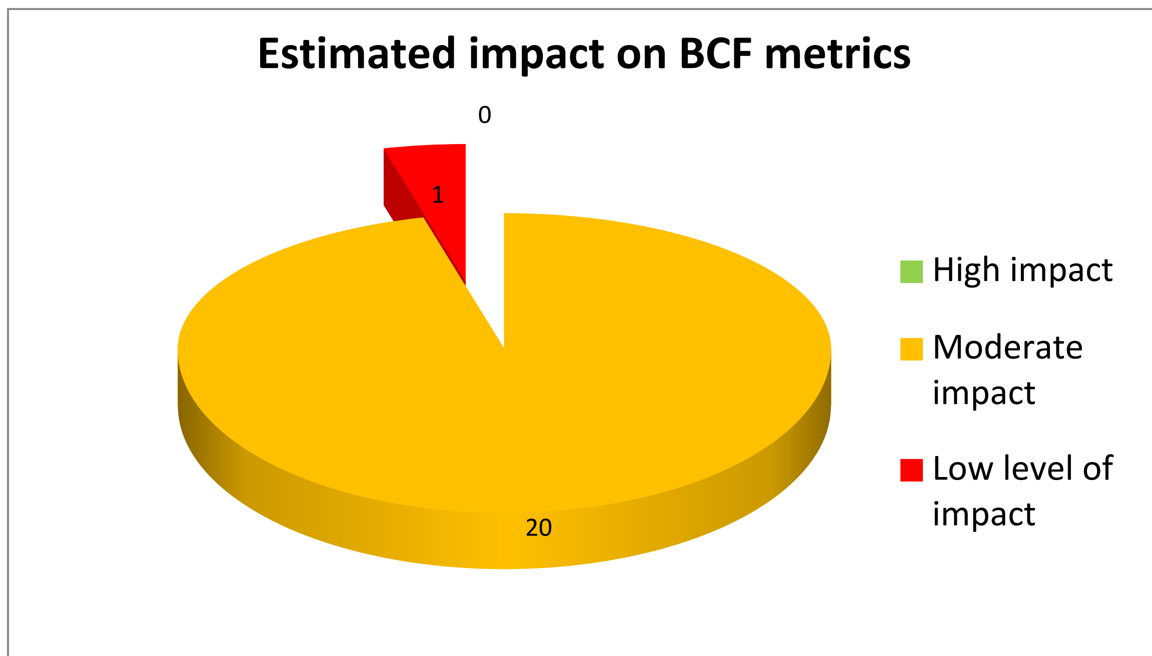


Chart 4

The absence of any scheme indicating a high impact on BCF metrics reflects the difficulty in making the direct connection between scheme activity and overall impact rather than a lack of belief in the scheme effectiveness. The original assumptions of impact for each scheme were based upon informed estimates of the links between inputs, outputs and quantified effect.

4. Making the connection between Better Care Fund Plan and its impact

The schemes within the Better Care Fund Plan were selected and designed as a result of their planned impact upon the aims of the Better Care Fund. This was based upon an evidence base for each, included in the plan that included for example: UK and international exemplars and research, local context and experience, peer experience, international best practice etc. etc. The evidence base also drove assumptions about the impact that schemes could have and the likely outcomes.

The planned impact, against the prescribed metrics of the 21 schemes, brought together at CCG /LA level, within the 2015/16 BCF plan was:

	Residential Admissions	Reablement	Delayed Transfers of Care	Non Elective Admissions
Scheme Footprint	Reductions	Improvement	Reductions	Reductions
East Lancashire	-10	0	-384	-778
Fylde and Wyre	0	0	-64	-345
GP / SR&C	-10	6	0	-1386
Lancashire CC	-43	15	-182	-680
Lancashire North	0	0	-134	-241
Pan Lancashire	0	0	-114	-533
West Lancashire	0	0	0	-276
Total	**-63**	**21**	**-878**	**-4239**
Unit costs £s	2,575	3,596	285	1,490
Savings £s	**162,225**	**75,516**	**250,230**	**6,316,110**
Total savings £s	**6,804,081**			

In addition to showing the quantified impact the table also makes the link to the unit cost of the anticipated “avoided” intervention / support and hence potential savings to the system. The values do take into account the cost of any alternative intervention / support and are adjusted to give a full year value.

If the above is compared with actual performance:

	Residential Admissions	Reablement	Delayed Transfers of Care	Non Elective Admissions
Scheme Footprint	Reductions	Improvement	Reductions	Reductions
Total	**-113**	**35**	**4447**	**-1662**
Unit costs £s	2,575	3,596	285	1,490
Savings £s	**290,975**	**125,860**	**-1,267,395**	**2,476,380**
Total savings £s	**1,625,820**			

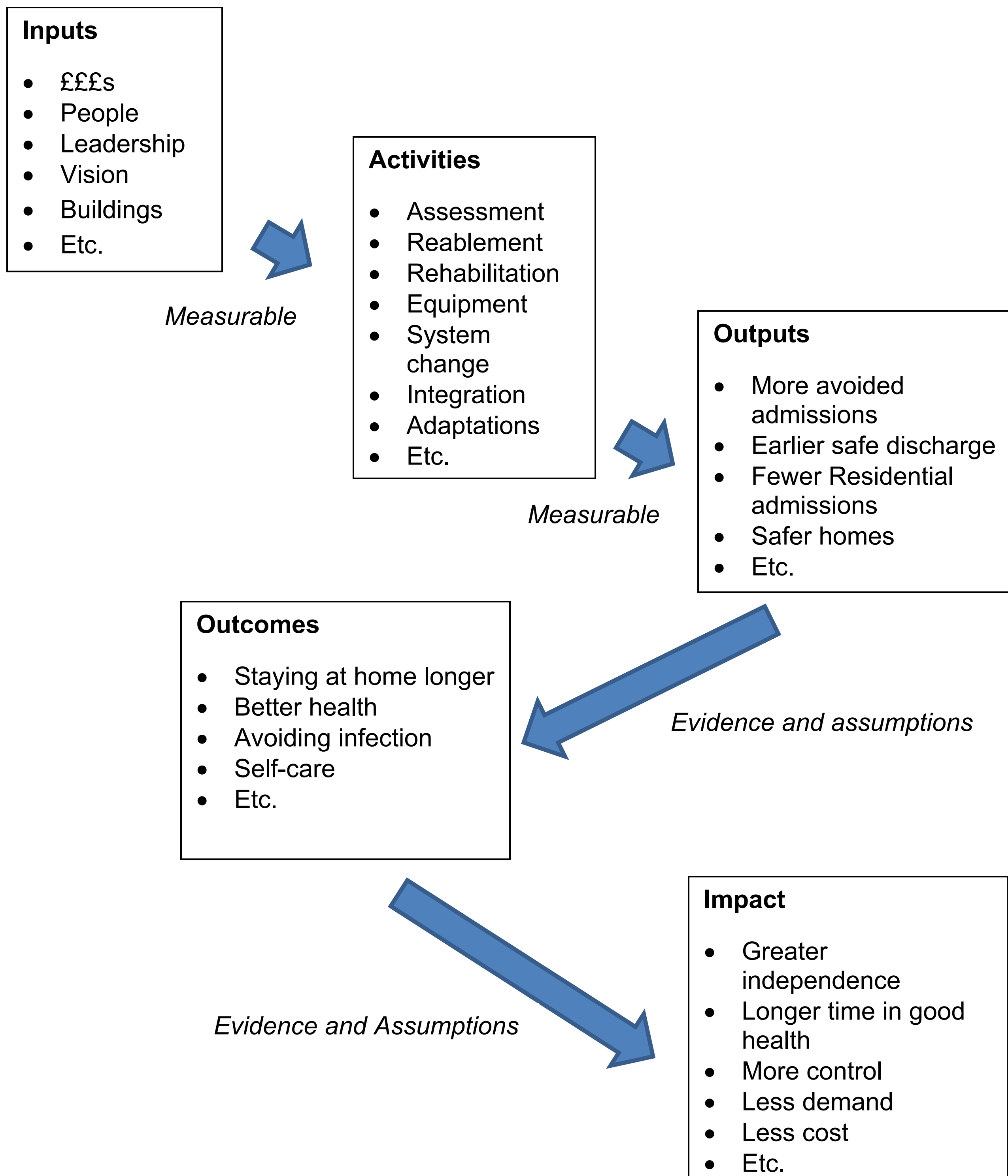
While this appears to demonstrate a reduced level of saving it does not take account of the other factors that have impacted during this period especially the recognised increase in demand and complexity of need. Making a direct, sole, connection would arguably underplay the level of financial savings made through BCF scheme activity.

Perhaps more importantly it does also not give the human dimension of the outcomes for individuals. Assumptions can be made about the impact, and the evidence base supports these, but the above metrics need to be enhanced through the inclusion of more immediate patient experience input and feedback alongside meaningful proxy measures that have a closer link to the actual activity.

5. Developing evaluation

a. Logic modelling

The basis for the evaluation of the BCF, beyond what has been described above, will be the use of Logic modelling. This avoids the complication of attempting to factor in all system variables while providing a connection between the BCF activity and the desired change. For BCF schemes this means:



Each BCF scheme is creating its own model of the above so that each step is clear in terms of what is measured and what is assumed based upon evidence. From that a baseline of each stage is established that is clear on what is to be measured and what assumptions will be made and why.

Through improving systems to measure and record activity a more accurate picture of outcomes and impact will be available.

Each scheme model will be subject to critical review of the BCF programme management team with measuring and recording systems and the assumptions being made tested. This will not only ensure that each is sufficiently robust but also will achieve a common approach across all six CCGs and Lancashire County Council so that comparison can be made across schemes.

b. Proxy measures

It is important that the success of BCF schemes is not only based on a theoretical approach but also on real experience and individual outcomes.

A small suite of proxy measures is being developed initially at scheme level to be able to give the human feel to evaluation. BCF programme managers are currently reviewing what is already in use locally and how this can be used for the BCF.

6. Conclusions

This evaluation has been carried out at a high level so as to better understand the complexities and challenges of the BCF programme and to support the development of an evaluation framework.

a. Performance

The evaluation shows that there has been mixed success when measured against the BCF metrics in 2015/16.

The low performance on NEAs and DTOC appears to be due to a range of factors, many common across the country and linked to higher level of demand and complexity of need. Performance has been better than the national picture.

The position regarding both residential admissions and the effectiveness of reablement is positive indicating that there is an impact on support for the most vulnerable and that diversion from long term care is working.

The dementia diagnosis rate good level of performance is in line with aspirations and priority given to it across the county and the patient satisfaction level shows an overall increasing level of satisfaction despite the challenges in the system.

b. Savings

The tables in section indicate an expected level of saving in 2015/16 of £6,804,081 and an “actual”, £1,625,820 based upon the performance against BCF metrics. A more accurate view will be available through the use of the logic modelling approach as described in section 5 when robust assumptions on impact and related costs are built in.

c. Scheme progress

The high level assessment of scheme related development, delivery and impact gives a positive, if measured, view of the overall progress of the BCF in 2015/16.

There is a significant advanced level for both development and delivery with the remainder being at good / moderate so all have moved on in 2015/16.

The “moderate” view expressed for the impact assessment is based on the Scheme leads need to have the confidence through access to the right tools and information to make that link.

d. Evaluation

There is an overall indication of significant progress and in terms of the metrics some challenges requiring wider analysis.

To fill the gap in understanding the impact of the BCF, there is a need for a consistent robust, yet simple, evaluation framework.

Connecting activity to actual performance as set out in section 5 will give an assessment of assumptions made, clarify cause and effect relationships and grow an in depth understanding of how each scheme is intended to deliver results.

The need to continue to develop evaluation techniques is not unique to Lancashire. The Kings Fund has pointed out this in BCF evaluation nationally and the National Audit Office reflects on the time that it can take for any evaluation to identify impact:

"*While projects can be appraised before implementation it takes time for their impact to be established in practice, so there needs to be a strong commitment to monitoring and evaluation over the long term*" (NAO report; *Case Study on integration: Measuring the costs and benefits of Whole-Place Community Budgets*)

7. Recommendations

A robust evaluation framework for the Lancashire Better Care Fund is being created. All BCF partners are involved in this development and will sign off the end product so as to ensure that it aligns with individual organisational evaluation processes.

The framework will include the reporting requirements to Lancashire Health and Wellbeing Board, the BCF steering group and NHS England.

Given its common use, and recognised value, in NHS planning and evaluation e.g. in the new care model vanguards the evaluation framework is based around Logic modelling. It will also retain the monitoring of high level performance and overall progress of scheme development and delivery. In addition it will be given a more human and real time aspect through the inclusion of proxy measures.

So as to give the required level view of impact logic models will be created for each scheme and the BCF plan overall.

Once in place the evaluation framework will be used to report on BCF plan progress. The first report will also provide an update for the approach taken in this evaluation.

The BCF evaluation reporting timing will align with Lancashire Health and Wellbeing Board meeting timetable and NHS England quarterly submissions.

Sharing learning on BCF evaluation and undertaking joint evaluation is being explored with Blackburn with Darwen and Blackpool. This will support the alignment of evaluation methods with those of the Lancashire and South Cumbria Change and STP programmes.

NHS England has allocated £24,000 to Lancashire BCF from its Local Integration Support Fund to enhance the evaluation process and share learning from it. The intention is to use local academic expertise on this detail of which will be shared once confirmed.

It is recommended that all partners to the Lancashire Better Care Fund support the approach being taken and to be further developed as described above.